SSM - Health Systems 6 (2026) 100179

Contents lists available at ScienceDirect

SSM - Health Systems

journal homepage: www.sciencedirect.com/journal/ssm-health-systems

International Monetary Fund and World Bank influence on domestic health financing sources: A mixed-methods case study of Senegal

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A B S T R A C T

Background: International Monetary Fund (IMF) and World Bank (WB) influence on domestic health financing has been heavily debated. In this debate, in-depth country case studies are lacking. We conducted a mixed-methods case study of IMF and WB policy recommendations and conditionality in Senegal to better understand their influence on the mix of domestic health financing sources at the country level.
Methods: We performed a purposive document review of reports from IMF, WB and government websites and academic literature from 1966 to 2024, semi-structured interviews between October 2019 and January 2020 with 25 key informants, and descriptive quantitative analysis of health financing sources from 2000 to 2022.
Results: Before 2002, IMF/WB policy recommendations and conditionalities promoted public sector austerity, health sector user fees, hospital autonomisation and private health service delivery. After 2002, more targets and safeguards were introduced to protect and increase government health spending within general public sector austerity, expand community-based health insurance, while still building the role of the private health sector. These efforts failed to achieve real-term increases in domestic government health spending between 2006 and 2019, and user fees have prevailed.
Conclusions: Instead of broad social sector spending floors at 40 % of government expenditure, a specific health expenditure floor at 10–15 % of government expenditure could support progress toward the Abuja pledge. Other policy options include a relaxation of general fiscal austerity measures and improved terms of lending to support expansion of government health spending, provided this sector receives government priority. We encourage further in-depth country-level studies into IMF/WB influence on domestic health financing.

1. Introduction

All loans provided by external official creditors have different terms of lending. Unlike other creditors, loans from the International Monetary Fund (IMF) and the World Bank (WB) are offered under programs with a range of macroeconomic and fiscal policy recommendations and conditionalities in addition to requirements for repayment. These have historically involved measures of fiscal consolidation, decentralization, privatization and trade liberalization, which can also affect domestic health financing. We focus on these two creditors because of their privileged and extensive role as the main global actors in macrofiscal policymaking historically across the Global South (Kentikelenis and Stubbs, 2023; Millet and Toussaint, 2004; Cornia et al., 1987) and the reported influence on health financing (Kingston, 2011; Akazili et al., 2017; Mhazo and Maponga, 2022; Stubbs et al., 2017; Ooms and Schrecker, 2005; Center for Global Development, 2007; Brunswijck, 2018; Stuckler and Basu, 2009, 2013; Abocejo, 2014; Isiani et al., 2021; Meurs et al., 2019; Birn et al., 2016; Stubbs and Kentikelenis, 2017; Ochs, 2017) including in Senegal (Foley, 2010). These organisations have distinct mandates: IMF ensuring macroeconomic stability, and the

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https://doi.org/10.1016/j.ssmhs.2026.100179
Received 12 May 2025; Received in revised form 30 November 2025; Accepted 20 January 2026
Available online 22 January 2026
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WB promoting social and economic development (IMF, 2020a, 2024; International Development Association, 2024; International Bank for Reconstruction and Development, 2024). We therefore discuss their influence individually and comparatively as appropriate.

IMF/WB loan conditionalities were associated with the introduction of user fees for health services in the 1980's and 1990's across several Sub-Saharan African (SSA) countries (Kingston, 2011; Akazili et al., 2017; Mhazo and Maponga, 2022; Okuonzi and Macrae, 1995; Kusi-Ampofo et al., 2015). Policy recommendations and conditionalities of austerity such as public spending cuts, containing the wage bill, and privatization of public entities from the IMF have been criticized for leading to constrained government health spending (Kingston, 2011; Stubbs et al., 2017; Ooms and Schrecker, 2005; Center for Global Development, 2007; Brunswijck, 2018; Stuckler and Basu, 2009, 2013; Abocejo, 2014; Isiani et al., 2021; Meurs et al., 2019; Birn et al., 2016; Stubbs and Kentikelenis, 2017; Foley, 2010; Wemos, 2024), including in Senegal (Foley, 2010). However, the IMF and WB have conversely claimed that government health spending is protected from austerity measures, and even increased in IMF Structural Adjustment Programme (SAP) countries compared to non-adjusting countries (Clements et al., 2013; Gupta, 2017; Martin and Segura-Ubiergo, 2004; van der Gaag and Barham, 1998; Thomas, 2006). Other researchers have reported findings that align with those of the IMF/WB across Low- and Middle-Income Countries (LMICs) (Daoud and Reinsberg, 2019), SSA Low-Income Countries (LICs) though not for non-SSA LICs (Kentikelenis et al., 2015), and in Ghana (Boachie et al., 2022).

The literature discussing IMF/WB policy for the health sector in Senegal includes reviews and analyses of Universal Health Coverage (UHC) policy in Senegal (Paul et al., 2019, 2020); commentaries and grey literature analysing WB promotion of Community-Based Health Insurance (CBHI, in Senegal named *Mutuelles*) and Performance-Based Financing (PBF) in Senegal (Caffin, 2018; Ridde et al., 2024a; Deville, 2018; Paul et al., 2018); analyses of HIV, TB and malaria policy in Senegal (Eboko, 2015, 2005; Eboko et al., 2015); and an ethnography of the political economy of health as experienced by participants in Saint Louis (Foley, 2010).

While essential contributions to our understanding of each of these respective issues, much of the identified literature both from Senegal and elsewhere tends to offer rather blanket critiques of the IMF/WB focusing on the era of SAPs in the 1980's and 1990's or specific allocation policies such as PBF, with limited or absent documentation from IMF/WB policy documents or lending agreements. Only one of the identified studies has systematically investigated IMF policy documents in Senegal from a health sector perspective, briefly describing IMF documents for Senegal from 2004 and 2005 among data from 15 other SSA countries (Stubbs et al., 2017). We identified no country case studies, in Senegal or elsewhere, providing a systematic, historical interrogation of IMF/WB policy documents and lending agreements from a health financing perspective. Neither did we identify any studies interviewing key informants about their experiences with IMF/WB policy recommendations and conditionalities pertaining to health financing sources in their country. Conducting this type of empirical investigation is essential to critically assess the validity of criticisms and defense on either side from a country perspective, and offer nuance and substance to an often heated debate about the role of the International Financial Institutions (IFIs) in health financing, with great informational value and policy relevance for stakeholders in health financing, both in Senegal and elsewhere.

Our study aims to understand the influence of IMF and WB policy recommendations and loan conditionalities on the mix of domestic health financing sources at the country level through an in-depth mixed-methods case study of Senegal. To help provide a more complete and accurate representation of IMF/WB influence in Senegal, we also review their loans that have directly benefited the health sector in Senegal.

2. Methods

2.1. Economic concepts and hypotheses

External official loans from the IMF/WB come with associated policy recommendations, targets and objectives, as well as binding and non-binding conditionalities. IMF policy advice and loan conditionalities generally pertain to the central and structural levels such as balance of payments, fiscal deficit, tax revenue, public financial management, etc. (IMF, 2023b). These factors co-determine a government's ability to finance its different sectors, the balance between the public and private sector, and how the government will prioritise its resources to ensure it meets IMF requirements. WB policy advice and loan conditionalities may target the central and the sectoral level, including project-level advice (World Bank, 2023a), thereby affecting government policy at all system levels.

From the perspective of the health sector, these external influences could help determine how much of the government budget is allocated to the health sector. If IMF/WB policy recommendations and conditionalities conversely expand the role of the private health sector, this might lead to a similar expansion of private health insurance and user fees to pay for private health services. Together, this affects the balance between the main domestic health financing sources: government health spending from domestic revenue (Government Health Expenditure as a Source (GHE-S)), health insurance payments and Out-Of-Pocket payments (OOP). This balance in turn affects the overall degree of equity in the mix of domestic health financing sources by influencing to what extent funds are contributed progressively in accordance with ability to pay, are prepaid and pooled, which in turn affects health service access for the poor and associated health outcomes (Ataguba et al., 2018; Makinen et al., 2000; Xu et al., 2007; WHO, 2010; Chuma and Okungu, 2011; Moreno-Serra and Smith, 2011, 2015; Qin et al., 2018; Martinez-Alvarez et al., 2020).

For a glossary of the debt-related abbreviations used in this paper, please see the Online Appendix.

2.2. Study setting

Senegal is a Francophone West African country with a population of approximately 18 million (Agence nationale de la statistique et de la demographie, 2023). It had a Gross Domestic Product (GDP) per capita of $1706 in 2023 and is classified as a Lower Middle-income Country (LMC) (World Bank, 2025). Senegal has seen major improvements in health outcomes over time (Fig. 1). Total life expectancy has improved from 40 years in 1960 to 69 years in 2023 (World Bank, 2025). Over the same time period, the Infant Mortality Rate (IMR) has dropped from 126 to 30 deaths per 1000 live births, and the Under-5 Mortality Rate (U5MR) from 293 to 93 deaths per 1000 live births (UN Inter-agency Group for Child Mortality Estimation, 2025).

As seen in Fig. 2, OOP expenditure in Senegal is higher than other sources and growing, reaching US$549 million in 2022 (WHO, 2024). Except for a temporary spike during the Covid-19 pandemic, GHE-S has not increased in real terms between 2006 and 2022 (247 vs. 248 million constant 2022 US$) (WHO, 2024). External health financing has become increasingly predominant (US$239 million in 2022), with Social Health Insurance (SHI) and voluntary prepayments to CBHI and private health insurance schemes both increasing though at much lower levels (WHO, 2024).

2.3. Study design

This study was a mixed methods case study consisting of a purposive document review and analysis, thematic analysis of key informant interviews, and descriptive quantitative data analysis. This mix of methods were used to gain both a thorough factual understanding of the research question, including by cross-checking information between

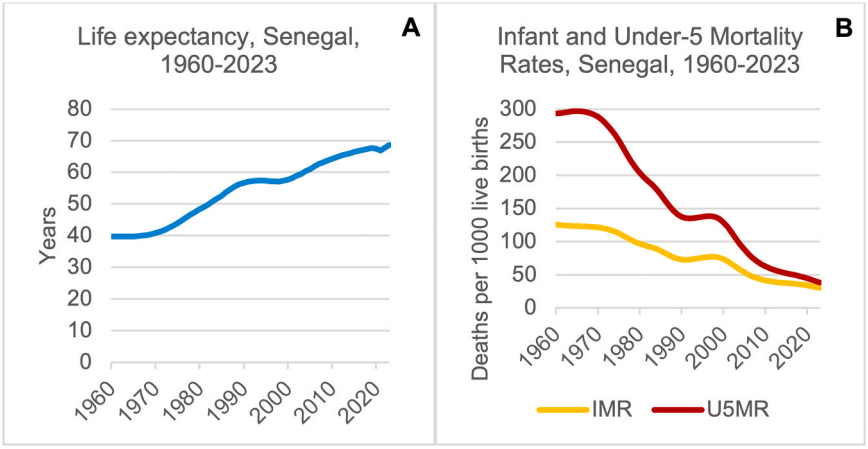

Fig. 1. Panel A: Total life expectancy at birth in Senegal, 1960–2023 (World Bank, 2025). Panel B: Infant Mortality Rate (IMR) and Under-5 Mortality Rate (U5MR) in Senegal, 1960–2023 (UN Inter-agency Group for Child Mortality Estimation, 2025).

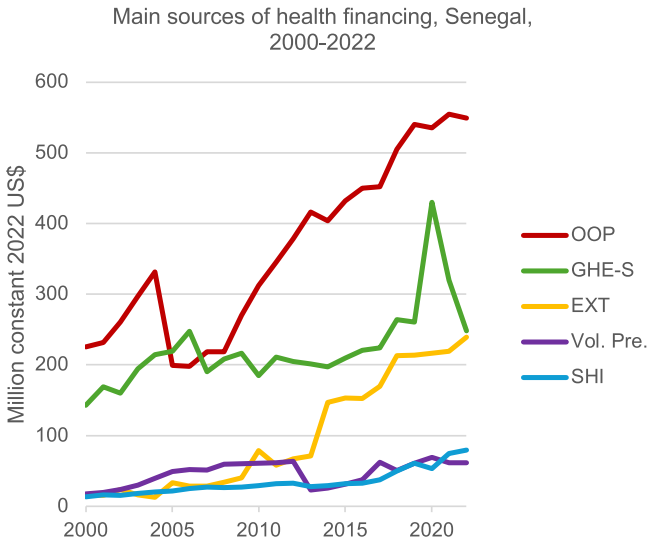

Fig. 2. Health financing by source in Senegal from 2000 to 2022 (million constant 2022 US$) (WHO, 2024). OOP: Out Of Pocket payments. GHE-S: Government Health Expenditure as a Source. EXT: External health financing. Vol. pre: Voluntary prepayments, which include both voluntary contributions to Community-Based Health Insurance (CBHI) and private health insurance schemes. SHI: Social Health Insurance (government transfers to SHI deducted). Numbers do not include capital health expenditures.

sources, while also reaching a deeper and more comprehensive analytical understanding, exploring problems of a qualitative nature, eliciting possible explanations for observations made and generating more nuanced policy conclusions (O'Cathain et al., 2007; Greene et al., 2016).

We considered the following as evidence of IMF/WB influence on domestic health financing sources. A: Written documentation of IMF/WB policy recommendations, targets, objectives or conditionalities directly pertaining to domestic health financing sources, or B: statements from interviewees identifying an influence of the IMF/WB on domestic health financing sources. We triangulated these sources of evidence against national health financing data to critically assess the scale of described health financing impacts.

2.3.1. *Purposive document review*

We reviewed IMF (IMF, 2023d, 2023c), WB (World Bank, 2023b) and Senegalese government websites (Agence nationale de la statistique et de la demographie, 2024; Ministère de l'Economie du Plan et de la Coopération, 2023; Ministère des Finances et du Budget, 2023a, 2023b; Agence de la Couverture Maladie Universelle, 2024; Ministère de la Santé et de l'Action Sociale, 2024) to identify key documents that contained information on IMF/WB loans to the health sector, economic policy discussions, recommendations and loan conditionalities (215 full text documents reviewed).[1] We also used the London School of Hygiene & Tropical Medicine (LSHTM) Discover platform and Google Scholar to search all academic publishing databases and collections, including PubMed, Embase, CINAHL, Cochrane, EconLit, Scopus and Web of Science, for academic literature describing loan-associated policy recommendations/conditionalities in Senegal, both health-specific and not (search strings available in appendix). 11 academic articles were identified for full-text review. From the identified loan agreements, reports and articles, we included and summarised A: the main IMF and WB policy and lending programmes in place, and B: all WB project-level loan agreements to the health sector, in Table 3 (Online Appendix). We did not apply any time period constraint to the document review. This was done to allow for a better understanding of how historical and more recent IMF/WB influence have helped shape health payment patterns in Senegal.

From included documents, we extracted the year an IMF/WB instrument or arrangement was instituted, amount borrowed under instrument/arrangement, loan duration, the main purpose and policy content, including policy recommendations, targets, objectives and binding and non-binding loan conditionalities directly relevant to domestic health financing sources (GHE-S, health insurance payments and OOP). Direct relevance to health financing was defined as a recommendation/ conditionality *directly* pertaining to the levels and balance of the different domestic health financing sources and coverage of health financing schemes, and not working only indirectly through various upstream mechanisms. Documents were collected before, during and after conducting interviews in-country in Senegal, up until July 2024.

2.3.2. *Interviews*

Using stakeholder mapping, we first purposively identified relevant bilateral and multilateral partner representatives, government ministry/agency representatives, civil society leaders, academics and hospital management staff, to obtain views from both individuals centrally placed in policy processes as well as outside observers and analysts. We then used snowball sampling to identify additional key stakeholders from these groups. Participants were included based on their perceived

[1] Main policy programme documents and accompanying loan agreements reviewed. Individual WB development project loan agreement documents for non-health sectoral loans were not reviewed, while health sector specific loan agreements were reviewed.

Table 1
Interview participants.

Stakeholder group	Number of participants
Bilateral partners	4
Multilateral partners*	4
Central government*	9
Hospital management	1
Civil Society Organisations	4
Academics	3
Total interviews	25

**Multilateral partners included participants from the IMF and WB. Central government participants came from four different ministries.*

likelihood of being knowledgeable on health financing policy in Senegal, including the historical political economy and contents of health financing reforms as they had evolved over time. We identified 32 key stakeholders of which 25 agreed to participate. Our sampling criteria resulted in our final sample consisting of senior officials, senior technical staff, leaders/directors and academics, with a deep level of insight and involvement in current and historical Senegalese health financing policy.

We conducted interviews in Dakar between September 2019 - January 2020. Our final sample of included participants is presented in Table 1.

The interview method used was Semi-Structured Interviews (SSIs). This interview method was chosen to enable an in-depth, qualitative exploration of the research topic, pursuing the specific knowledge areas and expertise of each interviewee through open-ended questions (145). We maintained the same overall interview topics[2] and key questions for all interviewees to enable valid comparison across stakeholders, while also tailoring some questions to better fit the interviewee's expertise as relevant. We obtained informed consent for interview from all participants. The supplementary interview materials used (information sheet, informed consent form and an example interview guide) are available in the Online Appendix and the online LSHTM data repository (London School of Hygiene and Tropical Medicine, 2025).

Interviews were conducted in either French or English, with an interpreter used for the interviews conducted in French. Interviews were recorded where consent for this was given. Interview recordings were transcribed by a professional transcriptionist. All interviewee statements were reported anonymously.

We used the Framework method to analyse interview data (Ritchie and Spencer, 1994). The thematic framework used was validated by an independent researcher, agreed upon by the co-authors, and used to code all interview data. Interview data were coded using NVivo 12 (QSR International Pty Ltd, 2020). Data summaries and key quotations for each theme were written under each interviewee in a spreadsheet, or Framework "matrix" (Ritchie and Spencer, 1994; Ward et al., 2013), in Microsoft Excel (Microsoft, 2024). The final Framework matrix was then examined for emerging patterns which are described in corresponding results sections.

2.3.3. Quantitative data analysis

We performed a descriptive analysis of quantitative data from the World Health Organisation (WHO) Global Health Expenditure Database on GHE-S, External health financing (EXT), OOP, Voluntary Health Insurance (VHI) and Social Health Insurance (SHI) (WHO, 2024). These data were available from 2000 to 2022. We presented the data in constant 2022 US$ as directly available from the WHO website. We also performed a descriptive analysis of these key health financing sources as available in 1981 and 1989 from a 1993 WB public expenditure review (World Bank, 1993c). We used these data to provide contextual background on the study setting, examining levels and trends over time to understand IMF/WB prescriptions in relation to existing health financing payment patters, and to gain an impression of the scale of influence – or lack thereof – from the IMF/WB on the different main domestic health financing sources.

[2] Overarching topics: Stakeholder views and priorities for health sector financing in Senegal; external development partner influence on public health budget, health sector implications of loans, debt repayments and IMF/WB programs and loan conditionalities. Please see online appendix for further details.

3. Results

3.1. IMF/WB policy recommendations and conditionalities for health financing

We approach this section historically, because a key finding was that both IMF and WB health financing policy recommendations and conditionalities in Senegal evolved over time. This was especially the case for the WB from the launch of Senegal's Poverty Reduction Strategy Papers (PRSPs) in 2002 and onward.

Throughout Senegal's history of engagement with the International Financial Institutions (IFIs), policy recommendations, targets, objectives, and loan conditionalities from the IMF/WB have included austerity measures working to balance the government's books by increasing revenue and controlling public spending. This has had a double-sided influence on the overall scope for government health spending. In the 1980's and 1990's, the IMF/WB promoted user fees, hospital autonomisation and private health service delivery, along with increased government health spending. Especially after 2002, an increasing number of targets and safeguards were put in place from the IMF/WB to protect and increase government health spending, accompanied by a mixed health financing approach from the WB, expanding Community-Based Health Insurance (CBHI) while building the role of the private health sector. IMF/WB efforts have however failed to achieve real-term increases in GHE-S between 2006 and 2019, and OOP has prevailed. Our findings pointed to lingering IMF/WB policy influence from the 1980's and 90's as a possible explanation for this, as well as government priority of economic growth before investing in the health sector.

A government official explained how an evolution in IMF conditionalities had occurred:

> *"The conditionalities have evolved a lot since the 80's … Now it's the benchmarks … This question of human capital … The monetary fund took it up because of the criticism that was made of the adjustment programs of the 80's and 90's"* (Government)

A CSO representative concurred for both IFIs:

> *"Our relations with the World Bank … and IMF have evolved much … The IMF come just to see if the macroeconomic framework really respects basic principles… For the World Bank* [their role] *is more to support priority development programmes … The World Bank had led the government not to finance social sectors, whereas now we have seen that the World Bank supports certain health initiatives."* (CSO)

A donor representative explained that while the WB had evolved toward prioritising investing in human capital through social spending, there was still a belief within the government that economic growth through investments in productive sectors and industries was more important:

> *"There still is that belief that first economic growth with investment. Productivity, industries, and that investing in people is nice to have when … you can afford it. And even though that's changing a little, and we see that change from the World Bank, still it's here… I would not be surprised if within the government in Senegal, some people believe that investing in people is a waste of money… So they cut social spending."* (Donor)

3.1.1. IMF/WB influence on health financing sources before year 2002

3.1.1.1. 1966–1995: Structural adjustment, austerity and health cost sharing. Table 3 (Appendix) provides a detailed historical overview of the IMF and WB arrangements and instruments in place in Senegal since 1966. Senegal first became a member country of the IMF and the WB in 1962 (IMF, 2023d; World Bank, 1989), and the country received its first loan from the WB in 1966 (World Bank, 1989; IMF, 2004). Following economic crisis in the late 1970's, Senegal's first IMF/WB Structural Adjustment Program (SAP) was initiated in 1979 (Agajelu and Aniefiok-Hanson, 2018; World Bank, 1984, 1995; IMF, 1995), and structural adjustment occurred through the 1980's and 90's (Foley, 2010; Agajelu and Aniefiok-Hanson, 2018; World Bank, 1984; IMF, 1995; Republic of Senegal, 2002; Koddenbrock, 2024). IMF/WB prescriptions were centred around public austerity, privatization, decentralization, market liberalization, stimulating growth and exports, increasing domestic revenue mobilisation and reducing the size of the civil service (Agajelu & Aniefiok-Hanson 2018; Foley 2010; IMF 1997a,1997b,1997c; Tahari et al. 1996; World Bank 1981,1984,1986, 1987c,1993b,1993c,1993d, 1995,1997b).

In the late 1970's and early 1980's, Senegal struggled with large external current account deficits, public sector deficits and high inflation rates (World Bank, 2025; Tahari et al., 1996; International Monetary Fund. Independent Evaluation Office, 2003). In the early/mid 1980's, government adherence to structural adjustment measures to stabilise the macroeconomy was however limited (Foley, 2010; World Bank, 1993c, 1993d). Between the first and second halves of the 1980's, total real current health expenditures declined by 21 % (World Bank, 1993d). This was partly explained by cumulative inflation over the decade amounting to 69 %, and scarcely by IMF/WB influence given that government compliance with their recommendations was limited (Foley, 2010; World Bank, 1993c, 1993d, 2025; Rouis, 1993). Fig. 3 shows the composition of total health financing sources in Senegal in 1981 and 1989 (World Bank, 1993d) (later years with available full data pre-Covid 19 added for comparison (WHO, 2024)). Overall little change was seen over this decade, though with a slight relative decrease in government health financing and OOP/health insurance with limited private sector and external financing expansion.

From initial nonconformity, Senegal's compliance with IMF/WB policy prescriptions increased between 1985 and 1996, particularly following a 1993 WB audit of public finances which led to a *"plan d'urgence"* to address growing economic crisis through the implementation of a range of austerity measures (Foley, 2010; World Bank, 1993c, 1993d; Rouis, 1993; Bastien, 1993). Public expenditures were cut, and while government current health spending increased from 4 % to 5.5 % of total current expenditure from 1986 to 1996, it stagnated as a percent of GDP around 0.5 % over this time period (World Bank, 1993c). In 1984, the WB had recommended for the government to consider cost sharing (i.e. user fees) before embarking on projects to improve or expand health service coverage, because the government could not expect to be able to finance the recurrent costs of such projects (World Bank, 1984). This included external project financing from themselves and other partners, limiting the overall scope for health sector investment due to a limited current health budget (World Bank, 1984).

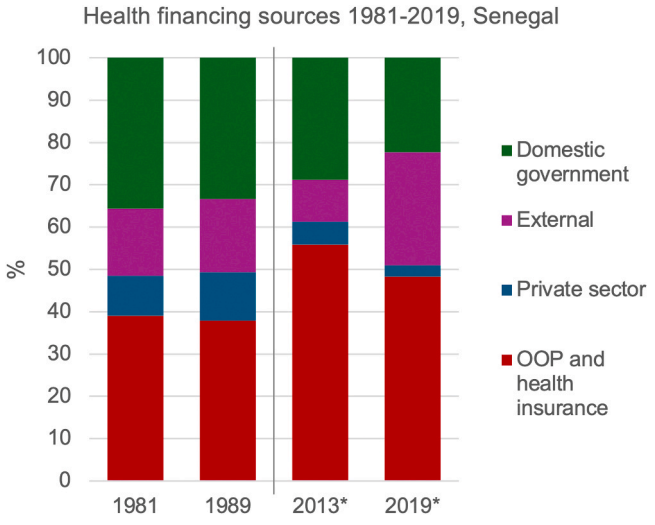

Fig. 3. Composition of total health financing sources (capital + current) in selected years with available full data between 1981 and 2019 in Senegal (WHO, 2024; World Bank, 1993d). Note: this figure combines data from two different data sources – a 1993 WB public expenditure review (1981 and 1989) (World Bank, 1993d) and the *WHO Global Health Expenditure Database (2013 and 2019) (WHO, 2024). Differences in accounting methodology necessitates a caveat when interpreting these data between sources.

Recommendations for user fees continued from the WB (World Bank, 1987b), and user fees were introduced from 1985 and onward to help pay for primary health services in the context of public sector austerity (Foley, 2010; World Bank, 1986, 1993d). This was also facilitated by the UNICEF/WHO Bamako Initiative adopted by African health ministers in 1987 and implemented in Senegal in the 1990's. The initiative involved patients paying into so-called revolving drug funds so that facilities could recover their costs, restock drugs and locally balance their finances in a decentralised fashion (Foley, 2010; World Bank, 1993b; IMF, 2013b; Keshavjee, 2014; Hanson and McPake, 1993).

A 1991 WB health project in Senegal had as an objective to "*restructure the health sector to enable it to provide improved basic health services*", which included private sector provision of family planning services (World Bank, 1991). In 1993, the WB recommended for Senegal to develop health insurance and drug cost recovery, whilst also protecting expenditure on health "*to ensure minimum efficiency of public services*" (World Bank, 1993b, 1993c). This however now came with the target of significantly increasing current health expenditure out of total government expenditure from 4.1 % in 1989/90 to 6.7 % in 1995 (World Bank, 1993c). An academic interviewee commented that:

> *"The World Bank published a document, that inspired our government which is "Investing in Health". Otherwise, the money spent in health was perceived as expenditure and not investment … When they said "investing in health", they started pushing the government to invest more money in primary health care which was good … Senegal took over from UNICEF the funding of the immunization program, which was for us a big success, started putting more money in programs like malaria".* (Academic)

This refers to the influential 1993 WB World Development Report "Investing in Health", which introduced burden of disease data and emphasized economic benefits of making health sector investments (World Bank, 1993a). This offered a new awareness and economic incentives for LMIC health planners, accompanied by recommendations for user fees (although with more cautious recommendations about circumstances in which they should be used), privatisation and decentralisation of health systems also present in the earlier 1986 report "Financing Health in Developing Countries: An Agenda for Reform" (World Bank, 1987a; Gorsky and Sirrs, 2023; Stein, 2008).

3.1.1.2. 1995–2002: Increased government health spending, mixed health insurance schemes, health cost sharing and hospital autonomisation. From 1995 up until around 2002, policy recommendations under the IMF Enhanced Structural Adjustment Facility (ESAF), Poverty Reduction and Growth Facilities (PRGF) and WB Country Assistance Strategy (CAS) focused on similar means of public sector austerity and private sector liberalisation. However there was now a new emphasis, particularly from the WB, on equity, poverty reduction, promoting the status of women, environmental and social sustainability (IMF, 2001a; 2001b; 2002; 2003; Republic of Senegal, 1998; 1999; World Bank, 1995; 1997b). IMF and WB recommendations now targeted an increase in

current budget share allocation to health from 6 % in 1996 to 9 % in 2002, though with greater use of beneficiaries (i.e. patients) and NGOs in the financing of basic health care services (World Bank, 1997b; Republic of Senegal, 1998, 1999). The IMF recommended a mixed health sector financing approach, with increased government financing emphasizing primary health care and improved access of vulnerable groups to health services, combined with decentralized cost sharing, formal sector health insurance, CBHI, and private sector health insurance (IMF, 2001b; 2002; 2003; Republic of Senegal, 1998; 1999).

In 1998, the government enacted a national hospital reform where hospitals were made autonomous and user fees for their services were introduced[3] (Caffin, 2018; Lemiere et al., 2012; Gueye and Kopp, 2009). This reform followed numerous studies and reports identifying hospital managerial issues from the WB and the French Development Agency (AFD) (Gueye and Kopp, 2009). It was described in the 1998–2000 IMF ESAF as required to achieve "*sustainable financial equilibrium and autonomous management*" of hospitals (Republic of Senegal et al., 1998). The reform was however also heavily inspired by a 1991 hospital reform in France, as well as by external consultant reports from 1996 (unpublished) (Lemiere et al., 2012). Ensuing hospital performance contracts in the 2000's signified the "*commitment of the Senegalese government to the World Bank*" (Gueye and Kopp, 2009). The product of the reform was in 2012 described by World Bank staff as: "*Senegal has virtually privatized its hospitals*" (Lemiere et al., 2012). An academic commented:

> *"The spirit of the World Bank was to tell governments: "Stop spending for the hospitals and trying to get free services at the hospital level. Let people who can pay, pay. Let people who are poor be organized in community insurance, that is the mutuals."* (Academic)

IMF/WB promotion of *Mutuelles* was corroborated in an ESAF policy framework paper from 1998 (Republic of Senegal et al., 1998). A hospital management staff member in Dakar believed that past IFI influence on the health service payment pattern in the 1990's had lingered on:

> *"… The international institutions* [mentions IMF] *encouraged the state to reform the health system. And it is this health system reform that has precisely recommended payment for healthcare by the population with financial autonomation of hospitals… Still the same rhythm of payment for population health care at their own expenses* [is there today] *… in terms of who pays there is no evolution"* (hospital management staff member).

Besides the above policy recommendations, no specific IMF/WB conditionality for health financing sources was identified until 2007 (below section).

Senegal's Heavily Indebted Poor Countries (HIPC) program launched in 2000, with debt relief criteria consisting of privatisation of public sector enterprises and liberalisation of the private sector, increased DRM, along with social objectives including increasing primary health centre utilization (IMF and World Bank, 2000, 2004).

The plateau seen in the otherwise steady improvements in life expectancy, IMR and U5MR in the 1990's (Fig. 1) was partly due to an emergence of chloroquine-resistant malaria, decreased immunisation coverage, and less so the HIV/AIDS epidemic (Delaunay et al., 2001; Garenne and Gakusi, 2005). It was beyond the scope of this study and its methodology to assess whether some of these setbacks were partly attributable to IMF/WB policy.

[3] The reform provided hospitals with a legal personality, a board of directors, rules for budgeting and financial management close to the commercial sector, and the ability to charge patients for health care services, while still receiving public subsidies (Lemiere et al., 2012).

3.1.2. IMF/WB influence on health financing sources from 2002 and onward

3.1.2.1. 2002–2010: Increased government health spending, debt relief, and mixed health insurance schemes. Starting in 2002, Senegal's PRSPs were launched. PRSPs I and II ran from 2002–2010, supported by IMF loans via the PRGF and WB International Development Association (IDA) loans and grants via Poverty Reduction Support Credits (PRSCs). These had a similarly austere fiscal policy stance as previously, but with a series of stipulations to support the health sector. This included increasing budget allocations to health, allocating HIPC funds to the health sector, improving access for vulnerable groups to health insurance schemes, expanding CBHI and formal sector health insurance mechanisms as well as the role of the private sector in health service delivery (IMF, 2004, 2005, 2006; IMF and World Bank, 2002; Republic of Senegal, 2002, 2004; World Bank, 2004, 2007a, 2007b, 2008b). They also involved subsidizing health care and establishing a health risk protection system for vulnerable groups, reducing the financial burden of payment for health services for the poor, and expanding health insurance cover for formal sector employees and dependents (IMF, 2010a; IMF and World Bank, 2007, 2008; Republic of Senegal, 2006; World Bank, 2004, 2007b, 2008a, 2008b, 2010). The overall aim was for 50 % of the population to be covered by health insurance by 2015, compared to 8 % in 2005. By 2018, Demographic and Health Survey (DHS) data estimated that only 16.5 % of the Senegalese population were covered by some type of health insurance (Agence nationale de la statistique et de la demographie, 2018), while the Senegalese government put this number at 49 % in 2017 (Ministère de la Santé et de l'Action Sociale, 2019). Accompanying conditionalities in loan agreements directly pertaining to health financing included a WB indicative trigger (non-binding) to extend a pilot of health insurance for transport and agricultural sector workers (World Bank, 2007b); and triggers (non-binding) and prior actions (binding) to prepare and implement a state financial support mechanism for health mutuals (CBHI) and supporting 50 new health mutuals (World Bank, 2010). PRSC I (2004) and II (2005) also contained triggers and prior actions (PAs) to decentralize budget execution in the health sector (World Bank, 2004, 2008b). Between 2003 and 2006, the budget execution rate for the health sector increased from 73 % to 94 % (World Bank, 2008b), which is a direct way of increasing GHE-S within the existing budgetary framework, and GHE-S did increase substantially in that time period (Fig. 2).

PRSC III (2007) had as objectives to increase state subsidy of essential drugs and services, and government-enforced stronger controls on drug tariffs, notably in remote regions (World Bank, 2007b). Prior actions (binding conditionality) under PRSC III required a harmonized tariff system to control tariffs on drugs, in order to lower the burden of payment on the poor, taking steps to expand CBHI, and establishing public subsidies for essential health services for vulnerable groups (World Bank, 2007b). It also included an indicative trigger (non-binding) requesting an extension of a pilot program providing health insurance to uninsured workers in the transport and agricultural sectors, working to increase prepaid and pooled financing for these groups, and an indicative trigger requesting enhancement of contracting with the private sector in health service delivery (World Bank, 2007b). A CSO leader was critical of IMF/WB promotion of the private sector in health due to the difficulties for poor people to pay for private health services:

> "[The World Bank and IMF], *their ideology is first to say less state. The state must reduce its market intervention and guarantee more space for the private sector…* [But] *it is not the job of the private sector to provide basic social services … to take care of those who don't have the resources to enter the market… It is to generate profits for its shareholders, and therefore … there is a risk of not having quality social services or a good geographical distribution"* (CSO).

3.1.2.2. 2010-onward: Austerity, safeguarding health spending, exemption schemes and CBHI. In the 2010's, IMF fiscal policy objectives, articulated through Policy Support Instruments (PSIs, non-financing instruments), were of a similar nature as previously, however the first social spending floor (non-binding) was introduced from 2010 at 35 % of total government spending (IMF, 2010b). This would remain until 2022 where it was increased to 40 % (IMF, 2023f). Senegal consistently met and frequently exceeded the social sector spending floors by a few percentage points. However, since 2010, the Senegalese government has spent between 21 % and 26 % of its total expenditure budget on education,[4] so it has met these floors primarily by funding the education sector (World Bank, 2025). Fiscal prudency measures were recommended by the IMF to increase fiscal space for social spending (IMF, 2015a), and frontline health workers were exempted from a wage bill freeze (IMF, 2015b).

The third IMF/WB PRSP running from 2013 to 2017 aimed to establish UHC including through health mutuals, extend free healthcare to vulnerable groups, set up a health solidarity fund, target 95 % health budget execution, and increase the health mutual scheme coverage rate to 66 % by 2017 (IMF, 2013a; IMF and World Bank, 2013). Based on DHS data, the health mutuals however had an estimated total coverage of only 5 % of the population in 2018 (Agence nationale de la statistique et de la demographie, 2018), while the Senegalese UHC Agency's own data estimated this number at 19 % in 2017 (Ministère de la Santé et de l'Action Sociale, 2019). WB conditionality gradually moved away from making stipulations for the health (and other) sectors and instead simply required that the WB IDA was satisfied with the existing development programme and macroeconomic policy framework in place (e.g. (World Bank, 2011)).

Promotion of a mixed health financing approach in PRSPs was found to align with the government's overall development strategy for the health sector (Ministère de la Santé et de l'Action Sociale, 2017, 2019; Government of Senegal, 2014).

From 2020 onward, the IMF disbursed loans via different facilities for the Covid-19 response, accompanied by a Policy Coordination Instrument (PCI) (non-financial), jointly supporting increased health spending while increasing the social spending floor to 40 % of total government spending (IMF, 2020b, 2020c, 2020d, 2021a, 2021b, 2021c, 2023a, 2023f). A temporarily increased fiscal deficit was allowed to respond to the pandemic before fiscal consolidation was again recommended in 2023 (IMF, 2023e). The WB also supported the Senegalese emergency health system response to Covid-19 and the country's UHC programme, aiming to improve its progressiveness, expand coverage, expand grants/subsidy under CBHI (*Mutuelles*) for poor and vulnerable groups, and expand maternal health vouchers (*Gratuités*) (World Bank, 2020a, 2020b, 2021, 2023c).

In spite of these policy changes over time, an academic explained that governments would still limit investments in the health sector due to the general austerity requirements from the IFIs:

> *"All the countries that work with* [the IMF and WB], *countries that are in economic difficulties, that are being asked to cut certain positions… Even if they don't cut for health, they will no longer invest in this sector."* (Academic)

3.2. IMF/WB lending for the health sector

The above influence has occurred in the context of IMF and WB lending, which can also benefit the health sector and should therefore be considered when their health financing policy influence is discussed.

Since Senegal became a member country of the WB, our review identified WB project lending for the health sector to the areas of health systems strengthening; family planning; infectious disease control; results-based financing for health and nutrition; establishing and expanding exemption schemes and CBHI; improving utilization of reproductive, maternal, neonatal, child and adolescent health and nutrition, and more (World Bank, 1983, 1991, 1997a, 2002, 2014, 2020b, 2021; Ministère des Finances et du Budget, 2021).[5]

As for the IMF, except for the case of supporting the country's Covid-19 response, IMF lending did not directly target the health sector but was instead disbursed to address balance of payment issues and support the general adjustment policy programmes in the country (Table 3, Appendix).

4. Discussion

In this study we aimed to explore how IMF and WB policy recommendations and loan conditionalities have influenced the mix of domestic health financing sources in Senegal. We found that this influence had gone through different phases:

The 1980's and '90's were characterized by IMF/WB austerity prescriptions, user fee promotion, and promotion of hospital autonomisation and private health service delivery, though also with recommendations to increase government health spending. Our findings lent support to the hypothesis that some of the prevailing issues with relatively low progressivity in the mix of health financing sources in Senegal in part stem from IMF/WB influence from this era, in spite of an ensuing evolution in policy stance, particularly from the WB.

The 2000's were characterized by ongoing IMF fiscal austerity measures though with a series of measures to support the health sector, increasingly progressive health financing policy influence from the WB, IMF/WB-promoted CBHI expansion, and growing GHE-S in the first half of the decade followed by real-term stagnation. WB binding conditionality for decentralization of health sector budget execution in 2004–05 led to strong increases in health budget execution rates (World Bank, 2004, 2008b). These efficiency gains accompanied by PRSP stipulations for increased government health spending, including through allocation of HIPC debt relief funds to the health sector, supported significant real-term increases seen in GHE-S between 2004 and 2006.

The 2010's saw a series of policy recommendations and conditionalities from the IMF to protect and increase government social and health spending, and increasingly progressive WB health financing policy influence. In spite of this, no real-term gains were seen in GHE-S, and OOP prevailed. In 2020, a temporary increase in GHE-S was seen to respond to Covid-19, which was fully reverted by 2022.

While IMF policies to some extent and especially WB policies pertaining to health financing have evolved over the past two decades, it seems they have been somewhat ineffective in transforming the health payment patterns in Senegal. Government priority of profitable investments and economic growth as well as ongoing austerity measures and lingering influence from IMF/WB-promoted health system reforms in the 1980's and 1990's, were identified as possible explanations for why the degree of progressivity in the mix of domestic health financing sources has not improved much over time.

Whether IMF/WB policy influence has historically constrained or supported government health spending has been a subject of heated debate with academics and civil society on one side and IMF/WB staff on the other (Kingston, 2011; Stubbs et al., 2017; Ooms and Schrecker, 2005; Center for Global Development, 2007; Brunswijck, 2018; Stuckler and Basu, 2009, 2013; Abocejo, 2014; Isiani et al., 2021; Meurs et al., 2019; Birn et al., 2016; Stubbs and Kentikelenis, 2017; Ochs, 2017; Foley, 2010; Wemos, 2024; Clements et al., 2013; Gupta, 2017; Martin and Segura-Ubiergo, 2004; van der Gaag and Barham, 1998; Thomas,

[4] Reported 2010-value of 2.5 % was deemed as measurement or reporting error and omitted.

[5] Both broader WB lending under multi-sectoral development strategies as well as individual project lending has of course benefited across a multitude of sectors in Senegal (World Bank, 2024).

2006; Daoud and Reinsberg, 2019; Kentikelenis et al., 2015; Boachie et al., 2022). Our results point to a mixed effect, in part due to lingering influences from past policies, and due to ongoing austerity policies on one side and efforts to increase GHE-S on the other. The ongoing WB promotion of CBHI and private health service delivery may also have limited the scope for progress on UHC in Senegal. Issues with CBHI in Senegal have included voluntary enrolment with limited reach, user co-payment, small risk pools, variable financial sustainability and risk protection of poor members, and limited cross subsidy from rich to poor (Ridde et al., 2023, 2024a; Daff et al., 2020; Wood, 2023; Mladovsky and Ndiaye, 2015; Ly et al., 2022). Informed by an Enabel-led pilot, the government of Senegal is consolidating CBHI at the departmental level (Daff et al., 2020; Ridde et al., 2022, 2023, 2024a, 2025a). This will likely address some of these issues by expanding risk pooling and cross-subsidy, achieving some efficiency gains and improving financial viability, however departmental aggregation is unlikely to help overcome the inequality between the Dakar region and the rest of the country (Caffin, 2018; Ridde et al., 2024a, 2024b; Deville, 2018; Daff et al., 2020; Federspiel et al., 2024).

In the general literature, private health service delivery has been associated with increased service costs, inequitable availability and access patterns for poor and vulnerable groups, high user co-payments and failure to advance financial risk protection (Homedes and Ugalde, 2005; Chapman, 2014; Coveney et al., 2023). This mixed health financing approach is however in line with the government's overall development strategy for the health sector (Ministère de la Santé et de l'Action Sociale, 2017, 2019; Government of Senegal, 2014).

The IMF and WB's continued promotion of CBHI and private sector health service provision may have helped contribute to a state of path dependence (David, 2007). The *Mutuelles* have strong support from the mutualist movement in Senegal, and *Mutuelle* leaders enjoy both social status and financial incentives for their work, leading to resistance to change (Ridde et al., 2025b). Financial incentives are likely to be even more prominent in the private for-profit sector, constituting a self--preserving, growth-focused (and thereby self-reinforcing) and influential set of agents in the health sector. Path dependence through fragmentation, with a multitude of different actors across institutions and schemes with different vested interests, has been analysed as an impairment to progress on UHC in Senegal (Deville, 2018). Additionally, once hospitals start functioning as decentralised, independent financial units reliant on user fees to generate revenue, it may become difficult to pivot into an alternative model with increased central government funding to pay for their services.

Before the era of the IFIs in Senegal, private practice of colonial doctors and user fees in the health system were highly prevalent in Senegal during the French colonial period (documented 1840–1960) (Ridde et al., 2025a). French colonial institutions may thereby have laid a conducive foundation for the later liberal reforms as promoted by the IMF/WB, with a degree of institutional path dependence spanning across both colonial and postcolonial Senegal (Ridde et al., 2025a).

Our finding that WB policy had become more progressive over time in Senegal seems to follow a general evolution within the WB (Gorsky and Sirrs, 2023; Cormier and Manger, 2020; Vetterlein, 2007; Tichenor et al., 2021). This change can be viewed as partly internally derived and partly the result of decades of exchanges with branches of government, multilaterals, civil society, academia and the populations served, including through Global Health Initiatives (GHIs) such as Gavi, The Global Fund for Aids, Tuberculosis and Malaria (GFATM) and The United States President's Emergency Plan for AIDS Relief (PEPFAR).[6] This has led to a greater degree of support and promotion of the health sector as part of a general move toward social sector development lending and inclusive social development policy making, as opposed to a previously more narrow focus on investments in infrastructure, productivity and economic growth, with GHIs in particular bringing attention, cooperation and co-financing opportunities within health system strengthening and disease prevention and treatment programs (Gorsky and Sirrs, 2023; Cormier and Manger, 2020; Vetterlein, 2007; Gavi, 2021; World Bank, 2013; Gerrard, 2012; Vetterlein and Schmidtke, 2024).

A lesser degree of change was seen at the IMF in Senegal, which aligns somewhat with findings across countries from other authors (Kentikelenis and Stubbs, 2023). However, our findings of social spending floors being raised over time, funding to respond to Covid-19, and numerous measures to increase and safeguard social and health spending, did show some signs of a transition from traditional austerity policy towards increasing social concern at the IMF. These latter findings should serve a nuancing role in relation to some of the more critical literature on the IMF's influence on health financing.

We found that social spending floors were consistently met or exceeded, which is not the norm across West Africa, though mainly by prioritising the education sector (Kentikelenis and Stubbs, 2023; IMF, 2023e). This prioritization may partly be due to 0–14 year-olds making up 38 % of the Senegalese population, compared to only 4 % being above 65 years old (2024) (World Bank, 2025). However, an issue with IMF social spending floors is that the IMF defines social spending in Senegal very broadly, covering a range of sectors and purposes (IMF, 2023e). In other countries, IMF definitions of social spending vary widely, and the health sector is not always included or explicitly mentioned (Kentikelenis and Stubbs, 2024). This means that countries can focus their spending heavily on variable subsets of social purposes and satisfy this non-binding target, which somewhat dilutes the meaning of a social spending floor from the perspective of individual sectors, including the health sector. In a traditional economic growth logic, investments in education, water supply, electrification and sanitation could receive priority over investing in the health of poor and vulnerable groups. This is an underappreciated issue in the academic literature on the role of the IMF in health financing, perhaps due to its somewhat technical and intersectoral nature. Our study findings from Senegal provide novel documentation of how social spending floors can be ineffective at raising individual sector funding levels, strengthening the empirical justification for an informed scepticism toward social spending floors as a universal remedy for struggling individual social sectors in LMICs.

This research explored external creditor influence on domestic health financing policy through mechanisms such as aim/target setting (e.g. conditionalities), providing policy advice and financing (Federspiel et al., 2024; De Raeve et al., 2022; Start and Hovland, 2004; Steinberg, 2003). It focused on policy content and actors/institutions, rather than the policymaking process itself (Walt and Gilson, 1994; Grindle and Thomas, 1991; Gautier and Ridde, 2017; Kingdon, 1984), the underlying ideas and interests behind IMF/WB policy influence (Hall, 1997; National Collaborating Centre for Healthy Public Policy, 2014; Mulvale et al., 2017), or the politics and political economy shaping the observed policy content (Sparkes et al., 2019; Fox and Reich, 2015; Rizvi et al., 2020). The exchanges between the IMF/WB and the Senegalese government can also be viewed as power dynamics (e.g (Milsom et al., 2021; Lukes, 2005; Bachrach and Baratz, 1962; Alesina and Dollar, 2000; Matteis, 2016; Steele, 2017; Rye Olsen, 2002; Erasmus and Gilson, 2008; Shiffman, 2014; Fergus, 2022)). For example, the influences in Senegal stemming from the 1993 WB "*Investing in Health*" report can be viewed as examples of both agenda-setting and discursive power (World Bank, 1993a; Milsom et al., 2021; Lukes, 2005; Gaventa, 2006; Naylor, 2011; Preker and Carrin, 2004), while structural policy reform programs and associated loans can be seen as examples of structural and financial power (Milsom et al., 2021; Lukes, 2005; Bachrach and Baratz, 1962; Herberholz, 2020). Our work could be extended by applying either of these alternative analytical lenses to better understand the relevant dimensions of IMF/WB influence on Senegalese health financing policy, and potentially elsewhere.

[6] The World Bank Group is a founding partner of Gavi, and trustee and non-voting member of the of GFATM board (Gavi, 2021; World Bank, 2013).

4.1. Limitations

This study focused on policy influence from the IMF/WB, however there are of course other external official creditors to Senegal, multilateral and bilateral. The influence of some of these has been explored elsewhere (Federspiel et al., 2024), however an in-depth exploration of health financing effects of loan conditionalities from e.g. the French Development Agency or the African Development Bank might reveal different results.

Beyond the external influence investigated, there is also a set of domestic political economy factors that co-determine health financing in Senegal, however it was beyond the scope of this study to unpack these factors as well. Our findings should therefore be interpreted as one source of influence among many political and economic considerations for the Senegalese government when deciding on health financing policy.

Five interview participants did not consent to interviews being recorded, so we had to rely only on written notes from these interviews, greatly decreasing their level of detail and utility for our analysis. Additionally, seven potential key stakeholders were unavailable or did not respond to interview requests. However, our final group of interviewees was well balanced across stakeholder groups (Table 1).

We chose to interview a broad range of stakeholders who had knowledge and experience with IMF/WB policy for the health sector from many different angles. This meant we did not interview a multitude of participants from any single organisation. Our focus was also purely domestic, and we therefore did not juxtapose the views of international officials with those working at the country-level for any of the organisations included. What these decisions have added to our study in terms of breadth of perspective and balancing of narratives, they may have deducted in terms of depth of oral history from the perspective of single institutions.

5. Conclusions

This study has offered the first in-depth, systematic historical interrogation of IMF/WB policy from the perspective of health financing sources in a case country. We found that in spite of increasing efforts and ambitions, non-binding targets under IMF/WB programs have failed to achieve adequate levels of GHE-S. While especially WB health financing policy has become more progressive over time and clearly supports GHE-S increases, impacts of past policies of cost recovery and hospital autonomisation seem to linger and shape the inequitable payment patterns seen in Senegal.

Within the highly variable IMF social spending floors, sectoral floors for the health and education sectors of at least 10 % of the government expenditure budget each, from domestic revenue, could be considered. If the Abuja pledge was to be taken seriously, it would be closer to 15 % for the health sector, while a more pragmatic floor would lie somewhere in between. Contingent on fiscal priority of the health sector by the Senegalese government, a relaxation of general fiscal austerity measures and improved terms of lending would be other policy options that could potentially help facilitate increases in GHE-S.

Such measures could support expansion of well targeted state subsidy of health services through exemption schemes and CBHI premium coverage, or alternatively a move toward broader, integrated risk protection schemes and decreased emphasis on the private health sector with its reliance on co-payments and inequitable access patterns (Homedes and Ugalde, 2005; Chapman, 2014; Coveney et al., 2023).

Future research could explore both IMF/WB influence on the mix of domestic health financing sources in other countries, and influence from other creditors, for informed policy discussions pursuing UHC, both in Senegal and elsewhere.

Ethical approval

Ethical approval was obtained from the London School of Hygiene Observational / Interventions Research Ethics Committee (*ref: 16420*) and the National Health Research Ethics Committee in Senegal (*protocol SEN19/56, ref: 00172*).

CRediT authorship contribution statement

Frederik Federspiel: Writing – review & editing, Writing – original draft, Visualization, Software, Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Elhadji Mamadou Mbaye:** Writing – review & editing, Resources, Formal analysis, Conceptualization. **Henning Tarp Jensen:** Writing – review & editing, Supervision, Formal analysis, Conceptualization. **Josephine Borghi:** Writing – review & editing, Supervision, Methodology, Formal analysis, Conceptualization. **Melisa Martinez-Alvarez:** Writing – review & editing, Supervision, Resources, Project administration, Methodology, Formal analysis, Data curation, Conceptualization.

Declaration of Competing Interest

The authors declare to have no competing interests.

Acknowledgements

We thank the interview participants for kindly sharing their time and knowledge with us. We thank Ms. Aminata Diop for interpretation and Ms. Aminta Gueye for transcription of interviews. We also thank Dr. Penelope Milsom for co-validating our interview coding framework.

Finally, we thank the funders of this research: The Economic and Social Research Council (ESRC) Doctoral Training Partnership (DTP), Reinholdt W. Jorck og Hustrus Fond, Torben og Alice Frimodts Fond, Christian Larsen og Dommer Ellen Larsens Legat, The Anglo-Danish Society Scholarship, Den Raben-Levetzauske Fond, Christian og Ottilia Brorsons Rejselegat for yngre videnskabsmænd- og kvinder, and Carl og Ellen Hertz' legat til Dansk Læge- og Naturvidenskab.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.ssmhs.2026.100179.

Data availability

The ethical consent form, participant information sheet and example interview topic guide are available at the LSHTM Data Compass (London School of Hygiene and Tropical Medicine, 2025) and in the online appendix.

The used data can be shared in anonymous form on reasonable request to the corresponding author.

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