



ZIMBABWE NATIONAL HEALTH FINANCING STRATEGY 2026 - 2030





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The Government of Zimbabwe remains firmly committed to ensuring that every Zimbabwean has access to quality essential health services without financial hardship. Health remains central to national development, human capital formation, economic productivity, and social protection, and is a key pillar for achieving Vision 2030 and the National Development Strategy 3 (NDS3). The Health Financing Strategy 2026–2030 provides a comprehensive framework to strengthen the sustainability, equity, efficiency, and resilience of our health system as we accelerate progress toward Universal Health Coverage.

Over the past years, the government has prioritised investments to strengthen the health sector despite a constrained fiscal environment. This includes the introduction of earmarked health levies and taxes, refurbishment and modernisation of hospitals and nurses' homes across the country, expansion of primary health care infrastructure, and investments in specialised services such as cancer diagnosis and treatment equipment. These reforms reflect the government's commitment to progressively strengthen domestic financing for health, improve service delivery capacity, and, over time, reduce dependence on external financing. The Strategy builds on these efforts by establishing a stronger framework for mobilising, pooling, allocating, and using health resources more efficiently, transparently, and equitably.

The Strategy further recognises the growing importance of health sovereignty, domestic ownership, and resilient health systems in an evolving global financing landscape. In line with the Lusaka Agenda, the Africa Health Security and Sovereignty Agenda, and broader regional and global commitments, Zimbabwe is committed to strengthening nationally led financing systems that are sustainable, accountable, and responsive to population needs. The COVID-19 pandemic demonstrated the importance of resilient financing systems that support emergency preparedness, maintain the continuity of essential services, and protect households during crises. This strategy, therefore, prioritises stronger domestic financing, improved financial protection, strategic purchasing, stronger governance, and the establishment of the National Health Insurance as a long-term mechanism to support sustainable and equitable financing for health.

Successful implementation of this Strategy will require strong collaboration across Government, Parliament, development partners, local authorities, private sector actors, civil society organisations, communities, and all stakeholders in the health sector. I therefore call upon all partners to support the implementation of this Strategy and work collectively toward building a stronger, more equitable, resilient, and self-sustaining health system for all Zimbabweans.

Hon. Dr. D.T. Mombeshora
Minister of Health and Child Care

Aknowledgements

The Zimbabwe Health Financing Strategy 2026–2030 provides a comprehensive framework for strengthening the mobilisation, pooling, allocation, purchasing, governance, and accountability of health financing in Zimbabwe. The Strategy aligns with the National Health Strategy, the NDS3, and Zimbabwe's broader commitments to Universal Health Coverage, health security, and sustainable domestic financing. Its successful implementation will be critical to strengthening financial protection, improving the efficiency and equity of resource allocation, and ensuring that health financing reforms support the delivery of quality essential health services for all Zimbabweans.

The Ministry of Health and Child Care expresses its sincere appreciation to all institutions, partners, and individuals who contributed to the development of the Zimbabwe Health Financing Strategy 2026–2030. The successful completion of this Strategy reflects a broad collaborative effort and a shared commitment to strengthening sustainable, equitable, and resilient health financing systems for Zimbabwe. Special recognition is extended to the leadership of the Ministry of Health and Child Care, particularly the Policy, Planning and Health Financing Division, for coordinating and guiding the Strategy development process. The Ministry further acknowledges the valuable oversight and technical guidance provided through the Health Financing Technical Working Group, whose contributions helped shape the strategic direction and reform priorities contained in this document.

The Ministry expresses its profound gratitude to the World Health Organisation and UNICEF for their technical leadership and support throughout the development of this Strategy. The HFPM provided an important evidence base for identifying system priorities and informing the reform agenda articulated in this document. Appreciation is also extended to the World Bank country team for their valuable technical support, which was instrumental in advancing the financing agenda, and to the Global Financing Facility for their continued engagement. Further appreciation is extended to the Clinton Health Access Initiative (CHAI), which provided financial support during the review and refinement of the Strategy, and to the Health Resilience Fund (HRF) for supporting key technical processes and stakeholder engagements. The Ministry further acknowledges the technical contribution of Mr Munyaradzi Mareke, Consultant, who led the drafting and technical development of the Strategy with support from WHO and key stakeholders across the sector. Appreciation is also extended to Provincial Medical Directors (PMDs), Medical Superintendents (MedSups), programme managers, local authorities, development partners, private sector representatives, civil society organisations, and all stakeholders who participated in consultations and provided technical inputs throughout the process.

The Ministry remains grateful for the continued partnership, commitment, and collaboration of all stakeholders working to strengthen Zimbabwe's health financing system and advance universal health coverage for all Zimbabweans.

Dr. A.J.V Maunganidze

Secretary for Health and Child Care

Zimbabwe's health system has achieved significant gains in service coverage and health outcomes over the past decade, driven by sustained investments in primary health care, disease control programmes, reproductive, maternal, newborn, child and adolescent health services, and expansion of essential health interventions. The country's Universal Health Coverage Service Coverage Index has steadily improved, reflecting progress in access to essential health services. However, these gains remain vulnerable due to existing and emerging challenges in health financing, macroeconomic risks, and declining external financing.

The health financing system continues to face significant structural challenges. Public financing remains inadequate, unpredictable, and highly vulnerable to fiscal and macroeconomic pressures. Government financing declined sharply from 39.2% of Current Health Expenditure (CHE) in 2021 to 13.8% in 2023 before partially recovering to 24.4% in 2024, while out-of-pocket expenditure increased from 18.9% of CHE in 2021 to 27.8% in 2023, (NHA 2021-2-24), increasing the financial burden on households. External financing remains substantial and fragmented, reinforcing dependence on programme-specific financing arrangements and exposing the system to external shocks. At the same time, pooling arrangements remain fragmented across government budgets, donor programmes, local authority financing, private medical aid schemes, and various earmarked and facility-level funds, limiting redistribution, equity, and financial protection.

Purchasing arrangements remain largely passive and input driven, with financing weakly linked to service delivery outputs, population health needs, quality, or provider performance. Expenditure patterns remain skewed toward curative and hospital-based care despite policy commitments to primary health care and prevention. Weak public financial management systems, delayed disbursements, fragmented reporting, and limited use of evidence in allocation decisions continue to constrain efficiency and accountability across the sector.

The Health Financing Strategy (HFS) 2026–2030 responds to these challenges and provides a comprehensive framework for strengthening the mobilisation, pooling, allocation, purchasing, governance, and accountability of health financing in Zimbabwe. The Strategy builds on lessons from the implementation of the previous Health Financing Strategy and aligns with Zimbabwe's Constitution, Vision 2030, National Development Strategy 3 (NDS3), the National Health Strategy, the Health Financing Policy, and regional and global commitments to universal health coverage, health security, and sustainable domestic financing.

The Strategy adopts a phased reform approach anchored around five interrelated reform pillars: revenue generation, pooling, strategic purchasing, governance, and establishment of the National Health Insurance (NHI). Together, these reforms aim to strengthen fiscal sustainability, improve redistribution and financial protection, align financing with population health needs, and establish more integrated and accountable financing arrangements.

Under revenue generation reforms, the Strategy prioritises improving the predictability, protection, and purchasing power of domestic financing through stronger budget prioritisation, ring-fencing of selected health revenues, improved budget execution, Programme-Based Budgeting (PBB), strengthened Medium-Term Expenditure Framework (MTEF) implementation, and improved integration of financial reporting across all financing streams. The Strategy recognizes that Zimbabwe's constrained fiscal environment requires a focus not only on increasing financing



volumes, but also on improving stability, efficiency, and value for money. Pooling reforms focus on reducing fragmentation and strengthening redistribution across financing arrangements.

The Strategy proposes progressive consolidation and coordination of financing pools through virtual pooling arrangements, integrated reporting systems, common allocation mechanisms, and strengthened equalisation across sub-national financing pools. Reforms will also strengthen subsidy mechanisms for poor and vulnerable populations and progressively align donor and private financing with national systems and priorities.

Strategic purchasing reforms will focus on aligning financing with defined service entitlements, population health needs, and service delivery outcomes. Priority reforms include operationalising a costed Essential Health Benefit Package (EHBP), strengthening primary health care financing, harmonising user-fee and exemption policies, developing needs based allocation mechanisms, reforming provider payment mechanisms, strengthening provider contracting arrangements, and integrating market-shaping approaches into procurement and supply systems. Together, these reforms aim to improve efficiency, quality, responsiveness, and financial protection.

Governance reforms will strengthen stewardship, coordination, accountability, and enforcement across all health financing functions. The Strategy prioritises integrated planning and reporting systems, stronger coordination between the Ministry of Health and Child Care, Ministry of Finance, Economic Development and Investment Promotion (MoFED), local authorities, development partners, and private sector actors, as well as institutionalisation of evidence-informed decision-making through routine use of National Health Accounts (NHA), Resource Mapping and Expenditure Tracking (RMET), Public Expenditure Reviews (PER), and Health Financing Progress Matrix (HFPM) assessments.

A central reform under the Strategy is the establishment of the National Health Insurance (NHI) as a legislated, government-led financing mechanism to strengthen pooled financing, improve predictability of funding, and progressively expand universal health coverage. The NHI will complement core government budget allocations through protected, rules-based financing arrangements linked to defined service entitlements and strategic purchasing mechanisms. Over time, the NHI is expected to strengthen redistribution, improve financial protection, and support progressive transition toward more integrated financing and purchasing arrangements.

Implementation of the Strategy will require supportive legal and regulatory reforms to formalise institutional mandates, strengthen accountability, and provide the basis for enforcement of major financing reforms. Priority reforms include the enactment of the NHI Act, the regulation of medical aid schemes, the legal recognition of the Essential Health Benefit Package, the harmonisation of local authority financing arrangements, and the strengthening of public-private partnership frameworks. The Strategy will be implemented over the period 2026–2030, aligned with NDS3, the National Health Strategy, and the Sustainable Development Goals agenda. While the Strategy outlines reforms and targets to be achieved within this period, many interventions are catalytic and institution-building, intended to lay the foundations for longer-term transformation beyond 2030.

Implementation will be coordinated by the Ministry of Health and Child Care in collaboration with MoFED, local authorities, development partners, private sector actors, civil society organisations, Parliament, and communities. Monitoring, Evaluation, Research and Learning (MERL) arrangements have been integrated into the Strategy to ensure systematic tracking of implementation progress, financing performance, financial protection, and service delivery outcomes. The MERL framework

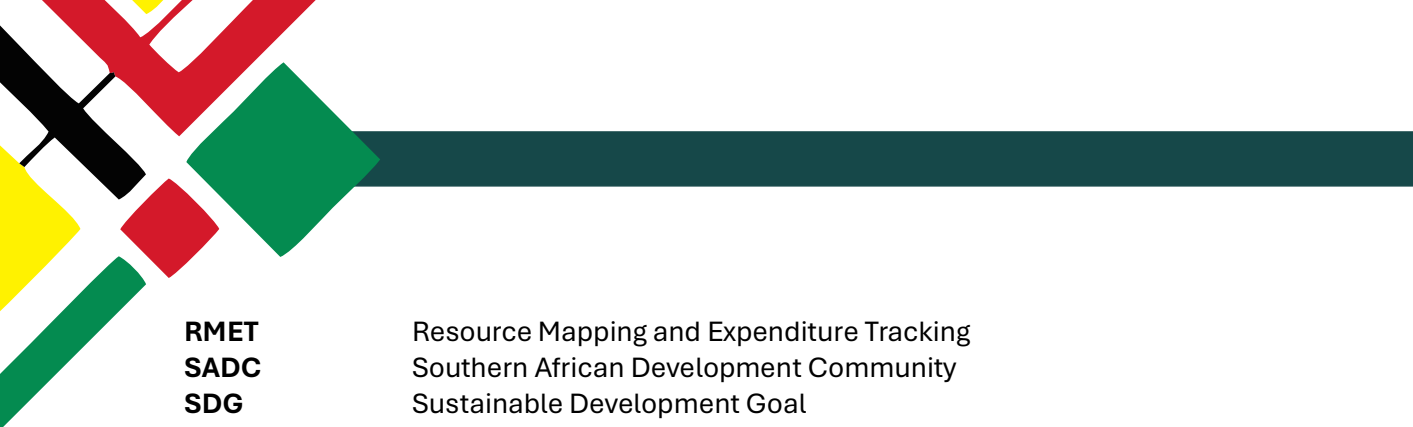


includes impact, outcome, and process indicators aligned to the strategic objectives and will be embedded within existing accountability mechanisms, including joint sector reviews, budget reviews, and Parliamentary oversight processes.

Through these reforms, the Health Financing Strategy 2026–2030 seeks to strengthen domestic ownership, improve fiscal sustainability, enhance financial protection, and establish a more coherent, equitable, and resilient health financing system capable of sustaining progress toward universal health coverage and national development priorities.

Acronyms

AfDB	African Development Bank
AG	Attorney General
AIDS	Acquired Immunodeficiency Syndrome
AMTO	Assisted Medical Treatment Order
AU	African Union
CBHI	Community-Based Health Insurance
CDC	Centers for Disease Control and Prevention
CHE	Current Health Expenditure
CSO	Civil Society Organisation
EHBP	Essential Health Benefit Package
EHSP	Essential Health Services Package
GDP	Gross Domestic Product
GHO	Global Health Observatory
GNI	Gross National Income
GAVI	Global Alliance for Vaccines and Immunisation
HCC	Health Centre Committee
HFS	Health Financing Strategy
HFPM	Health Financing Progress Matrix
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRF	Health Resilience Fund
IFI	International Financial Institution
IFMIS	Integrated Financial Management Information System
IHR	International Health Regulations
IPSAS	International Public Sector Accounting Standards
LMIS	Logistics Management Information System
MAS	Medical Aid Society
MDA	Ministries, Departments and Agencies
MTEF	Medium-Term Expenditure Framework
MoFED	Ministry of Finance, Economic Development and Investment Promotion
MoHCC	Ministry of Health and Child Care
NAC	National AIDS Council
NDS3	National Development Strategy 3
NHA	National Health Accounts
NHS	National Health Strategy
NHI	National Health Insurance
NSSA	National Social Security Authority
OOP	Out-of-Pocket
PBB	Programme-Based Budgeting
PER	Public Expenditure Review
PFM	Public Financial Management
PFMS	Public Financial Management Systems
PHC	Primary Health Care
PMI	President's Malaria Initiative
PPP	Public-Private Partnership
RBF	Results-Based Financing



RMET	Resource Mapping and Expenditure Tracking
SADC	Southern African Development Community
SDG	Sustainable Development Goal
SI	Statutory Instrument
TB	Tuberculosis
THE	Total Health Expenditure
TWG	Technical Working Group
UHC	Universal Health Coverage
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
USG	United States Government
VHI	Voluntary Health Insurance
WHO	World Health Organization
WCF	Workmen’s Compensation Fund
ZIMRA	Zimbabwe Revenue Authority
ZIMSTAT	Zimbabwe National Statistics Agency
ZiG	Zimbabwe Gold Currency

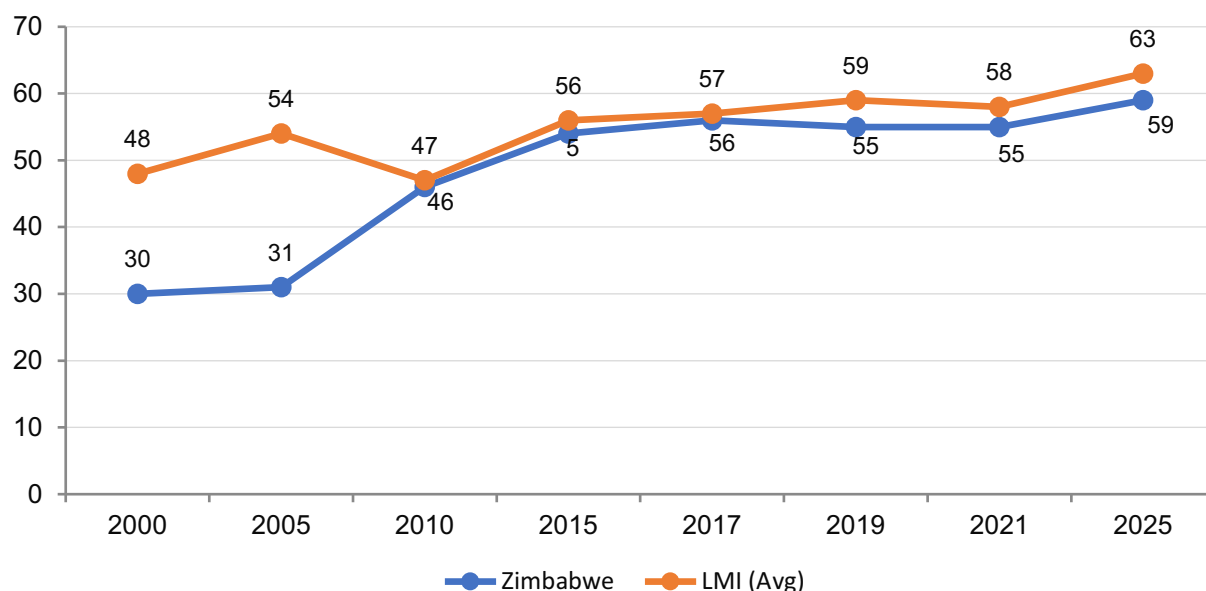
1.0 Introduction

1.1 Background

This Health Financing Strategy (HFS) provides a practical roadmap for translating Zimbabwe's health policy commitments into concrete financing actions to accelerate progress toward Universal Health Coverage (UHC). Building on the principles set out in the Health Financing Policy, the HFS defines how financial resources can be mobilised, pooled, allocated, and used more strategically to expand access to quality health services and strengthen financial protection for the population. The HFS focuses on aligning financing arrangements with national health priorities, particularly the expansion of essential services, revitalisation of primary health care, and improved efficiency and equity across the health system.

Zimbabwe has made substantial progress in service coverage since 2000, with the UHC Service Coverage Index rising from 30 in 2000 to 59 in 2025. This compares favourably with the WHO Africa regional average of 51, but is below the Lower-Middle Income Countries average of 63. This progress reflects sustained investments in primary health care and the expansion of essential services. However, gains in the UHC Service Coverage Index are largely driven by strong performance in HIV, TB and malaria, and reproductive, maternal, newborn, child and adolescent health programmes, which were predominantly supported by external financing prior to 2025. With the recent decline in development assistance for health, there is a risk that these gains may stall or reverse if funding gaps are not addressed through increased and reprioritised domestic resources. This strategy, therefore, sets out the reforms required to strengthen health financing and sustain progress towards universal health coverage in a rapidly evolving fiscal context.

Figure 1: Service coverage index trend in Zimbabwe 2000- 2025



Source: WHO&WBG. Tracking UHC -2025 Global Monitoring Report

1.2 Rationale for the development of the health financing strategy

The Health Financing Strategy 2026 – 2030 builds on lessons from the implementation of the previous strategy and the need to realign countries' health financing systems with the evolving

national and international social, political and economic context. The strategy translates the policy directions outlined in key national documents and international frameworks into health financing approaches to achieve universal access to quality health services in the country. Section 76 of the Constitution (2013) guarantees the right to access basic health care services, including reproductive health, and places an obligation on the State to progressively realise this right. This establishes the basis for prioritising financial protection, defined service entitlements, and equitable access within the strategy. Vision 2030 and the National Development Strategy 2 (NDS2, 2026–2030) frame health as a driver of human capital development and economic growth, reinforcing the need for increased domestic resource mobilisation, improved efficiency, and stronger accountability in public spending. The Health Financing Policy (2017) provides the technical foundation across revenue mobilisation, pooling, and purchasing, which this strategy operationalises and sequences in line with current fiscal constraints and system capacity.

The strategy is shaped by international and regional commitments that define both the objectives and the direction of reform. SDG 3.8 and World Health Assembly resolutions anchor the focus on universal health coverage, financial risk protection, and equitable access to quality services. The International Health Regulations (2005) and the African Health Security and Sovereignty Agenda emphasise the need for resilient, domestically financed systems capable of sustained public health response. The Abuja Declaration and African Union Agenda 2063 reinforce commitments to increased domestic financing and reduced reliance on external resources. The Lusaka Agenda (2025) further sharpens this direction by calling for a transition from fragmented, externally driven financing toward nationally led, integrated systems anchored in primary health care, sustainable domestic funding, and regional production capacity. The SADC Protocol on Health supports regional alignment and policy coherence.

1.3 Process of Developing the Strategy

The development of HFS follows a structured, evidence-driven, and consultative process designed to ensure continuity with past reforms while responding to current fiscal and health system opportunities and challenges. The process builds on completed analytical work, lessons from implementation of the 2017 HFS, and stakeholder engagement, and is being undertaken in parallel with the development of the National Health Strategy (NHS) to ensure strategic alignment across policy, planning, and financing frameworks. The process included:

- A comprehensive Health Financing Progress Matrix assessment was completed in 2025, and the findings provide the primary diagnostic foundation for the revised Strategy.
- A structured review of the HFS 2017 was conducted by the World Bank to assess implementation experience, results, and constraints, and to inform prioritisation and sequencing of reforms.
- A national stakeholder consultation on HFS development in January 2026, which validated the diagnostic findings and proposed priority reform directions to be included in the strategy.
- Guidance by the Health Financing Technical Working Group, which supported the translation of analytical findings and stakeholder inputs into a coherent strategy, implementation plan, and monitoring and evaluation framework.
- Development of the strategy in parallel with the National Health Strategy development to ensure alignment with overall national health priorities, timelines, and institutional responsibilities across the health sector.

2.0 Macroeconomic, Fiscal, and Health System Context

The HFS is grounded in Zimbabwe's macroeconomic, fiscal, and political economy context, as these conditions fundamentally shape what is feasible, sustainable, and scalable in financing UHC. Trends in economic performance, government revenues and expenditures, debt dynamics, and donor financing directly influence the level, predictability, and composition of resources available for health. At the same time, fiscal shocks, implementation capacity constraints, and political economy risks affect the effectiveness with which resources are translated into services.

2.1 Socio-economic context

Zimbabwe is a lower-middle-income country with a growing population and persistent socio-economic vulnerabilities. The population stands at approximately 15.2 million, reflecting continued demographic growth and sustained demand for public services, including health (ZIMSTAT, 2022). The country's economic trajectory has been shaped by prolonged economic contraction, recurrent macroeconomic instability, and more recent financial shocks, with adverse effects on household welfare and public service delivery. Poverty levels remain high. The national poverty headcount ratio was estimated at 38.3 percent in 2019, while more recent assessments indicate that a majority of the population lives below the lower-middle-income international poverty line (US\$3.65 per day) (World Bank, 2022; World Bank, 2025). These conditions have increased reliance on publicly financed social services, including health care, whilst placing a burden on the low-income groups.

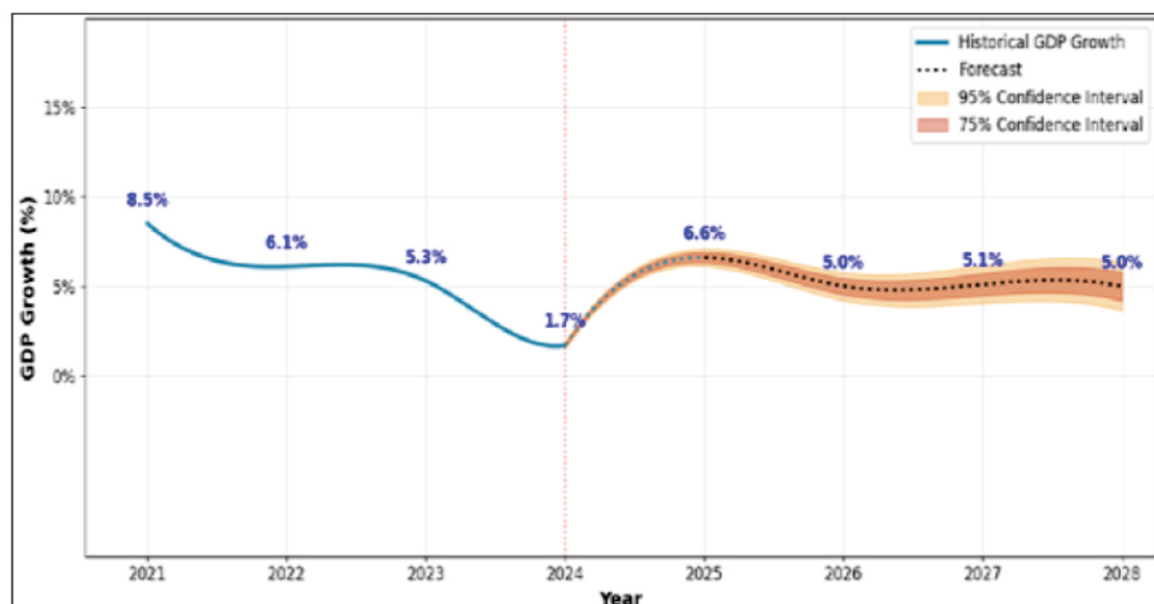
Labour market outcomes continue to be shaped by structural constraints. Recent labour force surveys report unemployment rates in the range of 8–20 percent, with underemployment remaining widespread and formal employment opportunities remaining limited (ZIMSTAT, 2023; World Bank, 2025). Informality remains a key feature of the economy, with recent data indicating that more than half of total employment is informal (ZIMSTAT, 2023). The PFR further records that post pandemic growth was driven largely by private consumption, expansion of the informal sector, and dollarisation, reinforcing structural features—particularly informality, that are expected to persist over the strategy period (World Bank, 2025). Climate variability has further increased vulnerability, with the frequency of droughts rising from one in ten growing seasons (1902–1979) to one in four growing seasons (1980–2011), with implications for household resilience, health needs, and demand for publicly financed services (World Bank, 2025).

2.2 Fiscal Space Constraints and Economic Growth

Zimbabwe's fiscal environment has been shaped by recurrent macroeconomic shocks. By April 2024, the official exchange rate had depreciated by more than 95% from December 2023, with a parallel market premium exceeding 50%, prompting the replacement of the Zimbabwe dollar with the Zimbabwe Gold (ZiG) currency in April 2024 (World Bank, 2025). Economic growth is projected to remain robust over the medium term, with real GDP growth expected to range between 4 and 6 per cent annually through 2030. Reflecting improved macroeconomic performance, GDP estimates for 2023 and 2024 have been revised upwards to approximately US\$44.5 billion and US\$45.7 billion, respectively. In 2025, nominal GDP is projected to reach US\$52.4 billion, with gross national income (GNI) per capita estimated at US\$3,200. Growth in 2025 is now projected at 6.6 per cent (compared to the initial projection of 6%). This revision is driven primarily by a strong recovery in the agricultural, mining and manufacturing sectors.

In 2026, economic growth is projected at 5.0 per cent , anchored on higher investment in manufacturing, sustained improvements in agricultural output, and strong domestic demand . Given ongoing global and domestic uncertainties, GDP growth projections are volatile but distributed around the 5% mark as shown in Figure 3.

Figure 3: Projected Economic Growth for Zimbabwe



Source: 2026 National Budget

2.3 Government revenue and expenditure trends

The country's macroeconomic framework over the medium term is focused on stabilisation, fiscal discipline, domestic resource mobilisation, and structural transformation. Within this framework, government revenues are projected at approximately 16.9% of GDP, while expenditures are projected at 17.1% of GDP, leaving limited fiscal space for expansion of public spending. Recurrent expenditures dominate the budget, constraining the scope for additional allocations to capital and other critical social sector inputs such as medical commodities for the health sector. Within this constrained expenditure envelope, social sectors, including health, face severe competition with other national priorities, reinforcing the importance of efficiency and prioritisation over the strategy period. At the same time, rising public debt levels and ongoing external arrears further limit fiscal flexibility. Domestic debt continues to increase, while external debt remains high, with a significant share in arrears and ongoing debt service obligations.

3.0 Organisation and Performance of the Health Financing System

3.0 Organisation of the Health Financing System

The Health Financing Strategy focuses on key financing schemes shaping reform in Zimbabwe. These include government financing, comprising central MoHCC funding, local authority services, and targeted schemes such as the National AIDS Council, the AIDS Levy, and AMTO, as well as private voluntary health insurance and largely off-budget donor-funded programmes in priority areas such as HIV, TB, malaria, and maternal and child health. Together, these schemes define the current financing architecture and provide the basis for assessing fragmentation and identifying pathways toward improved pooling, strategic purchasing, and universal health coverage

3.1.1. Government allocations for health

A mix of government led schemes reflects different policy choices, institutional mandates, and historical arrangements, and collectively determines how public resources are mobilised, pooled, and used to deliver health services.

- **Central Government Health Budget:** The central government budget remains the backbone of the system, financing services across all levels of care, public health functions, and sector governance. Resources are allocated primarily to the MoHCC and selected ministries (e.g. Defence, Home Affairs) and are funded through general revenues and earmarked levies. Funds are pooled nationally, but purchasing is largely input-based through line-item budgets, limiting flexibility, efficiency, and alignment with service delivery priorities.
- **Local Authority Health Budgets:** Governed by the Urban Councils Act [Chapter 29:15] and Rural District Councils Act [Chapter 29:13], local authorities finance and deliver services mainly at primary and secondary levels. Funding is derived from locally generated revenues, including user fees, rates, and service charges, with significant variation in fee policies and exemptions across councils due to differing fiscal capacity. Resources are managed independently across over 90 councils, resulting in fragmented pools with limited redistribution. Purchasing remains input based, and access varies by location, reinforcing inequities and inefficiencies.
- **Targeted Sub-schemes – National AIDS Trust Fund:** Established in 2000, the AIDS Trust Fund finances HIV and AIDS programmes for priority populations, including people living with HIV, key populations, and vulnerable groups. It is funded through a 3% levy on income and profits, collected by ZIMRA and managed by the National AIDS Council outside the Treasury pool. Funds are pooled nationally and partially devolved to sub-national structures to support community-level interventions.
- **Targeted Sub-schemes – Assisted Medical Treatment Order (AMTO):** AMTO is a government social assistance scheme administered by the Ministry of Public Service, Labour and Social Welfare to protect vulnerable populations from financial barriers. It targets groups such as orphans, the elderly, and persons with disabilities through means testing. The scheme covers costs at public facilities without co-payments, but access is conditional on referral pathways and is limited to private care.

3.1.2. Voluntary and Mandatory Prepayment Schemes

Zimbabwe's prepayment landscape comprises two main arrangements: private medical insurance, primarily through Medical Aid Societies (MASs), and the Workmen's Compensation Fund (WCF), a statutory scheme for occupational injuries and diseases.

- **Private Medical Aid Societies:** Private insurance is dominated by member owned, non-profit Medical Aid Societies regulated under Statutory Instrument 330 of 2000, with a smaller role for commercial insurers. Coverage is limited to around 10% of the population, largely among formally employed and higher-income groups, with access tied to active membership and premium payments. Benefits are package-based and subject to co-payments, waiting periods, exclusions, and suspension for arrears. Although over 30 schemes are registered, the three largest account for most of the enrolment. Provider payment is predominantly fee-for-service, leading some schemes to vertically integrate service provision.
- **Workmen's Compensation Fund (WCF)** The WCF, established under the NSSA Act and Statutory Instrument 68 of 1990, is a mandatory scheme for formally employed workers, funded through employer payroll contributions based on sector risk. The scheme provides medical care and income-replacement benefits for work-related injuries without co-payments, although benefit levels have declined in real terms. Funds are pooled nationally under NSSA, enabling risk-sharing, with providers reimbursed mainly through fee-for-service arrangements, including care at NSSA facilities and contracted providers

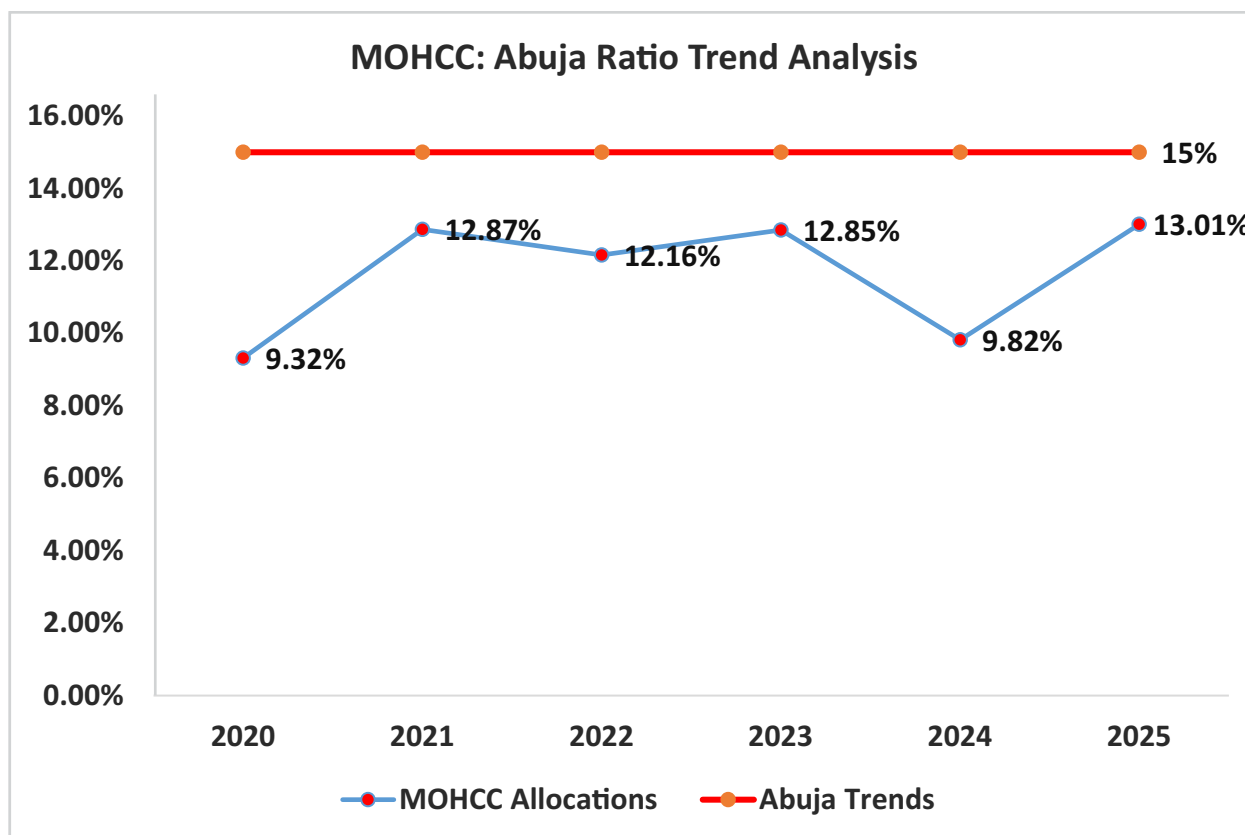
3.1.3. Vertical programmes and off-budget donor financing

Vertical programmes are donor-financed through major bilateral and multilateral sources, including USG (PEPFAR, CDC, USAID, PMI), the Health Resilience Fund, and the Global Fund, with resources largely channeled outside government pool systems. They focus on priority areas such as HIV, TB, malaria, maternal and child health, and emergency response, while also supporting, to some extent, broader health systems strengthening. Coverage is condition-based, and services are delivered through public facilities, typically free of charge, with clearly defined benefit entitlements aligned with programme objectives, thereby reducing financial barriers to targeted services. The exit and transition of the USG development support, and the subsequent decline in funding from other partners and development agencies like the Global Fund and GAVI, will significantly reduce the share of vertical program funding and leave funding gaps that shall need to be covered through domestic public funding.

3.2. Health Financing System Performance

3.2.1. Revenue Generation

Zimbabwe has made policy progress in recognising the importance of domestic public health financing. Health has consistently been amongst top 3 sectors in terms of government allocation, averaging 11.89% of national budget allocation between 2023 and 2025 (Figure 4). However, this remains below the Abuja target of 15% and generally in nominal terms the revenue levels for health remain insufficient to support the government UHC ambitions.

Figure 4: Government Allocations to Health Compared to Abuja Target

Source: MoHCC Directorate of Finance

Public and compulsory financing accounts for less than 60% of total health expenditure, with continued reliance on out of-pocket payments and donor funding. Per capita government health spending remains low at around US\$48.9, and user fees through the Health Services Fund have become a key source of operational financing, reflecting inadequate and unreliable budget support. Despite the adoption of the MTEF, funding remains poorly predictable, with weak alignment between projections, approved budgets, and actual disbursements. Execution rates are low, around 50–60% for recurrent spending and often below 20% for capital, with only 34% of approved allocations disbursed by Q3 2025, largely due to Treasury cash constraints and macroeconomic instability.

Revenue generation is further constrained by inflation, exchange rate volatility, and reliance on indirect taxes and user fees, which shift the burden to households and expose them to catastrophic spending. Earmarked taxes have improved short-term liquidity but have not increased overall funding or predictability. At the same time, service gaps force households to pay privately despite tax contributions, while private insurance, though covering a small population, accounts for over 30% of total health expenditure. Facility and local authority revenues are increasingly important but fragmented and poorly tracked. Given limited fiscal space, the priority for the strategy is not revenue expansion, but improving the predictability, stability, and purchasing power of existing resources, alongside more efficient allocation and use.

3.2.2. Pooling of Funds

Pooling of health financing remains fragmented across multiple parallel arrangements, including government budgets, donor-funded vertical programmes, the AIDS Levy, local authority financing, private medical aid schemes, facility-level Health Services Funds, and social protection mechanisms such as AMTO. These financing arrangements operate under separate institutional and reporting systems with limited coordination, constraining redistribution and effective risk sharing across population groups and levels of care. National Health Accounts data show that government financing declined sharply from 39.2% of Current Health Expenditure (CHE) in 2021 to 13.8% in 2023, before partially recovering to 24.4% in 2024, while external financing increased to 43.5% of CHE in 2022, reinforcing reliance on fragmented, largely programme-specific funding streams. At the same time, allocations remain largely historical rather than needs based, contributing to persistent geographic and service-level inequities.

Financial protection remains weak, with compulsory and public pooled financing remaining below 60% of CHE throughout the period, while out-of-pocket expenditure increased from 18.9% of CHE in 2021 to 27.8% in 2023. Private voluntary insurance expenditure also increased significantly, rising from 9.4% of CHE in 2021 to 21.6% in 2024, despite covering a relatively small, higher-income segment of the population. Although earmarked taxes and external financing increase overall resource availability, much of this financing remains off budget or weakly integrated into national allocation systems, limiting visibility, coordination, and strategic redistribution across pools. The proposed National Health Insurance Scheme (NHIS) aims to strengthen financial protection and progressively improve pooling and redistribution through ring-fenced financing arrangements and structured purchasing mechanisms linked to the Essential Health Benefit Package.

3.2.3. Purchasing of Health Services

Purchasing of health services remains largely passive, fragmented, and input driven, with public financing allocated mainly through historical line-item budgets that are weakly linked to population health needs, service utilization, or provider performance. National Health Accounts data show that spending remains heavily skewed toward curative and hospital-based care, with inpatient and outpatient curative services accounting for approximately 44–50% of Current Health Expenditure (CHE), while preventive care declined from 28.1% of CHE in 2021 to 19.1% in 2024. Expenditure on hospitals increased from 25.4% to 30.2% of CHE over the same period, despite policy emphasis on primary health care.

Provider payment mechanisms remain fragmented across public budgets, -donor supported Results-Based Financing (RBF), private fee-for-service arrangements, medical aid reimbursements, and household out-of-pocket payments, creating conflicting incentives and limiting efficiency. Voluntary health insurance expenditure increased from 9.4% of CHE in 2021 to 21.6% in 2024, while out-of-pocket spending rose to 27.8% of CHE, indicating increasing reliance on direct payments and fee-for-service purchasing. Although RBF has introduced some performance linkage, it remains limited in scale and dependent on external financing. Weak provider autonomy, delayed budget releases, and limited use of performance data continue to constrain strategic purchasing and responsiveness to population needs.

The approach to defining health service entitlements has evolved from the 2014 District Core Health Services Package, through multiple disease-specific packages, to the 2025 Essential Health Care Package. However, these frameworks have largely served as operational or policy guides rather than legally enforceable and funded entitlements, and remain poorly aligned with available resources,

purchasing arrangements, and service delivery capacity. As a result, access to services remains inconsistent, implicit rationing persists, and households continue to rely heavily on out of-pocket payments, particularly where medicine stock-outs, service gaps, and underfunding constrain delivery. The absence of a clearly defined, costed, and financed Essential Health Benefit Package (EHBP) further weakens strategic purchasing and limits the system's ability to allocate resources based on population needs and service priorities

3.2.4. Analysis of Technical Efficiencies

The efficiency gaps in the health system reflect broader weaknesses across the core health financing functions, rather than simply a shortage of resources. HFPM and PER findings point to a system in which available inputs, such as staff, beds, medicines, infrastructure, and financial resources, are poorly aligned and inadequately translated into service outputs due to financing, procurement, and management bottlenecks. Weak and unpredictable financing flows, combined with fragmented pooling arrangements and reliance on user fees, contribute to underutilisation of facilities, low bed occupancy, and bypassing of primary care, particularly where medicine shortages, limited diagnostics, and specialist gaps undermine service readiness. Purchasing arrangements remain largely input-based and insufficiently linked to population needs, referral pathways, or service performance, resulting in an inefficient service mix, concentration of skilled personnel at higher levels of care, limited task shifting, and poor staff deployment relative to workload. At the same time, procurement delays, fragmented ordering systems, weak forecasting, and supply chain inefficiencies continue to drive medicine stock-outs despite approved budgets, reducing the effectiveness of both frontline services and existing infrastructure. These challenges reflect a system in which financing, pooling, purchasing, and service delivery functions remain insufficiently integrated to ensure the efficient and equitable use of available resources.

3.2.5. Public Financial Management

Public financial management in the health sector is characterised by a structural disconnect between planning, budgeting, and execution. Between 2020 and 2025, approved allocations consistently ranged from only 13% to 51% of submitted bids, reflecting a chronic mismatch between sector needs and the macro-fiscal envelope. This gap is evident in critical inputs: in 2026, only 17% of required funding was allocated for key service delivery items, with drugs and medicines receiving just 14% of the bid, while existing arrears exceeded current allocations, crowding out new procurements. Although Programme-Based Budgeting has been introduced, execution is still governed by rigid line-item controls and cash-based releases, limiting flexibility and responsiveness at the service-delivery level.

Budget execution is highly volatile and driven by cash availability rather than approved plans. Execution rates have ranged from 65–80% underspending to extreme overspending of 137% (2022) and 312% (2023), reflecting weak commitment controls, inflationary effects, and arrears settlement outside budget frameworks. In 2025, only 41% of the approved budget was released; however, 92% of the released funds were utilised, confirming that the binding constraint is not spending capacity but Treasury disbursements. Priority programmes such as maternal health (13% released) and contraceptives (0%) remain severely underfunded, despite full utilisation of funds when available. Procurement inefficiencies further compound these challenges. While IPSAS adoption will improve reporting, it will not resolve underlying cashflow constraints, requiring stronger coordination across MoHCC, MoFED, procurement, and supply chain systems to improve predictability, execution, and credibility of public financing

Table 4: Budget execution rates, 2020–2025

Year	Zimbabwe (ZiG / ZWL)		USD equivalent			Exp. / release	Release / budget (2025)
	Budget allocation	Expenditure	Original budget	Revised budget	Expenditure		
2020	8,710,294,161	6,391,208,180	281,493,317	519,292,103	381,032,360	73%	—
2021	54,704,500,000	35,712,568,477	913,797,541	668,868,739	436,655,497	65%	—
2022	117,714,215,000	161,179,859,377	1,100,858,896	1,103,577,663	1,511,070,626	137%	—
2023	473,758,209,000	1,476,833,371,421	517,544,418	705,579,018	2,199,481,971	312%	—
2024	9,265,875,535	7,453,988,620	886,961,475	359,170,305	288,936,686	80%	—
2025	27,826,726,000	10,503,388,812	—	—	—	92%	41%

3.2.6. Governance, Stewardship, and Accountability

Governance and stewardship challenges further undermine system coherence. Roles and responsibilities across key health financing actors, the MoHCC, MoFED, local authorities, and development partners, are fragmented, limiting effective leadership and accountability. Coordination mechanisms exist but are insufficiently empowered to align financing decisions across institutions, resulting in parallel planning, budgeting, and reporting arrangements. Donor financing, in particular, continues to operate largely outside government systems, thereby weakening visibility, harmonisation, and system-wide prioritisation. Regulatory weaknesses in the private health financing space exacerbate fragmentation and inequity. Voluntary private health insurance is weakly regulated, contributing to duplication of publicly funded services, limited risk pooling, and unequal access. The absence of an independent entity to effectively regulate medical aid societies further undermines financial protection, transparency, and provider accountability, reinforcing a two-tier system that runs counter to UHC objectives.

4.0 Strategic Direction

4.1 Vision, Goals and Strategic Objectives

Vision

A sustainable and equitable nationally led health financing system that guarantees access to quality essential health services without financial hardship for all Zimbabweans.

Mission

To strengthen the mobilisation, pooling, and strategic use of financial resources through coordinated, efficient, and accountable systems that support progress towards Universal Health Coverage.

Goal

By 2030, Zimbabwe will have increased pooled and predictable health financing, reduced out-of-pocket expenditure, and expanded equitable access to essential health services and medicines for all

Strategic Objectives

The objectives of the HFS are to

- **SO 1:** Increase and ensure predictability in the level of and stability in the flow of domestic public financing for sustained progress towards UHC
- **SO 2:** Strengthen and integrate pooling mechanisms to improve equity, financial protection, and access to essential health services
- **SO 3:** Accelerate strategic purchasing reforms to improve efficiency, quality, and alignment of financing with service delivery outcomes
- **SO 4:** Strengthen governance and accountability to ensure coherent, enforceable, and performance-driven health financing systems
- **SO 5:** Establish and operationalise the National Health Insurance

4.2 Guiding Principles

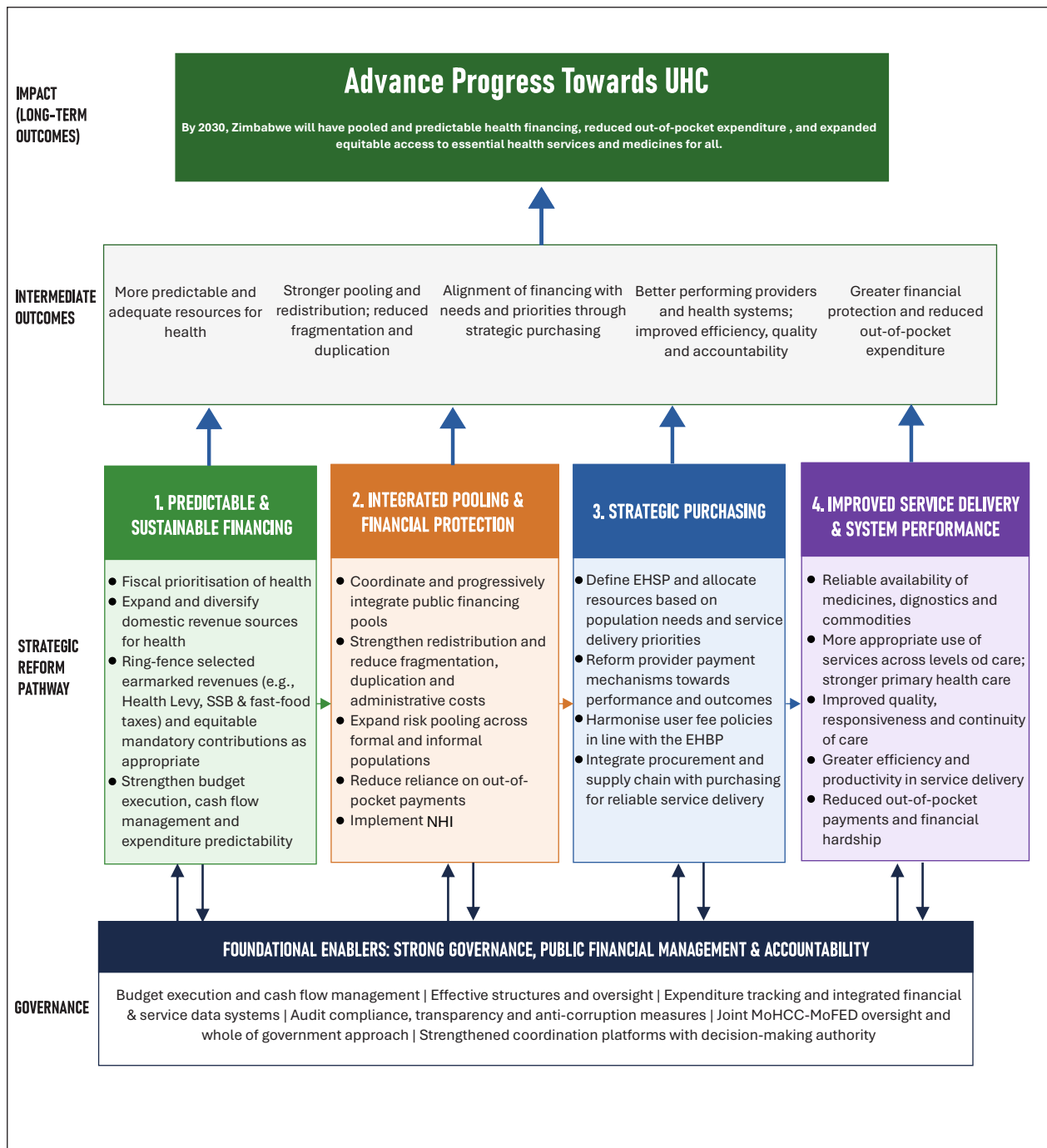
The strategic objectives were informed by, and the implementation of the strategic interventions will be guided by the following principles: -

1. **Equity, Solidarity and Financial Protection:** Prioritise financing arrangements that reduce out-of-pocket payments, expand risk pooling, and ensure equitable access to essential services.
2. **Sustainable and Predictable Financing:** Strengthen domestic resource mobilisation and ensure timely, reliable budget execution to support continuous service delivery.
3. **Efficiency and Value for Money:** Maximise the impact of available resources by improving technical and allocative efficiency and aligning spending with priority health outcomes.
4. **Accountability and Good Governance:** Strengthen financial oversight, reporting, and audit systems to ensure responsible use of resources and accountability for results.
5. **Coordination and System Integration:** Align financing flows, institutions, and stakeholders to reduce fragmentation and support a coherent, system-wide approach to health financing

4.3. Theory of Change

This Strategy sets out a coordinated package of reforms to strengthen the sustainability, equity, and performance of Zimbabwe's health financing system. Progress toward universal access to essential health services depends on financing that is predictable, pooled, strategically allocated, and supported by strong governance and public financial management systems. The Strategy therefore prioritises strengthening domestic public financing through increased fiscal prioritisation of health, improved revenue mobilisation, and ring-fencing of selected earmarked revenues, including the Health Levy and health-related taxes, to improve the predictability and stability of funding flows.

Figure 5: Theory of Change for HFS 2026- 2030



Strengthened financing will be complemented by reforms to pooling arrangements to improve redistribution, equity, and financial protection. The Strategy promotes greater coordination and progressive consolidation across public financing pools, including central government budgets, local authority financing, development assistance, AMTO, and other schemes, through virtual pooling and alignment with national systems. These reforms are expected to improve resource visibility, reduce duplication, strengthen redistribution, and reduce reliance on out-of-pocket payments.

The Strategy further advances a transition toward strategic purchasing by linking financing to a defined and costed Essential Health Benefit Package (EHBP). Reforms to resource allocation, provider payment systems, provider contracting, and user fee policies will align financing with population health needs, service delivery priorities, and performance. This is expected to improve efficiency, strengthen accountability, support more appropriate utilisation of different levels of care, and ensure that financing translates into the consistent delivery of medicines, diagnostics, and essential services at facility level.

These reforms will be supported by strengthened governance and institutional arrangements, including improved public financial management, expenditure tracking, audit compliance, integrated financial and service delivery reporting, and joint oversight between MoHCC and MoFED. Existing coordination platforms will be strengthened to support integrated decision making, alignment of financing flows, and accountability across all actors.

Within this broader reform agenda, the National Health Insurance (NHI) provides an important long-term mechanism to institutionalise pooled financing, expand mandatory prepayment arrangements, strengthen financial protection, and progressively integrate fragmented schemes into a more unified system aligned with the EHBP. The NHI will also support structured purchasing and provider accreditation arrangements linked to quality and service delivery standards. At the same time, the wider reforms in this Strategy are designed to deliver improvements in financing predictability, pooling, purchasing, and governance irrespective of the pace of NHI implementation, while creating the institutional and fiscal foundations required for its long-term success.

5.0 Strategic Interventions and main activities

The health financing system requires a systems-based approach to stabilise and strengthen public financing, improve risk sharing and enhance strategic purchasing. This strategy is structured around the core financing functions, revenue generation, pooling, and purchasing, underpinned by strong institutional frameworks, including a public financial management framework that ensures resources are predictable, reliable, and effectively deployed. To achieve each of the strategic objectives, a number of interventions and main activities have been defined and are as elaborated below, by strategic objectives under the health financing system functions.

5.1. SO 1: Increase and strengthen the predictability, stability, and sustainability of domestic public financing for health

Revenue generation reforms during the Strategy period will focus on strengthening predictable and protected financing flows for the health sector, improving alignment between allocations and sector priorities, and ensuring that financing translates into service delivery outcomes and sustained progress toward universal health coverage. The Strategy will prioritise increased domestic resource mobilisation, ring-fencing of selected health revenues, improved fiscal prioritisation of health within the national budget process, and strengthened public financial management systems to improve stability and predictability of funding flows to programmes and service delivery levels.

These reforms will be supported by stronger integration of financial reporting across government and off-budget financing flows, evidence-based prioritisation within the Medium-Term Expenditure Framework (MTEF), and improved linkage between financing, the Essential Health Benefit Package (EHBP), and pooling arrangements. Together, these measures are intended to reduce allocation volatility, strengthen allocative efficiency, improve accountability for resource use, and create the fiscal foundation required to sustain equitable expansion of essential health services. These will be achieved by implementing the following strategies:

Strategy 5.1.1: Strengthen evidence based investment planning and fiscal engagement to position health financing within national economic and fiscal policy through the following strategic interventions or main activities:

- 1.1.1. Establish a legal and regulatory framework for ring-fencing of earmarked taxes for health, including SSB, fast food taxes and Health Levy with clear tracking, reporting, and accountability mechanisms.
- 1.1.2. Strengthen mechanisms to ensure earmarked revenues are effectively integrated into national budgeting and pooling frameworks, with clear allocation rules to support priority health services and system strengthening
- 1.1.3. Develop a health sector investment case that positions health as an economic investment, clearly quantifying productivity gains, fiscal risk mitigation, and the cost of inaction, aligned to disease burden, service delivery needs, and the EHBP

Strategy 5.1.2: Institutionalise transparent and integrated PFMS to strengthen budget credibility, predictability, and fiscal engagement through the following strategic interventions or main activities: -

- 1.2.1. Strengthen parliamentary engagement throughout the PFMS cycle by institutionalising structured pre-budget submissions and post-budget performance reviews to Portfolio Committees on Health and Finance, supported by accessible evidence tools on allocations, disbursements, and sector performance.
- 1.2.2. Strengthen Budget and Finance committees as formal decision making structures responsible for developing credible, evidence-based budget bids aligned to fiscal ceilings and sector priorities
- 1.2.3. Drive and build capacity for systematic use of expenditure and service delivery data in budget formulation, reprioritisation, and fiscal engagement
- 1.2.4. Standardise financial reporting across all levels in line with IPSAS and national systems to reflect the full financial position of the sector and strengthen credibility with Treasury and partners
- 1.2.5. Strengthen and accelerate Programme-Based Budgeting implementation by aligning planning, budgeting, procurement, fund flows, and performance reporting with service delivery priorities and outputs, moving from representational to PBB execution of budgets.

Strategy 5.1.3: Strengthen and optimise domestic revenue sources for health through improved collection, earmarking, and accountability through the following strategic interventions or main activities: -

- 1.3.1. Reform the governance, collection, and accountability framework of the Health Services Fund, including enforceable allocation rules and regular independent audits, to ensure revenues are fully captured, aligned with national priorities, and protected from leakage.
- 1.3.2. Develop and deploy an electronic system to strengthen billing, debtor collection, recording and accounting for HSF funds to improve efficiency and reduce revenue leakages.
- 1.3.3. Develop and submit evidence-based policy proposals for adjusting existing excise taxes on alcohol, tobacco, sugar-sweetened beverages, and fast food to align with international benchmarks, maximise revenue potential, and influence consumption patterns
- 1.3.4. Develop evidence and mobilise for expanding the scope of health related excise taxes to emerging products, including e-cigarettes and other harmful commodities, to address evolving risk factors and broaden the tax base.

Strategy 5.1.4: Explore mechanisms to establish mandatory prepayment and contribution mechanisms through the following strategic interventions or main activities: -

- 1.4.1 Explore alternative approaches to introduce mandatory contribution mechanisms across all population groups, including formal, informal and rural and urban populations, to expand the NHI revenue base and reduce reliance on indirect taxes (sin taxes)
- 1.4.2 Integrate micro-insurance schemes (e.g., Harare City CBHI pilot) into national pooling arrangements as transitional mechanisms for the NHI

Strategy 5.1.5: Mobilise non-traditional and regional financing sources to enhance domestic resource mobilisation through the following strategic interventions or main activities: -

- 1.5.1. Develop and operationalise a legal and regulatory PPP framework for health infrastructure with a clear investment case for private sector participation.
- 1.5.2. Develop mechanisms to channel philanthropic and community financing into health system priorities, including infrastructure, digital systems, and supply chains.
- 1.5.3. Establish/strengthen mechanisms to promote investment in local manufacturing and domestic procurement of essential health commodities, including pharmaceuticals, vaccines, and diagnostics, in partnership with relevant line ministries.
- 1.5.4. Develop investment cases and mobilise blended financing from regional and international platforms (e.g. Africa CDC, AfDB, SADC, World Bank and other IFIs) to co-finance large-scale health and manufacturing investments.
- 1.5.6. Develop bankable investment cases that focus on leveraging blended financing instruments to de-risk investments and aligning financing with national health priorities.

5.2. SO 2: Strengthen and integrate pooling mechanisms to improve equity, financial protection, and access to essential health services

Pooling reforms will focus on strengthening coordination, integration, and redistribution across fragmented financing arrangements to improve equity, financial protection, and alignment of resources with population health needs. The Strategy will progressively move the system from parallel and fragmented financing streams toward a more coordinated pooling architecture that improves visibility of all financing flows, strengthens equalisation across national and sub-national pools, and aligns donor, public, and private financing with national priorities and systems. In the short to medium term, reforms will prioritise virtual pooling arrangements, integrated reporting systems, harmonised allocation approaches, and common accountability frameworks across government, donor, local authority, and social protection financing arrangements. Over the longer term, the Strategy will support phased consolidation of financing streams through a fiscally realistic NHI framework with a clearly defined benefit package, stronger cross-subsidisation mechanisms, and progressively integrated purchasing arrangements. The strategies and interventions required to achieve these reforms are detailed below.

Strategy 5.2.1: Progressively consolidate public financing pools to improve redistribution, equity, and resource visibility across the health system

- 2.1.1 Strengthen coordination and engagement across domestic financing pools and establish common reporting, monitoring, and operating arrangements across MoHCC, local authorities, missions, and other public pools.
- 2.1.2 Develop and implement a sub-national resource equalisation mechanism that explicitly addresses provincial and district level redistribution, allocating resources based on population size, poverty rates, disease burden, and service utilisation.

- 2.1.3 Strengthen resource mapping and donor coordination frameworks and develop an integrated national health financing dashboard for the virtual donor pool under MoHCC stewardship to align external financing.
- 2.1.4 Develop a consolidated transition roadmap for external financing, with clear bilateral commitment to limit transition shocks on service delivery financing.

Strategy 5.2.2: Strengthen pooled subsidy mechanisms for poor and vulnerable populations

- 2.2.1 Increase engagement and collaboration with the Ministry of Labour and Social Welfare to enhance the implementation of AMTO and related subsidy mechanisms.
- 2.2.2 In alignment with relevant line Ministries and stakeholders, establish an integrated social registry and beneficiary verification system to support targeted subsidies, exemptions, and entitlement management for effective coverage of intended beneficiaries.
- 2.2.3 Establish routine monitoring and evaluation of subsidy scheme performance, including coverage rates, reimbursement timeliness, targeting accuracy, and impact on OOP spending.
- 2.2.4 Align user fee exemption mechanisms and financing for vulnerable populations with the broader pooling towards effective risk coverage linked to service availability

Strategy 5.2.3: Strengthen the regulation and integration of voluntary health insurance to improve effective coverage and support pooling objectives

- 2.3.1 Review and operationalise a comprehensive regulatory framework for voluntary health insurance to improve governance, transparency, and alignment with national health financing objectives
- 2.3.2 Strengthen MoHCC oversight capacity on VHI in the short term and establish an independent regulatory body for voluntary health insurance in the medium to long term.
- 2.3.3 Introduce risk equalisation and standardisation mechanisms to strengthen cross subsidisation and reduce fragmentation across medical aid schemes, including limiting tax subsidies for private medical aid contributions.
- 2.3.4 Define and enforce a clear minimum benefits package and coverage standards to improve effective coverage and reduce excessive co-payments and out-of-pocket spending for patients covered under VHI
- 2.3.5 Separate and regulate pooling and purchasing functions within voluntary health insurance schemes to reduce conflicts of interest, improve purchasing efficiency, and strengthen alignment with the NHI cross-subsidisation framework

5.3. SO 3: Accelerate strategic purchasing reforms to improve efficiency, quality, and alignment of financing with service delivery outcomes

Strategic purchasing reforms will focus on aligning financing with defined service entitlements, population health needs, and service delivery outcomes. The Strategy will prioritise the establishment and financing of a clearly defined Essential Health Benefit Package (EHBP), strengthening primary healthcare financing, harmonising user-fee and exemption policies, and

strengthening subsidy mechanisms to improve financial protection and equitable access to services. Reforms will also strengthen provider payment systems, resource allocation mechanisms, and purchasing arrangements to improve efficiency, quality, accountability, and responsiveness across the health system.

The country will further prioritise stronger integration between financing, procurement, and supply systems to ensure that purchasing reforms translate into reliable availability of medicines, diagnostics, and essential health commodities. As domestic financing assumes a greater role, market-shaping approaches will be progressively embedded in national systems through coordinated procurement, demand aggregation, supply chain integration, and stronger alignment between financing decisions and service delivery priorities. Together, these reforms aim to establish more predictable, needs-based, and performance-oriented purchasing arrangements that strengthen service delivery, improve efficiency, and support universal access to essential health services with financial protection.

These will be achieved by implementing the following strategies:

Strategy 5.3.1: Define and finance a prioritised Essential Health Benefit Package to strengthen service entitlements and reduce out-of-pocket exposure

3.1.1 Finalise, cost, and operationalise a fiscally realistic Essential Health Benefit Package that clearly defines entitlements across levels of care.

3.1.2 Ring-fence and disburse non-wage operational budgets to PHC and district facilities on a predictable schedule aligned to service delivery plans and EHBP priorities.

3.1.3 Align budget allocation, pooled financing, and resource mobilisation to EHBP priorities, with emphasis on primary care, maternal and child health, and public health services.

3.1.4 Ensure availability of essential medicines and supplies at PHC level through integrated procurement, distribution, and stock monitoring systems linked to service delivery volumes.

3.1.5 Standardise PHC and community-level service delivery packages, including outreach and Village Health Worker programmes, linked to financing and performance frameworks.

Strategy 5.3.2: Reduce financial barriers and strengthen financial protection through harmonised user fee policies, effective exemption mechanisms, and improved demand-side protection measures

3.2.1 Standardise and enforce user fee schedules, co-payment policies, exemption rules, and implementation arrangements across all public providers, including local authorities, with clear protections for priority and vulnerable populations, including indigent groups.

3.2.2 Strengthen enforcement of referral and gatekeeping systems through financing and accountability mechanisms, including differential tariffs for non-referred tertiary access, performance-linked incentives for compliance, and clearly communicated referral rules for patients and providers.

3.2.3 Strengthen transparency, oversight, and accountability mechanisms to eliminate informal charges and non-transparent fee practices, including the establishment of patient rights, grievance, and escalation mechanisms at the facility and district levels.

3.2.4 Develop and implement a national health literacy and public communication strategy on service entitlements, user fees, exemption rights, and referral pathways to improve awareness, access, and compliance.

Strategy 5.3.3: Strengthen strategic purchasing through needs-based resource allocation, provider payment reform, and performance-informed financing mechanisms

3.3.1 Develop and implement a national health sector resource allocation formula aligned to population health needs, service delivery priorities, the EHBP, and equity considerations.

3.3.2 Develop and implement a harmonised national tariff and provider payment framework across public and private providers, including capitation for primary care, case-based payments for hospitals, and performance-based financing components to incentivise quality, efficiency, and service delivery outcomes.

3.3.3 Institutionalise performance-based financing within national systems through a funded government transition plan to progressively absorb donor-financed RBF programmes, including defined fiscal commitments, timelines, and minimum performance standards.

3.3.4 Establish formal provider contracting arrangements defining service expectations, quality standards, reporting requirements, and accountability mechanisms, particularly for faith based, council, and other publicly subsidised providers.

Strategy 5.3.4: Strengthen PFM execution, facility financing, and accountability systems to support purchasing functions

3.4.1 Embed allocation rules within Programme-Based Budgeting (PBB) and the Medium-Term Expenditure Framework (MTEF) to ensure that budget ceilings, allocations, and releases are aligned with sector priorities, service delivery outputs, and system performance.

3.4.2 Strengthen cashflow forecasting, commitment control, and disbursement systems to ensure predictable and timely funding.

3.4.3 Establish and enforce a cash flow forecasting and commitment control system at the facility level to ensure operational budgets are managed predictably across the fiscal year, reducing mid-year service disruptions.

3.4.4 Improve coordination between MoHCC and MoFED on budget releases and execution monitoring.

3.4.5 Increase facility-level autonomy over resource use within a strengthened accountability framework.

Strategy 5.3.5: Strengthen market shaping and supply-side financing to improve access, affordability, and availability of health commodities

3.5.1 Integrate demand forecasting, financing commitments, procurement planning, and supply chain data systems to generate predictable and credible market signals for suppliers and improve alignment between financing and commodity availability.

3.5.2 Expand pooled procurement, strategic sourcing, volume guarantees, and price negotiation mechanisms to improve purchasing efficiency, reduce costs, and strengthen the reliability of supply for essential medicines, diagnostics, and health commodities.

3.5.3 Strengthen integration of private pharmacies, distributors, manufacturers, and providers into national supply, financing, quality assurance, and reporting systems to improve access and reduce fragmentation across public and private markets.

3.5.4 Support development of regional and domestic manufacturing capacity for priority health commodities through aligned industrial policy, regulatory support, procurement commitments, and long-term contracting arrangements that create predictable demand for local producers.

3.5.5 Align industrial policy, procurement systems, health financing reforms, and regional market initiatives to strengthen supply resilience, reduce dependency on external markets, and improve long-term sustainability of commodity supply systems.

5.4. SO 4: Strengthen governance and accountability to ensure coherent, enforceable, and performance-driven health financing systems

Governance reforms will focus on strengthening formal, government-led systems with clear authority, coordination, accountability, and performance oversight across all health financing functions. The Strategy will strengthen the stewardship roles of the MoH CC and relevant Ministries, Departments and Agencies (MDAs) to ensure that financing flows, institutions, reporting systems, and accountability mechanisms are aligned with national priorities, service delivery objectives, and universal health coverage goals.

The reforms will prioritise integrated planning and reporting systems, evidence-informed decision-making, strengthened transparency, and enforceable accountability across all levels of the health system, including national institutions, provinces, districts, facilities, and communities. Particular emphasis will be placed on strengthening system stewardship, integrated oversight of financing flows, institutional coordination, regulatory enforcement, and routine use of financial and service delivery data to guide allocation, performance management, and policy decisions. Together, these reforms aim to establish a coherent, integrated, and performance-driven governance system that improves accountability, strengthens financial protection, and supports sustained progress toward universal health coverage.

These will be achieved by implementing the following strategies:

Strategy 5.4.1: Strengthen institutional capacity to lead, coordinate, and sustain domestic resource mobilisation

4.1.1 Upgrade existing coordination platforms, including the Donor Coordination Framework, into formal decision-making bodies with clearly defined mandates, quorum requirements, and binding authority over financing alignment decisions.

4.1.2 Establish formal recording, tracking, and follow-up systems for all decisions made within coordination platforms, with accountability assigned to named institutional leads.

4.1.3 Strengthen the Health Economics Unit and other relevant directorates within MoHCC, and MDAs to lead routine fiscal space analysis, revenue forecasting, and development of investment cases and mobilisation targeted to relevant stakeholders.

4.1.4. Generate and disseminate evidence on returns on health investment and the fiscal cost of inaction to support advocacy with Treasury and development partners.

4.1.5. Build capacity of budget committees to implement evidence-based approaches to budget bids, including resources needed for investment cases and priority health areas.

Strategy 5.4.2: Enhance integration, transparency, accountability, and oversight across all financing flows and actors

4.2.1 Consolidate financial reporting across all financing sources to provide a complete and consistent view of resource allocation, execution, and service delivery outcomes.

4.2.2 Enforce timely implementation of audit findings through formal tracking, escalation, and institutional accountability mechanisms, with Parliamentary oversight focused on execution and corrective action.

4.2.3 Strengthen regulatory oversight of public and private financing actors including insurance schemes and statutory funds, to ensure compliance with national financing policies.

4.2.4 Expand independent oversight by strengthening the formal role of civil society in monitoring financing performance, transparency, and accountability.\

4.2.5. Enact Medical Aid Regulatory Bill establishing an independent regulator; define solvency standards, minimum benefits, standardised reporting, consumer protection, grievance mechanisms, separation of pooling and purchasing, limit tax subsidies undermining cross subsidisation

Strategy 5.4.3: Strengthen and institutionalise the use of evidence and data in financing decisions

4.4.1 Institutionalise routine implementation of NHA, RMET, PER, and HFPM with dedicated capacity, and integrate outputs into budget formulation, allocation, and policy processes.

4.4.2 Build data use capacity at district and facility levels, including training, decision-support tools, and peer learning mechanisms, to ensure subnational actors can interpret and apply financial and service delivery data in planning and performance management.

4.4.3 Establish structured feedback mechanisms at national, provincial, and facility levels to ensure analytical outputs inform corrective actions, policy adjustments, and system reforms, with documented evidence of use in decision-making processes.

4.4.4 Strengthen the financial management and governance capacity of Health Centre Committees, Hospital Boards, and local authorities, including training on national financing rules, expenditure reporting, and performance accountability requirements.

5.5. SO 5 : Establish and operationalise the National Health Insurance

The National Health Insurance will be established as a legislatively mandated, government - led financing mechanism to strengthen pooled financing, improve the predictability of funding, and support the progressive expansion of universal health coverage. Embedded within the broader national health financing system, the NHI will complement core government budget allocations through protected, rules-based financing arrangements linked to defined service entitlements, facility operational needs, and service delivery outputs. The NHI will progressively strengthen cross-subsidisation, expand financial protection, and support the transition toward more strategic purchasing arrangements aligned with the Essential Health Benefit Package.

The country will focus on establishing legally protected financing flows, strengthening predictable facility-level operational financing, and introducing structured purchasing arrangements that improve service readiness, accountability, and linkage between financing and service delivery outcomes. Over time, the NHI will progressively evolve toward a broader pooled financing and purchasing platform as institutional capacity, fiscal space, provider payment systems, and health information systems mature. Together, these reforms aim to establish a sustainable and progressively integrated financing mechanism that strengthens equity, improves financial protection, and supports long-term progress toward universal health coverage.

These will be achieved by implementing the following strategies:

5.5.1 Establish the legal and institutional framework for the NHI through enactment and operationalisation of the NHI Act.

5.1.1 Enact NHI Act, establishing basis for mandatory ring-fencing, transparent reporting on collection, allocation, utilisation, of health taxes and a comprehensive framework for delivering the EHSP

5.1.2 Expand and diversify the NHI revenue base through phased inclusion of additional earmarked revenues, including tobacco and alcohol levies, subject to fiscal and legal feasibility.

5.1.3 Protect NHI revenues from in-year reallocation and cashflow diversion through strengthened public financial management and disbursement rules.

5.1.4 Integrate NHI financing flows into national PFMS and financial reporting systems to strengthen transparency, accountability, and alignment with national budgeting processes.

Strategy 5.5.2: Establish and progressively expand a defined and financially sustainable NHI benefit package

5.2.1 Develop and operationalise a phased NHI benefit package aligned with the national Essential Health Benefit Package.

5.2.2 Fully cost NHI benefit package entitlements and align implementation with available and sustainable financing to avoid implicit rationing.

5.2.3 Prioritise financing of high impact, operationally feasible primary healthcare and outpatient services with significant population health impact.

5.2.4 Align NHI service entitlements with referral pathways and provider readiness requirements, including medicines, staffing, and diagnostic availability.

5.2.5 Harmonise NHI entitlements with broader national service delivery and purchasing reforms to reduce fragmentation and conflicting benefit structures.

Strategy 5.5.3: Establish structured purchasing and predictable facility financing arrangements under the NHI

5.3.1 Implement predictable and scheduled direct transfers to facilities for non wage operational costs aligned to defined service delivery plans and NHI priorities.

5.3.2 Link facility financing to defined service outputs, reporting requirements, and service readiness conditions, including staffing, medicines, and diagnostic availability.

5.3.3 Establish protected financing arrangements for essential medicines and diagnostics through pooled and central procurement mechanisms.

5.3.4 Strengthen and standardise facility financing arrangements by building on existing Health Services Fund systems and integrating NHI financing into national PFMS and reporting frameworks.

5.3.5 Introduce phased performance- and compliance-based financing components linked to reporting, service delivery performance, referral compliance, and quality standards.

5.3.6 Align NHI purchasing arrangements with broader national provider payment reforms, including phased introduction of tariff frameworks, capitation, case-based payment systems, and strategic purchasing mechanisms as institutional capacity develops.

Strategy 5.5.6: Strengthen governance, accountability, and institutional capacity for NHI implementation

- 5.5.1 Establish clear governance, stewardship, and accountability arrangements for NHI oversight, financing, purchasing, and reporting functions.
- 5.5.2 Define institutional roles and coordination mechanisms across MoHCC, MoFED, facilities, local authorities, and other financing actors involved in NHI implementation.
- 5.5.3 Strengthen financial management, reporting, and accountability systems at national and facility levels to support transparent and efficient use of NHI funds.
- 5.5.4 Establish integrated monitoring, reporting, and performance review systems for NHI financing flows, purchasing arrangements, and service delivery outcomes.
- 5.5.5 Build institutional and technical capacity for NHI implementation, including purchasing, financial management, provider contracting, and performance monitoring systems.

6. Implementation Arrangements/Framework

6.1 Implementation timeframe

The implementation timeframe for this Health Financing Strategy spans 2026–2030, aligned with the National Development Strategy 3 (NDS3), the National Health Strategy, and Zimbabwe's commitments under the Sustainable Development Goals, particularly progress toward Universal Health Coverage by 2030. While the Strategy outlines reforms and targets to be achieved within this period, many of the interventions are catalytic, intended to establish the legal, governance, financing, and systems required for longer term transformation beyond 2030. Several reforms, including the NHI, Programme-Based Budgeting, strategic purchasing, and integrated pooling arrangements, will require phased implementation and progressive institutional maturity over multiple planning cycles. The Strategy also builds on unfinished and evolving priorities from the previous Health Financing Strategy, with a focus on accelerating implementation, consolidating existing reforms, and transitioning from policy development toward operationalisation, enforcement, and sustained system strengthening.

6.2 Institutional Arrangements/Framework

This strategy implementation framework places the MOHSS as the central coordinator of efforts towards UHC. The Ministry will ensure that strategic goals are cascaded and aligned to other policies and reforms within the health sector and relevant line ministries. Table 2 provides guidance on the roles each stakeholder is expected to play.

Table 5: Institutional roles in HFS implementation

Institution	Role
MoHCC	Leads overall sector stewardship of revenue generation, pooling and strategic purchasing, NHI design, partner coordination, and strategy implementation and monitoring.
MoHCC (Provincial Medical Directorates)	Coordinates national priorities with provincial and district implementation, including sub-national resource equalisation, provider payment reforms, and building district-level data use capacity.
MoFED	Ensures predictable disbursement of health allocations, enforces ring-fencing of earmarked revenues, and leads PFM and IPSAS reforms.
Ministry of Public Service, Labour and Social Welfare	Administers AMTO, claims processing, and alignment with broader pooling arrangements.
Ministry of Local Government	Oversees alignment of local authority health financing, user fee harmonisation, and council reporting with national policy.
Office of the President and Cabinet	Provides political leadership for health financing within NDS3, enforces inter-ministerial accountability.
Parliament (Portfolio and Budget Committees)	Oversight over health budget allocations and execution, oversees NHI and regulatory legislation, enforces corrective action on audit findings, and receives annual health financing performance reports.
National AIDS Council	Manages the AIDS Levy Trust Fund, maintains pooled HIV financing, and progressively aligns NAC governance and purchasing arrangements with the national health financing framework.
Development partners	Provide development assistance for health aligned to national priorities

Private sector (Medical Aid Societies, providers, manufacturers)	Provides complementary health services and pooling of resources/risk
Civil society organisations	Exercises independent oversight of financing performance, transparency, and accountability, and supports community-level monitoring, joint sector reviews, and HFPM assessments.
Health Centre Committees and Hospital Boards	Exercises legally defined financial oversight at the facility level, managing HSF resources and performance reporting within the national governance and accountability framework.

6.3 Health Financing Coordination

The Health Sector Coordination Framework provides established platforms that will be strengthened and leveraged during the strategy period. The High-Level Ministerial Meeting on Health Sector Coordination provides political oversight and inter-ministerial accountability at the highest level. The Health Sector Coordination Working Group, chaired by the Permanent Secretary, brings together relevant MDAs, development partners, private sector representatives, civil society organisations, and other stakeholders to oversee sector wide performance. The Health Financing Technical Working Group serves as the primary operational platform for tracking implementation of this strategy, reviewing quarterly performance, documenting decisions with assigned institutional leads, and escalating unresolved bottlenecks to senior management.

The coordination of health financing reforms will be led by the MoHCC, which will serve as the institutional anchor for strategy implementation, development partner engagement, and cross sectoral alignment. The Directorate of Policy and Planning will work in close collaboration with the MoHCC Directorate of Finance on all matters related to budgeting, budget execution, reporting of domestic resources, and alignment with external financing flows. This dual leadership arrangement ensures that policy direction and financial management operate as an integrated function rather than parallel workstreams.

Internal MoHCC coordination platforms, including programme-level planning meetings and directorate-level reviews, will be leveraged to ensure that health financing reforms are embedded across all technical programmes and not treated as a standalone workstream. Inter-ministerial government platforms, including joint MoHCC-MoFED budget formulation and review processes, will strengthen fiscal coordination. Parliamentary Portfolio and Budget Committees for both health and finance will be proactively engaged, with members invited to participate in health sector coordination platforms to strengthen their oversight, information-sharing, and advocacy roles. This engagement will complement the capacity-building initiatives for Parliamentary committees described in section 11.7.4.

6.4 Legal and Regulatory Arrangements

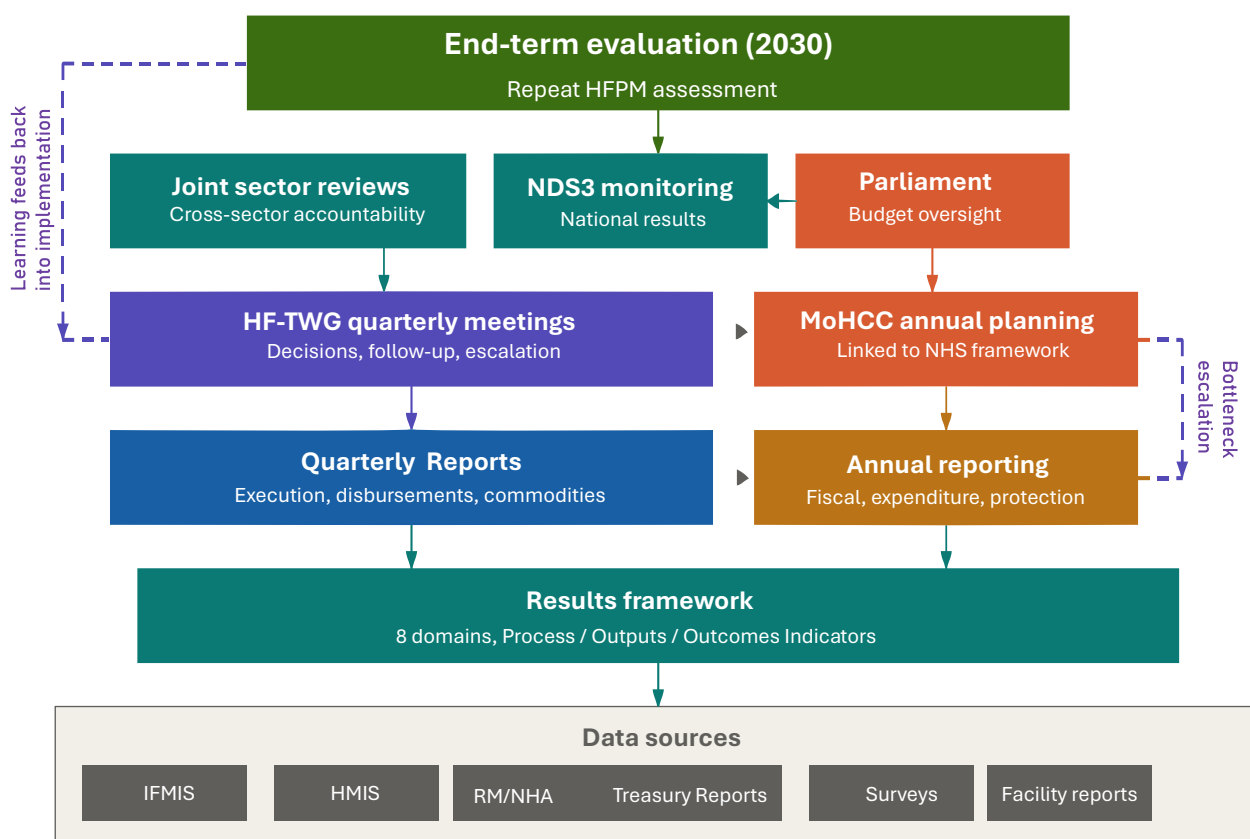
Implementation of the Strategy will require targeted legal and regulatory reforms to formalise institutional mandates, strengthen accountability, and provide the enforcement basis for key health financing reforms. Priority reforms include the enactment of the NHI Act, the establishment of legally protected and transparent health financing arrangements, the regulation of medical aid schemes, the legal recognition of the Essential Health Benefit Package, the harmonisation of local

authority financing arrangements, and the development of a dedicated health PPP framework. Together, these reforms will strengthen governance, improve predictability and transparency of financing flows, support strategic purchasing and financial protection, and provide the legal foundation for a more coherent, equitable, and sustainable health financing system

6.5. Reporting, Monitoring, Evaluation, and Learning Framework

The implementation of this Health Financing Strategy will be monitored through a results framework anchored to the findings of the 2024 Health Financing Progress Matrix (HFPM). The HFPM confirmed that Zimbabwe has a strong policy foundation across the core health financing functions but a persistent gap between policy intent and implementation. The monitoring and evaluation framework is therefore designed to track the operationalisation of reforms and their translation into measurable improvements in fiscal performance, financial protection, and service delivery, rather than the formulation of additional policy commitments. The M&E key processes and structures are shown in Figure 6 below:

Figure 6: Monitoring & Evaluation Processes and Structures



7.5.1. Results framework and indicator structure

The MERL framework in Table 6 provides the strategy's primary accountability mechanism, organizing indicators across three tiers, impact, outcome, and process, to track whether financing reforms are translating into measurable gains in fiscal space, financial protection, and service delivery performance. The framework is designed to serve three functions. First, it establishes a clear line of sight from reform inputs to population level outcomes, enabling decision makers to distinguish between implemented reforms and those producing results. Second, it provides a structured basis for mid-term course correction by combining annually tracked fiscal and operational indicators with periodic population level measures, ensuring that both the pace of implementation and the direction of impact are visible. Third, it strengthens mutual accountability across government, development partners, and oversight institutions by anchoring review processes in a common set of evidence-based benchmarks rather than relying solely on narrative reporting.

Baselines are drawn from the 2025 HFPM assessment, National Health Accounts, Treasury data, and routine health information systems. Where baselines require establishment through facility surveys or household data collection, these will be completed within the first year of implementation. Targets are phased annually to 2030 and calibrated to reflect both the sequencing of reforms and the fiscal constraints identified in the situation analysis. Where progress depends on achieving legislative or institutional milestones, targets are expressed as milestone-dependent rather than as fixed annual projections. The framework will be reviewed at mid-term to assess indicator relevance, data availability, and target adequacy, with adjustments made through the HF-TWG governance structure.

Table 6: Monitoring and Evaluation Indicator Tracker

A. Impact Indicators										
Domain	Type	Indicator	Baseline (2025)	2026	2027	2028	2029	2030 Target	Frequency	Data Source
Universal Health Coverage	Outcome	Service Coverage Index (SDG 3.8.1)	59					65	Periodic	WHO GHO
Financial Protection	Outcome	Incidence of catastrophic health expenditure (10% threshold)	~11%					5%	Periodic	Household Survey
Financial Protection	Outcome	Population impoverished by OOP health spending (%)	~5%						Periodic	Household Survey
Service Utilisation	Outcome	Outpatient visits per capita	2.5					2	Annual	HMIS
Service Delivery	Outcome	Skilled birth attendance (%)	86%						Annual	HMIS
Service Delivery	Outcome	Immunisation coverage (DPT3, %)	~84%					96%	Annual	HMIS

B. Outcome Indicators by Strategic Objective										
SO 1: Increase and strengthen the predictability, stability, and sustainability of domestic public financing for health										
Domain	Type	Indicator	Baseline (2025)	2026	2027	2028	2029	2030 Target	Frequency	Data Source
Fiscal Prioritisation	Output	Government health expenditure (% of total government expenditure)	11%	12 %	15%	15%	15%	15%	Annual	MoFED Budget
Domestic Financing	Output	Per capita government health expenditure (USD)	28.19 (2024)						Annual	NHA
Domestic Financing	Output	Share of domestic financing (GHE as % of THE)	~33.6%					75%	Annual	NHA
Earmarked Revenue	Process	Revenue from earmarked health taxes ringfenced to health through legislation	None						Annual	ZIMRA / MoFED
Budget Execution	Process	Non-salary operational budget execution rate (%)	~30%						Quarterly	IFMIS / Treasury
Budget Predictability	Process	Share of approved health budget disbursed within each quarter	Q3: 27%						Quarterly	Treasury
SO 2: Strengthen and integrate pooling mechanisms to improve equity, financial protection, and access to essential health services										
Domain	Type	Indicator	Baseline (2025)	2026	2027	2028	2029	2030 Target	Frequency	Data Source
Pooling	Output	Population covered by prepayment/pooled mechanisms (%)	~25%						Annual	NHI / NHA
Financial Protection	Outcome	Out-of-pocket expenditure (% of CHE)	~20.7% (2024)					10%	Annual	NHA
Fragmentation	Process	Number of separately governed health financing pools (fragmentation proxy)	5+						Annual	MoHCC

Aid Alignment	Process	Share of external financing reported through national PFM systems (%)	~50%						Annual	MoHCC / MoFED
NHI Development	Process	NHI bill development milestones achieved against the defined timeline	Concept stage						Annual	MoHCC / Parliament
Redistribution	Process	Resource allocation formula implemented	No formula						Annual	MoHCC
SO 3: Accelerate strategic purchasing reforms to improve efficiency, quality, and alignment of financing with service delivery outcomes										
Domain	Type	Indicator	Baseline (2025)	2026	2027	2028	2029	2030 Target	Frequency	Data Source
Purchasing Reform	Process	Share of health facility payments linked to outputs or performance (%)	~10%						Annual	MoHCC
PBB Implementation	Process	Share of budget aligned to PBB in execution (%)	~20%						Annual	MoHCC / MoFED
PHC Prioritisation	Output	Share of expenditure on PHC (%)	~45%						Annual	NHA
Claims Efficiency	Output	AMTO claims processing time (days from submission to reimbursement)/ Total AMTO arrears	>365 days						Quarterly	MoPSLSW
EHBP Definition	Process	EHBP costed with published financing gap analysis	Not costed						Annual	MoHCC
User Fees	Process	Share of primary care facilities where no formal or informal user fees are charged (%)	Baseline TBD						Annual	MoHCC / Survey

Commodity Security	Output	Share of EHBP tracer commodities available at facility level without stock-out (%)	Baseline TBD						Quarterly	HMIS / LMIS
Awareness	Output	Share of population aware of service entitlements under EHBP (%)	Low (TBD)						Periodic	Household Survey

Public Financial Management and Budget Execution

Domain	Type	Indicator	Baseline (2025)	2026	2027	2028	2029	2030 Target	Frequency	Data Source
Budget Execution	Process	Overall budget execution rate (%)	~80%					95%	Annual	IFMIS
Budget Variance	Process	Variance between approved and actual expenditure (%)	~20%						Annual	MoFED
Facility Systems	Process	Share of facilities with automated financial management systems integrated with national PFM (%)	~40%					100%	Annual	MoHCC
Arrears (Medicines)	Output	NATPHARM arrears as proportion of annual medicines budget (%)	High (TBD)						Quarterly	NATPHARM / MoHCC
Facility Reporting	Process	Share of facilities producing quarterly financial and performance reports (%)	~40%					100%	Quarterly	MoHCC

SO 4: Strengthen governance and accountability to ensure coherent, enforceable, and performance-driven health financing systems										
Domain	Type	Indicator	Baseline (2025)	2026	2027	2028	2029	2030 Target	Frequency	Data Source
Coordination	Process	HF-TWG meetings held with documented decisions, assigned leads, and tracked follow-up (per year)	Irregular, no follow-up	4	4	4	4	20	Quarterly	MoHCC
Aid On-Budget	Process	Share of donor funds on-budget and reported through national systems (%)	~50%						Annual	MoHCC / MoFED
Reporting Timeliness	Process	Timeliness of quarterly financial reports (%)	~50%					100%	Quarterly	MoHCC
Transparency	Process	Publication of annual health expenditure reports	Irregular						Annual	MoHCC
Audit Compliance	Process	Audit compliance rate (% of findings implemented within the defined timeframe)	~60%					100%	Annual	Auditor General
System Assessment	Output	HFBM composite score by assessment area (repeat assessment)	Progressing (most); Emerging (purchasing)						Mid-term / End-line	WHO / MoHCC
Analytical Products	Process	NHA, PER, RMET produced on schedule and referenced in budget submissions	Produced with partner support; not linked to budgets						Annual	MoHCC
Policy Briefs	Process	Standardised decision-support briefs produced and aligned with budget cycle	None						Annual	MoHCC

6.5.2. Institutional arrangements for monitoring

Monitoring will be led by the MoHCC Policy and Planning Directorate, with a dedicated health financing monitoring function responsible for data collection, consolidation, and reporting. The Health Financing Technical Working Group will serve as the primary platform for tracking the implementation of the strategy and for reviewing quarterly performance dashboards covering budget execution, disbursement rates, facility-level financial reporting, and tracer commodity availability. Each quarterly review will produce documented follow-up actions with assigned institutional leads and defined timelines, and unresolved bottlenecks will be escalated to MoHCC senior management and, where necessary, to joint MoHCC-MoFED review mechanisms.

6.5.3. Reporting and alignment with national frameworks

Performance against key health financing indicators will be reported annually through the MoHCC annual planning meeting, with results linked to the National Health Strategy results framework to ensure coherence between financing reforms and service delivery priorities. Annual reporting will also be integrated into joint sector reviews and NDS3 monitoring processes, ensuring that health financing performance is visible at the highest levels of government planning and subject to the same results-based accountability applied across national development priorities.

6.5.4. Evaluation and learning

An independent end-term evaluation will be conducted in 2030, incorporating a repeat HFPM assessment to provide a composite, externally validated measure of progress across all governance, financing, and purchasing functions. The strategy adopts an explicit learning orientation: annual reviews will document not only whether targets are being met but why specific reforms have succeeded or stalled, with findings systematically fed back into planning, budgeting, and institutional capacity-building. This ensures that monitoring functions as an active instrument of the governance reforms set out in section 10.4, rather than as a retrospective reporting exercise.

6.6 Advocacy and Dissemination

Implementation of this Health Financing Strategy requires coordinated action across all institutions and stakeholders that influence health financing outcomes. Advocacy and dissemination will therefore ensure that strategic priorities, institutional roles, and accountability arrangements are clearly understood and applied at national and sub-national levels. A structured communication approach will engage central government, Parliament, provincial and local authorities, communities, civil society, development partners, and the private sector, including private health insurers. Tailored policy briefs, investment cases, and technical summaries will be developed to support a consistent understanding and facilitate implementation across stakeholder groups.

Several reforms under this strategy, including cash management coordination, earmarked revenue transparency, AMTO administration, local authority financing, and public financial management modernisation, require action beyond the MoHCC. Engagement will leverage established government processes, including inter ministerial coordination mechanisms, joint planning platforms, and national and sub-national budget cycles, to ensure alignment and implementation. Health financing reforms are interdependent with broader health system functions. Dissemination

will therefore extend to technical working groups and coordination platforms across human resources, supply chain, health information systems, and service delivery to ensure alignment and reinforce system-wide performance. The strategy will be implemented within the framework of the National Health Strategy and monitored under the National Development Strategy 3 (NDS3). Progress against the results framework will be reported through joint sector reviews and NDS3 monitoring processes, ensuring alignment with national planning systems and accountability at the highest levels of government.

7. Implementation Framework: Zimbabwe Health Financing Strategy (2026 –2030)

Intervention / Activity		Short Term	Medium Term	Long Term	Status
Strategic Objective 1: Increase and strengthen the predictability, stability, and sustainability of domestic public financing for health					
Strategy 5.1.1: Strengthen evidence-based investment planning and fiscal engagement to position health financing within national economic and fiscal policy					
1.1.1	Establish a legal and regulatory framework for the ring-fencing of earmarked taxes for health, including SSB, fast-food, and Health Levy taxes, with clear tracking, reporting, and accountability mechanisms.				
1.1.2	Strengthen mechanisms to ensure earmarked revenues are effectively integrated into national budgeting and pooling frameworks, with clear allocation rules to support priority health services and system strengthening				
1.1.3	Develop a health sector investment case that positions health as an economic investment, clearly quantifying productivity gains, fiscal risk mitigation, and the cost of inaction, aligned to disease burden, service delivery needs, and the EHBP				
Strategy 5.1.2: Institutionalise transparent and integrated PFMS to strengthen budget credibility, predictability, and fiscal engagement					
1.2.1	Strengthen parliamentary engagement throughout the PFMS cycle by institutionalising structured pre-budget submissions and post-budget performance reviews to Portfolio Committees on Health and Finance, supported by accessible evidence tools on allocations, disbursements, and sector performance.				
1.2.2	Strengthen Budget and Finance committees as formal decision-making structures responsible for developing credible, evidence-based budget bids aligned to fiscal ceilings and sector priorities				
1.2.3	Drive and build capacity for systematic use of expenditure and service delivery data in budget formulation, reprioritisation, and fiscal engagement				
1.2.4	Standardise financial reporting across all levels in line with IPSAS and national systems to reflect the full financial position of the sector and strengthen credibility with Treasury and partners				
1.2.5	Strengthen and accelerate Programme-Based Budgeting implementation by aligning planning, budgeting, procurement, fund flows, and performance reporting with service delivery priorities and outputs, moving from representational to PBB execution of budgets.				
Strategy 5.1.3: Strengthen and optimise domestic revenue sources for health through improved collection, earmarking, and accountability					
1.3.1	Reform the governance, collection, and accountability framework of the Health Services Fund, including enforceable allocation rules and regular independent audits, to ensure revenues are fully captured, aligned with national priorities, and protected from leakage.				

1.3.2	Develop and deploy an electronic system to strengthen billing, debt collection, and record-keeping and accounting for HSF funds, improving efficiency and reducing revenue leakage.				
1.3.3	Develop and submit evidence-based policy proposals for adjusting existing excise taxes on alcohol, tobacco, sugar-sweetened beverages, and fast food to align with international benchmarks, maximise revenue potential, and influence consumption patterns				
1.3.4	Develop evidence and mobilise for expanding the scope of health-related excise taxes to emerging products, including e-cigarettes and other harmful commodities, to address evolving risk factors and broaden the tax base.				
Strategy 5.1.4: Explore mechanisms to establish mandatory prepayment and contribution mechanisms					
1.4.1	Explore alternative approaches to introduce mandatory contribution mechanisms across all population groups, including formal, informal and rural and urban populations, to expand the NHI revenue base and reduce reliance on indirect taxes (sin taxes)				
1.4.2	Integrate micro-insurance schemes (e.g., Harare City CBHI pilot) into national pooling arrangements as transitional mechanisms for the NHI				
Strategy 5.1.5: Mobilise non-traditional and regional financing sources to enhance domestic resource mobilisation					
1.5.1	Develop and operationalise a legal and regulatory PPP framework for health infrastructure with a clear investment case for private sector participation.				
1.5.2	Develop mechanisms to channel philanthropic and community financing into health system priorities, including infrastructure, digital systems, and supply chains.				
1.5.3	Establish/strengthen mechanisms to promote investment in local manufacturing and domestic procurement of essential health commodities, including pharmaceuticals, vaccines, and diagnostics, in partnership with relevant line ministries.				
1.5.4	Develop investment cases and mobilise blended financing from regional and international platforms (e.g. Africa CDC, AfDB, SADC, World Bank and other IFIs) to co-finance large-scale health and manufacturing investments.				
1.5.6	Develop bankable investment cases that focus on leveraging blended financing instruments to de-risk investments and aligning financing with national health priorities.				
Strategic Objective 2: Strengthen and integrate pooling mechanisms to improve equity, financial protection, and access to essential health services					
Strategy 5.2.1: Progressively consolidate public financing pools to improve redistribution, equity, and resource visibility across the health system					
2.1.1	Strengthen coordination and engagement across domestic financing pools and establish common reporting, monitoring, and operating arrangements across MoHCC, local authorities, missions, and other public pools.				
2.1.2	Develop and implement a sub-national resource equalisation mechanism that explicitly addresses provincial and district level redistribution, allocating resources based on population size, poverty rates, disease burden, and service utilisation.				

2.1.3	Strengthen resource mapping and donor coordination frameworks and develop an integrated national health financing dashboard for the virtual donor pool under MoHCC stewardship to align external financing.				
2.1.4	Develop a consolidated transition roadmap for external financing, with clear bilateral commitment to limit transition shocks on service delivery financing.				
Strategy 5.2.2: Strengthen pooled subsidy mechanisms for poor and vulnerable populations					
2.2.1	Increase engagement and collaboration with the Ministry of Labour and Social Welfare to enhance the implementation of AMTO and related subsidy mechanisms.				
2.2.2	In alignment with relevant line Ministries and stakeholders, establish an integrated social registry and beneficiary verification system to support targeted subsidies, exemptions, and entitlement management for effective coverage of intended beneficiaries.				
2.2.3	Establish a routine monitoring and evaluation framework for the subsidy scheme, including coverage rates, reimbursement timeliness, targeting accuracy, and impact on OOP spending.				
2.2.4	Align user fee exemption mechanisms and financing for vulnerable populations with the broader pooling towards effective risk coverage linked to service availability				
Strategy 5.2.3: Strengthen the regulation and integration of voluntary health insurance to improve effective coverage and support pooling objectives					
2.3.1	Review and operationalise a comprehensive regulatory framework for voluntary health insurance to improve governance, transparency, and alignment with national health financing objectives				
2.3.2	Strengthen MoHCC oversight capacity on VHI in the short term and establish an independent regulatory body for voluntary health insurance in the medium to long term.				
2.3.3	Introduce risk equalisation and standardisation mechanisms to strengthen cross-subsidisation and reduce fragmentation across medical aid schemes, including limiting tax subsidies for private medical aid contributions.				
2.3.4	Define and enforce a clear minimum benefits package and coverage standards to improve effective coverage and reduce excessive co-payments and out-of-pocket spending for patients covered under VHI				
2.3.5	Separate and regulate pooling and purchasing functions within voluntary health insurance schemes to reduce conflicts of interest, improve purchasing efficiency, and strengthen alignment with the NHI cross-subsidisation framework				
Strategic Objective 3: Accelerate strategic purchasing reforms to improve efficiency, quality, and alignment of financing with service delivery outcomes					
Strategy 5.3.1: Define and finance a prioritised Essential Health Benefit Package to strengthen service entitlements and reduce out-of-pocket exposure					
3.1.1	Finalise, cost, and operationalise a fiscally realistic Essential Health Benefit Package that clearly defines entitlements across levels of care.				

3.1.2	Ring-fence and disburse non-wage operational budgets to PHC and district facilities on a predictable schedule aligned to service delivery plans and EHBP priorities.				
3.1.3	Align budget allocation, pooled financing, and resource mobilisation to EHBP priorities, with emphasis on primary care, maternal and child health, and public health services.				
3.1.4	Ensure availability of essential medicines and supplies at PHC level through integrated procurement, distribution, and stock monitoring systems linked to service delivery volumes.				
3.1.5	Standardise PHC and community-level service delivery packages, including outreach and Village Health Worker programmes, linked to financing and performance frameworks.				
Strategy 5.3.2: Reduce financial barriers and strengthen financial protection through harmonised user fee policies, effective exemption mechanisms, and improved demand-side protection measures					
3.2.1	Standardise and enforce user fee schedules, co-payment policies, exemption rules, and implementation arrangements across all public providers, including local authorities, with clear protections for priority and vulnerable populations, including indigent groups.				
3.2.2	Strengthen enforcement of referral and gatekeeping systems through financing and accountability mechanisms, including differential tariffs for non-referred tertiary access, performance-linked incentives for compliance, and clearly communicated referral rules for patients and providers.				
3.2.3	Strengthen transparency, oversight, and accountability mechanisms to eliminate informal charges and non-transparent fee practices, including the establishment of patient rights, grievance, and escalation mechanisms at the facility and district levels.				
3.2.4	Develop and implement a national health literacy and public communication strategy on service entitlements, user fees, exemption rights, and referral pathways to improve awareness, access, and compliance.				
Strategy 5.3.3: Strengthen strategic purchasing through needs-based resource allocation, provider payment reform, and performance-informed financing mechanisms					
3.3.1	Develop and implement a national health sector resource allocation formula aligned to population health needs, service delivery priorities, the EHBP, and equity considerations.				
3.3.2	Develop and implement a harmonised national tariff and provider payment framework across public and private providers, including capitation for primary care, case-based payments for hospitals, and performance-based financing components to incentivise quality, efficiency, and service delivery outcomes.				
3.3.3	Institutionalise performance-based financing within national systems through a funded government transition plan to progressively absorb donor-financed RBF programmes, including defined fiscal commitments, timelines, and minimum performance standards.				
3.3.4	Establish formal provider contracting arrangements defining service expectations, quality standards, reporting requirements, and accountability mechanisms, particularly for faith-based, council, and other publicly subsidised providers.				

Strategy 5.3.4: Strengthen PFM execution, facility financing, and accountability systems to support purchasing functions					
3.4.1	Embed allocation rules within Programme-Based Budgeting (PBB) and the Medium-Term Expenditure Framework (MTEF) to ensure that budget ceilings, allocations, and releases are aligned with sector priorities, service delivery outputs, and system performance.				
3.4.2	Strengthen cashflow forecasting, commitment control, and disbursement systems to ensure predictable and timely funding.				
3.4.3	Establish and enforce a cash flow forecasting and commitment control system at the facility level to ensure operational budgets are managed predictably across the fiscal year, reducing mid-year service disruptions.				
3.4.4	Improve coordination between MoHCC and MoFED on budget releases and execution monitoring.				
3.4.5	Increase facility-level autonomy over resource use within a strengthened accountability framework.				
Strategy 5.3.5: Strengthen market shaping and supply-side financing to improve access, affordability, and availability of health commodities					
3.5.1	Integrate demand forecasting, financing commitments, procurement planning, and supply chain data systems to generate predictable and credible market signals for suppliers and improve alignment between financing and commodity availability.				
3.5.2	Expand pooled procurement, strategic sourcing, volume guarantees, and price negotiation mechanisms to improve purchasing efficiency, reduce costs, and strengthen the reliability of supply for essential medicines, diagnostics, and health commodities.				
3.5.3	Strengthen integration of private pharmacies, distributors, manufacturers, and providers into national supply, financing, quality assurance, and reporting systems to improve access and reduce fragmentation across public and private markets.				
3.5.4	Support development of regional and domestic manufacturing capacity for priority health commodities through aligned industrial policy, regulatory support, procurement commitments, and long-term contracting arrangements that create predictable demand for local producers.				
3.5.5	Align industrial policy, procurement systems, health financing reforms, and regional market initiatives to strengthen supply resilience, reduce dependency on external markets, and improve long-term sustainability of commodity supply systems.				
Strategic Objective 4: Strengthen governance and accountability to ensure coherent, enforceable, and performance-driven health financing systems					
Strategy 5.4.1: Strengthen institutional capacity to lead, coordinate, and sustain domestic resource mobilisation					
4.1.1	Upgrade existing coordination platforms, including the Donor Coordination Framework, into formal decision-making bodies with clearly defined mandates, quorum requirements, and binding authority over financing alignment decisions.				

4.1.2	Establish formal recording, tracking, and follow-up systems for all decisions made within coordination platforms, with accountability assigned to named institutional leads.				
4.1.3	Strengthen the Health Economics Unit and other relevant directorates within MoHCC, and MDAs to lead routine fiscal space analysis, revenue forecasting, and development of investment cases and mobilisation targeted to relevant stakeholders.				
4.1.4	Generate and disseminate evidence on returns on health investment and the fiscal cost of inaction to support advocacy with Treasury and development partners.				
4.1.5	Build capacity of budget committees to implement evidence-based approaches to budget bids, including resources needed for investment cases and priority health areas.				
Strategy 5.4.2: Enhance integration, transparency, accountability, and oversight across all financing flows and actors					
4.2.1	Consolidate financial reporting across all financing sources to provide a complete and consistent view of resource allocation, execution, and service delivery outcomes.				
4.2.2	Enforce timely implementation of audit findings through formal tracking, escalation, and institutional accountability mechanisms, with Parliamentary oversight focused on execution and corrective action.				
4.2.3	Strengthen regulatory oversight of public and private financing actors including insurance schemes and statutory funds, to ensure compliance with national financing policies.				
4.2.4	Expand independent oversight by strengthening the formal role of civil society in monitoring financing performance, transparency, and accountability.				
4.2.5	Enact Medical Aid Regulatory Bill establishing an independent regulator; define solvency standards, minimum benefits, standardised reporting, consumer protection, grievance mechanisms, separation of pooling and purchasing, limit tax subsidies undermining cross-subsidisation				
Strategy 5.4.3: Strengthen and institutionalise the use of evidence and data in financing decisions					
4.4.1	Institutionalise routine implementation of NHA, RMET, PER, and HFPM with dedicated capacity, and integrate outputs into budget formulation, allocation, and policy processes.				
4.4.2	Build data use capacity at district and facility levels, including training, decision-support tools, and peer learning mechanisms, to ensure subnational actors can interpret and apply financial and service delivery data in planning and performance management.				
4.4.3	Establish structured feedback mechanisms at national, provincial, and facility levels to ensure analytical outputs inform corrective actions, policy adjustments, and system reforms, with documented evidence of use in decision-making processes.				
4.4.4	Strengthen the financial management and governance capacity of Health Centre Committees, Hospital Boards, and local authorities, including training on national financing rules, expenditure reporting, and performance accountability requirements.				

Strategic Objective 5: Establish and operationalise the National Health Insurance					
Strategy 5.5.1: Establish the legal and institutional framework for the NHI through enactment and operationalisation of the NHI Act					
5.1.1	Enact NHI Act, establishing basis for mandatory ring-fencing, transparent reporting on collection, allocation, utilisation, of health taxes and a comprehensive framework for delivering the EHSP				
5.1.2	Expand and diversify the NHI revenue base through phased inclusion of additional earmarked revenues, including tobacco and alcohol levies, subject to fiscal and legal feasibility.				
5.1.3	Protect NHI revenues from in-year reallocation and cashflow diversion through strengthened public financial management and disbursement rules.				
5.1.4	Integrate NHI financing flows into national PFMS and financial reporting systems to strengthen transparency, accountability, and alignment with national budgeting processes.				
Strategy 5.5.2: Establish and progressively expand a defined and financially sustainable NHI benefit package					
5.2.1	Develop and operationalise a phased NHI benefit package aligned with the national Essential Health Benefit Package.				
5.2.2	Fully cost NHI benefit package entitlements and align implementation with available and sustainable financing to avoid implicit rationing.				
5.2.3	Prioritise financing of high-impact, operationally feasible primary healthcare and outpatient services with significant population health impact.				
5.2.4	Align NHI service entitlements with referral pathways and provider readiness requirements, including medicines, staffing, and diagnostic availability.				
5.2.5	Harmonise NHI entitlements with broader national service delivery and purchasing reforms to reduce fragmentation and conflicting benefit structures.				
Strategy 5.5.3: Establish structured purchasing and predictable facility financing arrangements under the NHI					
5.3.1	Implement predictable and scheduled direct transfers to facilities for non-wage operational costs aligned to defined service delivery plans and NHI priorities.				
5.3.2	Link facility financing to defined service outputs, reporting requirements, and service readiness conditions, including staffing, medicines, and diagnostic availability.				
5.3.3	Establish protected financing arrangements for essential medicines and diagnostics through pooled and central procurement mechanisms.				
5.3.4	Strengthen and standardise facility financing arrangements by building on existing Health Services Fund systems and integrating NHI financing into national PFMS and reporting frameworks.				
5.3.5	Introduce phased performance- and compliance-based financing components linked to reporting, service delivery performance, referral compliance, and quality standards.				
5.3.6	Align NHI purchasing arrangements with broader national provider payment reforms, including phased introduction of tariff frameworks, capitation, case-based payment systems, and strategic purchasing mechanisms as institutional capacity develops.				

Strategy 5.5.4: Strengthen governance, accountability, and institutional capacity for NHI implementation					
5.5.1	Establish clear governance, stewardship, and accountability arrangements for NHI oversight, financing, purchasing, and reporting functions.				
5.5.2	Define institutional roles and coordination mechanisms across MoHCC, MoFED, facilities, local authorities, and other financing actors involved in NHI implementation.				
5.5.3	Strengthen financial management, reporting, and accountability systems at national and facility levels to support transparent and efficient use of NHI funds.				
5.5.4	Establish integrated monitoring, reporting, and performance review systems for NHI financing flows, purchasing arrangements, and service delivery outcomes.				
5.5.5	Build institutional and technical capacity for NHI implementation, including purchasing, financial management, provider contracting, and performance monitoring systems.				

8.0 Conclusion: Realizing Universal Health Coverage Through Sustainable Health Financing

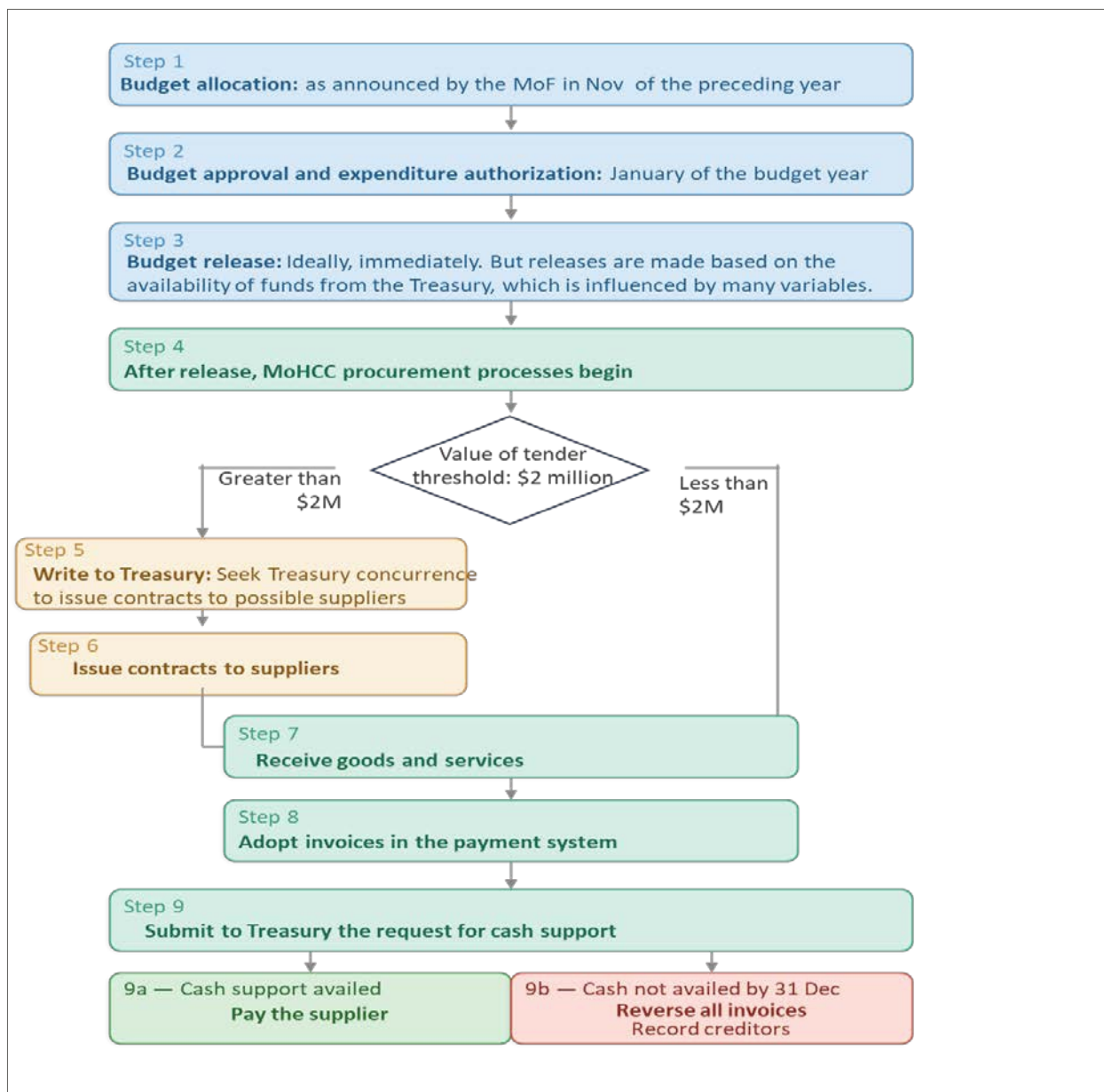
The Zimbabwe National Health Financing Strategy (2026–2030) marks a pivotal shift from policy formulation to decisive operational execution, system integration, and domestic ownership. Positioned within the framework of Vision 2030, the National Development Strategy 2 (NDS2), and global Universal Health Coverage (UHC) commitments, this strategy establishes a practical, evidence-driven roadmap to build an equitable, resilient, and self-sustaining health system.

Key Pillars of Transformation

- **Predictable & Sustainable Revenue Mobilization:** Moving beyond volatile, fragmented funding by strengthening fiscal prioritization, ring-fencing earmarked health revenues (such as the Health Levy, SSB, and sin taxes), and enforcing Programme-Based Budgeting (PBB).
- **Consolidated & Integrated Pooling:** Reducing systemic fragmentation across central government, local authority, donor, and private schemes. Through virtual pooling, resource equalization mechanisms, and the progressive establishment of the National Health Insurance (NHI), the strategy expands risk-sharing and financial protection for poor and vulnerable populations.
- **Strategic Purchasing & Efficiency:** Transitioning from passive, historical line-item budgeting toward active purchasing tied to a fully costed Essential Health Benefit Package (EHBP). Incentivizing quality and outcomes via needs based allocation formulas, provider payment reforms, and supply chain integration ensures value for money across all levels of care.
- **Enforceable Governance & Accountability:** Anchoring reforms with supportive legal frameworks—including the enactment of the NHI Act and the Medical Aid Regulatory Bill—while embedding rigorous Public Financial Management (PFM), audit compliance, and routine data use across the sector.

Achieving the vision of a health system that guarantees access to quality essential health services without financial hardship requires sustained political commitment, -inter ministerial synergy (particularly between MoHCC and MoFED), and active collaboration across local authorities, development partners, the private sector, and civil society. By executing these phased, structural reforms over the 2026–2030 period, Zimbabwe lays a durable foundation for long-term health sovereignty, equity, and human capital development.

Annex 1: Budget Execution Process



Annex 2: M & E Framework

Zimbabwe Health Financing Strategy: Monitoring & Evaluation Matrix (2025–2030)

Domain	Type	Indicator	Baseline (2025)	2026	2027	2028	2029	2030 Target	Frequency	Data Source
Revenue Mobilisation & Fiscal Space	Output	Government health expenditure (% of total government expenditure)	11%	12%	15%	15%	15%	15%	Annual	MoFED Budget
		Government health expenditure as % of GDP								
	Output	Per capita government health expenditure (USD)	US\$28.19 (2024)	41	54	66	78	90	Annual	NHA
	Output	Share of government health expenditure (% of THE)	33.6% (2024)	41.9	50.2	58.4	66.7	75	Annual	NHA
	Output	Share of the health sector budget allocation as a percentage of the budget bid submitted to the Treasury	30% (2025)	30	33	36	39	50	Quarterly	Treasury
	Process	Share of approved health budget disbursed within each quarter	Q3: 27%	60	65	80	80	90	Quarterly	Treasury
	Process	Budget execution rate	98% (confirm with finance)	100%	100%	100%	100%	100%	Quarterly	MOHCC

Pooling & Financial Protection	Outcome	Out-of-pocket expenditure (% of CHE)	20.7% (2024)	18	17	13	10	<10%	Annual	NHA
	Outcome	Incidence of catastrophic health expenditure (10% threshold)	9.8% (PICES)	10	10	10	10	10	Periodic	Household survey
	Output	Population covered by prepayment/pooled mechanisms (%)	~25% (Check ZDHS)	50%	70%	100%	100%	100%	Annual	NHI / NHA
Purchasing & Provider Payment	Process	Number of resource allocation formula developed	0 (No formula)		1	1	1	1	Annual	MoHCC
Benefits & Entitlements	Process	% of primary care facilities where no formal or informal user fees are charged (%)	Baseline TBD	100 %	100%	100%	100%	100%	Annual	MoHCC / Survey
PFM & Budget Execu	Process	Share of facilities with automated financial management systems integrated with national PFM (% excluding primary care facilities)	~40%	60%	100%	100%	100%	100%	Annual	MoHCC

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