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ZIMBABWE

2026 HEALTH BUDGET BRIEF

Key Takeaways

Zimbabwe's child and maternal health outcomes highlight the need for sustained better-targeted public financing. Under-five mortality remains high at 69 deaths per 1,000 live births, infant mortality at 56, and neonatal mortality rose from 24 to 37 between 1994 and 2024, now accounting for more than half of under-five deaths. Maternal mortality also remains high at 358 deaths per 100,000 live births. **Prioritising preventive and primary health care financing and expanding budget lines will be critical to reducing neonatal deaths, improving maternal and child survival, and advancing Zimbabwe's health commitments.**

CHILD HEALTH



69

Under-five Mortality
(per 1,000 live births)



56

Infant Mortality
(per 1,000 live births)



37

Neonatal Mortality
(per 1,000 live births)

MATERNAL HEALTH



358

Maternal Mortality
(per 100,000 live births)

The 2026 health budget remains insufficient to meet sector needs and national commitments. MoHCC was allocated ZiG30.4 billion, approximately US\$994 million, representing a 7.4% increase from ZiG28.3 billion in 2025. However, this accounts for only 10.5% of the national budget, below the 15% Abuja benchmark, and covers just 36% of the Ministry's ZiG85.3 billion bid, leaving a financing gap of ZiG54.9 billion. **Progressively increasing the health sector's share of the national budget toward the Abuja benchmark is critical, particularly as external financing continues to decline.**

HEALTH BUDGET



ZiG30.4B
=US\$994 million

Allocated to MOHCC
(only 10.5% of
National Budget)



15%

Abuja Benchmark
(Current - 10.5%
Gap - 4.5%)

The MoHCC allocated 80% of its total budget to Curative Services. Government should strive to strike a balance across all programme budget components.



80%

Total Budget
(to Curative Services)

Budget credibility and execution remain significant constraints to effective health service delivery. Approved allocations have not consistently translated into timely cash releases required to sustain uninterrupted delivery of essential health services. By end-September 2025, MoHCC had utilised only 37% of its approved budget, while capital budget execution stood at just 12%. Under-execution was particularly pronounced in critical service areas, with maternal and child health care utilising only 11% of its budget and drugs and medicines utilising 29%. **Strengthening service delivery will require improved alignment between approved allocations and actual cash disbursements, enhanced budget execution, and more robust expenditure tracking, particularly for medicines, maternal and child health, and frontline health facilities.**



37%

MOHCC Utilised Budget
(end-September 2025)



11%

Maternal & Child Health
(utilised budget)



29%

Drugs & Medicines
(utilised budget)

Introduction



This budget brief assesses the extent to which the 2026 National Budget responds to Zimbabwe's health financing needs, with a particular focus on children and women. It analyses the size, composition, and trends of the Ministry of Health and Child Care (MoHCC) budget, including how public resources are allocated and utilised to deliver primary health care, public health programmes, and essential child health interventions. The brief examines recurrent and capital spending, alignment with national health priorities, and the distribution of resources across programmes and provinces. It also assesses the adequacy, equity, efficiency, and effectiveness of public health financing, drawing on findings from previous health budget briefs. The analysis is framed against Zimbabwe's commitments under the National Development Strategy 2 (NDS2), Universal Health Coverage (UHC), the Sustainable Development Goals (SDGs), and the Abuja Declaration. It is prepared in the context of constrained fiscal space, declining external financing, and growing demand for public resources, all of which affect the Government's capacity to sustainably finance essential health services for children and vulnerable populations. The brief therefore provides evidence-based policy recommendations to strengthen health budget credibility, improve spending effectiveness, and advance equitable access to essential health services. Unless otherwise stated, all statistics are drawn from the 2026 National Budget Statement.

Overview of the Health Sector

Zimbabwe's health sector serves an estimated population of 15.92 million people and continues to face pressures from population growth, epidemiological transitions, and constrained public resources. While child survival has improved over the past decade, progress remains uneven. Infant mortality stands at 56 deaths per 1,000 live births, under-five mortality remains high at 69 deaths per 1,000 live births, and neonatal mortality increased from 24 to 37 deaths per 1,000 live births between 1994 and 2024. Neonatal deaths now account for more than half of all under-five deaths. Figure 1 presents trends in early childhood mortality rates.

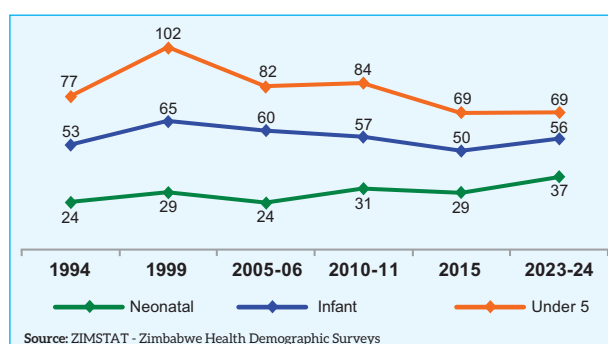


Figure 1. Early childhood rates - Deaths per 1,000 live birth

Maternal health outcomes have also improved, although maternal mortality remains high at 358 deaths per 100,000 live births. Nutrition outcomes remain a concern, with Zimbabwe off track on five of the six global nutrition targets.

Stunting affects 23–27% of children under five, wasting stands at 2%, anemia affects 27% of children and 29% of women, and exclusive breastfeeding remains low at 42%. Emerging concerns around overweight and low birthweight further point to persistent, multisystem nutrition challenges.



Health workforce capacity remains a priority area for investment and reform. Staffing levels are estimated at 47.5% of requirements, with a shortage of 57,543 workers. The Health Workforce Strategy (2024–2030) and Investment Compact (2024–2026) provide an important framework for addressing these gaps, but their implementation will require predictable and adequate financing.

HEALTH
WORKFORCE



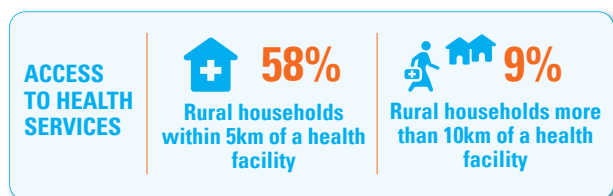
47.5%
of required staffing levels

Shortage of

57,543
health workers



Fully financing the Investment Compact and ring-fencing resources for village health workers (VHWs) will be critical to strengthening primary health care delivery. Zimbabwe currently has about 22,000 VHWs against an estimated need of 35,000, including resources for stipends, bicycles, and uniforms.



Access to health services remains uneven. The 2025 Rural Livelihoods Assessment Report found that only 58% of rural households live within 5 km of a health facility, while 9% live more than 10 km away. In urban areas, chronic disease prevalence includes hypertension at 3.1%, diabetes at 2%, and HIV/AIDS at 2.3%, underscoring the need for stronger community-level health support.

Overall, these trends point to a health sector that has made important gains but requires sustained, targeted, and well-executed public investment to strengthen primary health care, close service delivery gaps, and improve outcomes for women, children, and vulnerable populations.

Health Sector Spending Trend

The 2026 National Budget allocates ZiG30.4 billion, equivalent to approximately US\$994 million, to the Ministry of Health and Child Care (MoHCC). This represents a nominal increase of 7.4% from the 2025 allocation of ZiG28.3 billion. However, the allocation accounts for only 10.5% of the total national budget of ZiG290.9 billion, below the 15% Abuja Declaration benchmark, and finances just 36% of MoHCC's ZiG85.3 billion

budget bid, leaving an estimated financing gap of ZiG54.9 billion. Figure 2 presents health budget allocation trends against the Abuja benchmark. Projected development partner support of US\$280 million in 2026 remains important but is insufficient to offset the domestic financing shortfall.

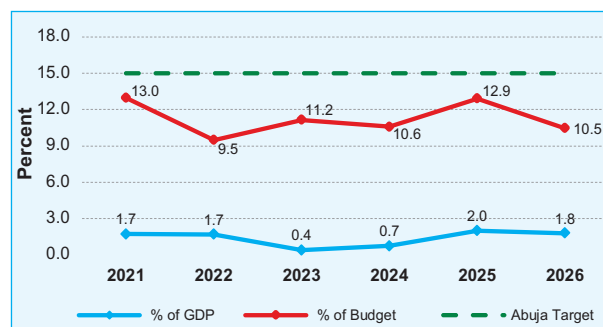


Figure 2. Trends in Health Sector Budget Allocation

At approximately 1.8% of GDP, the health allocation points to limited fiscal prioritisation of the sector relative to service delivery needs and national commitments. This constrains the Government's capacity to finance essential inputs, sustain primary health care, and reduce dependence on external financing for core health services. The trend underscores the need to strengthen domestic resource mobilisation, improve allocative efficiency, and prioritise high-impact interventions that deliver measurable gains for women, children, and vulnerable populations.

Closing the financing gap will require predictable and progressively increased domestic health financing, underpinned by stronger budget execution, improved cash management, robust expenditure tracking, and strategic alignment of resources with national health priorities.

Composition of the 2025 MoHCC Budget

Employment costs account for ZiG17.6 billion, equivalent to 58% of the total MoHCC budget. Of this amount, ZiG12.7 billion is allocated to central government, while ZiG4.8 billion is allocated to grant-aided institutions. Although the health sector is labour-intensive and requires adequate financing to improve health worker conditions, the expenditure remains heavily weighted toward compensation of employees. This, however, limits fiscal space for non-wage recurrent inputs and capital investment needed

to strengthen service delivery. Non-wage recurrent expenditure increased slightly from 25% to 29% of the budget, while the capital budget declined sharply from 40% in 2024 to 14% in 2025 and 13% in 2026. Figure 3 presents the composition of the MoHCC budget by economic classification.

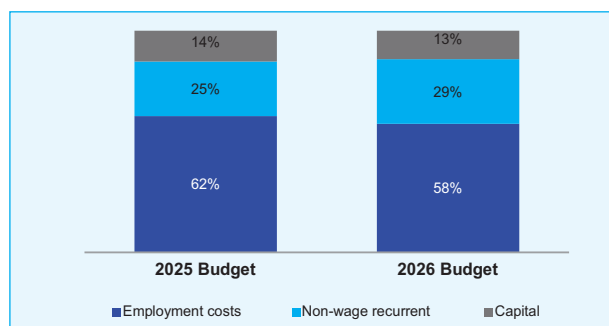
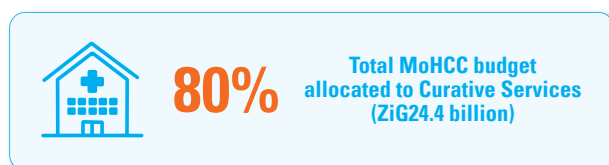


Figure 3. Composition of Health Spending by Economic Classification

Going forward, improving the expenditure mix will require protecting critical workforce financing while progressively increasing allocations for non-wage recurrent inputs and capital investment to strengthen service delivery readiness, infrastructure, and quality of care.

Curative Services Programme

Curative Services absorb the largest share of the MoHCC budget, accounting for 80% of the total allocation, equivalent to ZiG24.4 billion.



This concentration reflects the programme's role in financing treatment services across the health system, from health posts to central hospitals, and the substantial wage-related costs embedded in service delivery. Within the Curative Services envelope, Central Hospitals receive the largest share at 31%, while Rural Health Centres and Community Services are allocated ZiG5.5 billion, representing 23% of the Curative Services budget and 18% of the total MoHCC budget. Figure 4 presents the composition of the health budget by programme, while Figure 5 shows the Curative Services Programme budget by sub-programme. Strengthening allocative efficiency within the Curative Services Programme will be essential to ensure that hospital-based care is adequately

balanced with financing for primary health care, rural health centres, essential medicines, and community-level service delivery.

The Health Systems Strengthening budget under Results-Based Financing (RBF) increased by 239%, from ZiG232 million in 2025 to ZiG787 million in 2026. However, allocations for essential commodities declined, with the Drugs and Medicines budget reduced by 33% and the Blood and Blood Products budget declining slightly by 0.2%. Despite the significant decline in development partner support for HIV and AIDS and a widening financing gap, the allocation for Anti-Retroviral Drugs remained largely unchanged, increasing marginally by 0.9% from ZiG41 million in 2025 to ZiG42 million in 2026. Essential medicine stockouts persist due to declining donor support and limited access to earmarked health levies. This occurs alongside suboptimal vaccination coverage in several districts, with zero-dose children exceeding 15% in Shamva, Kwekwe, Buhera, Mutare, Mutasa, and Mhondoro-Ngezi, according to the ZDHS. Urban zero-dose prevalence stands at 17%, with Mashonaland West recording the highest level at 26%. To safeguard service delivery, Government should unlock and transparently channel earmarked levies, including the airtime levy, toward the procurement

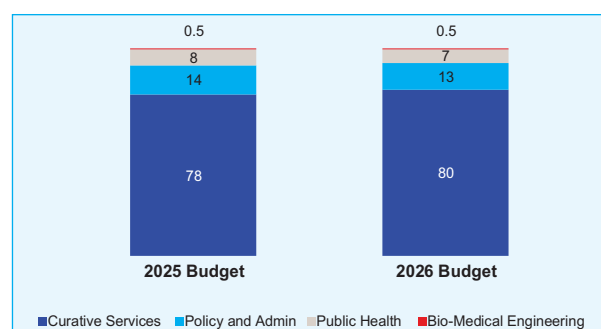


Figure 4. Composition of Health Spending by Economic Classification

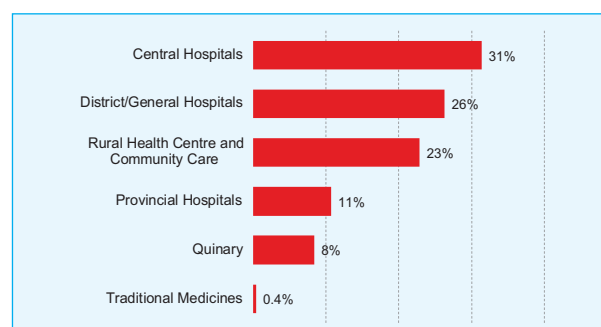


Figure 5. Composition of 2026 Curative Services Budget

of essential medicines and other priority health commodities. Table 1 gives highlights of the funding of some key interventions under the Curative Services Budget.

	2025 Budget (ZiG Million)	2026 Budget (ZiG Million)	% Change
Drugs and Medicines	162	108	-33%
Blood and Blood Products	495	494	-0.2%
Anti-Retroviral Drugs	41	42	0.9%
Maternal and Child Health Care	515	516	0.1%
Medical Gas	207	218	5.2%
Health System Strengthening: RBF	232	787	239%
Infrastructure	3,621	3,654	

Public Health Programme

The Public Health Programme (PHP) was allocated ZiG1.98 billion in 2026, equivalent to 7% of the total MoHCC budget. This represents a 27% decline from ZiG2.7 billion in 2025, reducing the fiscal space available for preventive and promotive health interventions. The Communicable Diseases sub-programme was the most affected, with its allocation declining by 64%, from ZiG613 million in 2025 to ZiG219 million in 2026. Allocations for the Family Health and Non-Communicable Diseases sub-programmes also declined sharply, while the Environmental Health budget increased by 18%, from ZiG718 million to ZiG927 million. Figure 6 presents the PHP budget by sub-programme.

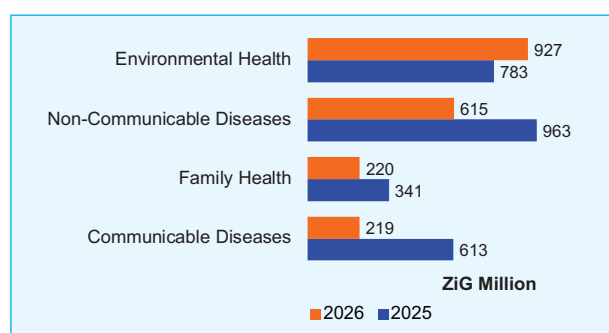


Figure 6. Composition of PHP Budget by Sub-Programme

Strengthening the Public Health Programme will require protecting and progressively increasing allocations for preventive, promotive, communicable disease, family health, and non-communicable disease interventions to improve population health outcomes and reduce future treatment costs.

The Environmental Health sub-programme accounts for the largest share of the Public Health Programme budget, increasing from 29% in 2025 to 47% in 2026. Non-Communicable Diseases account for 31%, while Communicable Diseases and Family Health each receive 11% of the PHP budget, as shown in Figure 7.

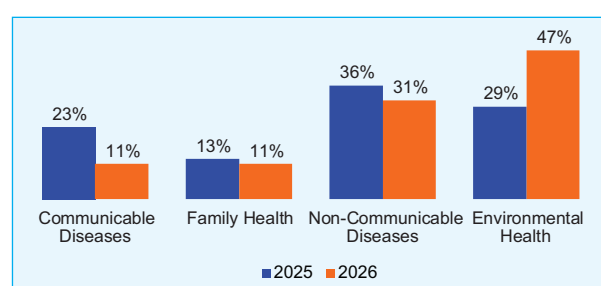


Figure 7. Share of PHP budget by Sub-Programme

By economic classification, the PHP budget remains concentrated in employment costs, which account for 58% of the total allocation, followed by goods and services at 25%, current grants at 10%, and capital expenditure at 8%, as shown in Figure 8. Current grants include ZiG190 million for the Zimbabwe National Family Planning Council and ZiG1.417 billion for local authorities. This expenditure composition highlights the need to strengthen allocative balance within the PHP to ensure adequate financing for preventive, promotive, disease-control, and family health interventions.

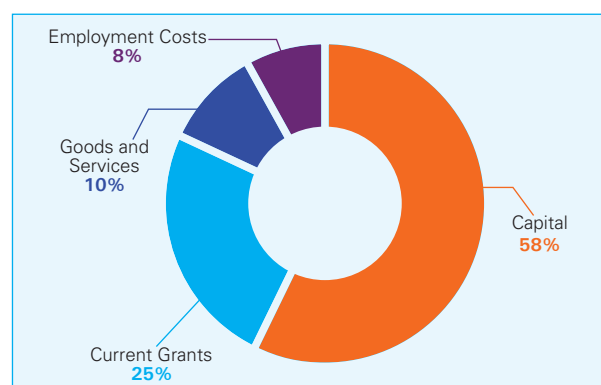


Figure 8. Composition of PHP budget by Economic Classification

Bio-Medical Engineering, Bio-Medical Science, Pharmaceutical and Pharmaceutical Production

Bio-Medical Engineering, Bio-Pharmaceutical Engineering and Production, and Bio-Medical Science Research were allocated ZiG153.6 million, equivalent to 0.5% of the MoHCC budget. Compared with 2025, the budget declined by 3%. Three sub-programmes, namely Bio-Medical Engineering, Bio-Pharmaceutical Engineering and Production, and Bio-Medical Science Research, did not receive any allocation. This is despite the Government's policy thrust to promote medical research and revive the local pharmaceutical industry. In terms of outputs, the budget refers to locally produced assistive medical devices and identified hospitals producing tracer medicines.

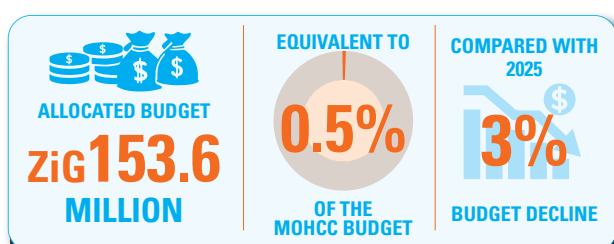


Table 2: Bio-Medical Engineering, Bio-Medical Science, Pharmaceutical and Pharmaceutical Production (ZiG Millions)

	2025	2026
Bio-Medical Engineering	2	0
Bio-Pharmaceutical Engineering and Production	2	0
Bio-Medical Science Research	2	0
Bio-Analytics	74	70
Health Research	80	83
Total	159	154



January to September 2025 MOHCC Budget Performance

The Ministry of Health and Child Care's 2025 budget execution remained significantly constrained, with overall disbursement rate stood at 37% of the approved budget by end September, reflecting persistent cash disbursement shortfalls. Expenditure performance was uneven across programmes, with relatively higher absorption in Policy and Administration (46%) and Curative Services (37%), but weak execution in Public Health (22%), indicating underfunding of preventive services.¹

The expenditure mix was heavily skewed toward employment costs (58%), crowding out non-salary inputs critical for service delivery. Capital spending remained particularly low at 12%, signaling delays in infrastructure and equipment investment. At programme level, Maternal and Child Health recorded very low absorption at 11%, while grant-aided institutions faced funding gaps, including salaries. Overall, these execution challenges point to systemic budget credibility and cash management constraints which, alongside declining external support, risk undermining the delivery of essential health services. Below is a snapshot of MoHCC budget performance as of end-September 2025.

As at end-September 2025, 37% disbursement rate of approved budget.

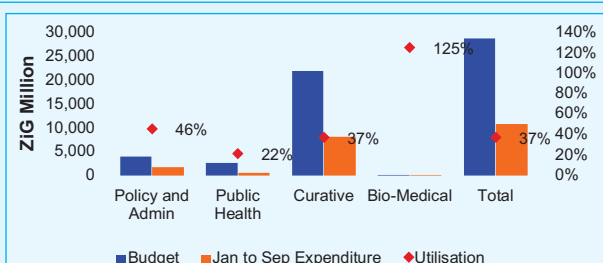


Figure 9. Overall MoHCC Budget Disbursement Rate, January to September 2025

Only 12% of the capital budget was disbursed as of end-September 2025.

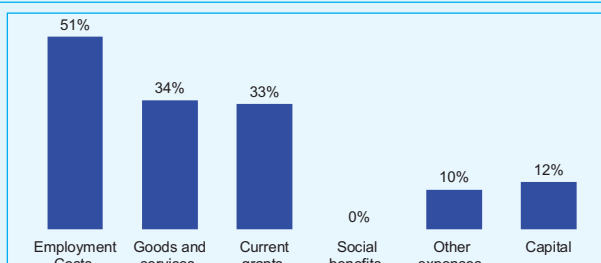


Figure 10. Percent Disbursement Rate of Approved Budget

Employment costs accounted for 58% of overall total actual expenditure to September.

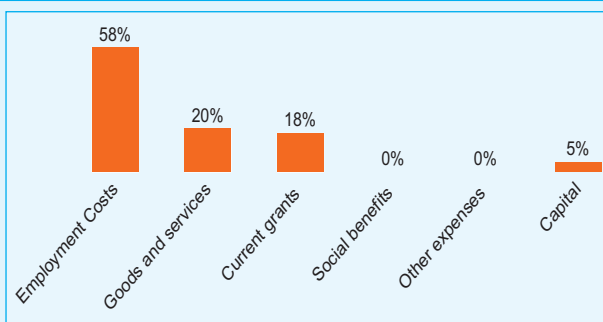


Figure 11. Composition of Actual Expenditure

Only 11% of the Maternal and Child Care Budget was utilised by September.

Utilisation of Selected Interventions			
	2025 Budget	Actual Expenditure	Utilisation
Drugs and Medicines	162	46	29%
Blood and Blood Products	495	335	68%
Anti-Retroviral Drugs	41	24	58%
Maternal and Child Health Care	515	56	11%
Medical Gas	207	113	55%
Health System Strengthening: RBF	232	148	64%

Grant-aided institutions did not receive budgetary support including for salaries.

	2025 Budget	Actual Expenditure Jan - Sep 2025
ZNFFPC		
Compensation of employees	559,395,000	
Operations	9,765,000	
Parirenyatwa		
Compensation of employees	1,198,370,000	
Operations	363,632,000	
Mission Hospital		
Compensation of employees	1,985,144,000	
Operations	136,729,000	1,910,962,447
Voluntary Organisation		
Compensation of employees	112,776,000	
Operations	16,097,000	3,022,112
Local Authorities		
Compensation of employees	1,353,132,000	
Operations	38,390,000	

- Low budget utilisation is undermining the effective delivery of essential health services.
- Approved budget allocations must be matched by timely and predictable cash disbursements to translate financing commitments into improved health outcomes.
- As development partner support declines, Government should prioritise domestic budgetary support to close emerging financing gaps and safeguard essential health services.

¹ The analysis of the MOHCC budget performance is for the period January to September 2025 due to gaps in publicly available data. The analysis is based on the data in the 2026 Estimates of Expenditure Book.



Health Financing

Sustained and predictable health financing is increasingly critical as Zimbabwe faces shrinking external support, persistent service delivery gaps, and rising household out-of-pocket spending. Zimbabwe's health financing landscape remains constrained, with current health expenditure estimated at only 2.79% of GDP in 2026. This reflects persistent fiscal pressures and continued reliance on development partner support for priority programmes, including HIV and AIDS, immunisation, and nutrition. Public health financing remains insufficient to meet growing service delivery needs, contributing to high out-of-pocket spending by households and raising concerns for equity and financial protection, particularly for vulnerable populations. The expiry of the Health Resilience Fund in 2025 is expected to create an annual financing gap of more than US\$90 million, placing essential services at risk, including village health worker stipends, essential medicines, and health workforce incentives.

Zimbabwe has introduced health-related earmarked taxes, including the sugar tax, introduced in February 2024 at US\$0.002 per gram, which had raised more than US\$30 million by June 2025. The fast-food levy, introduced in January 2025 at 0.5%, generated US\$954,912 in its first six months.

International experience shows that earmarked taxes, such as Mexico's sugar-sweetened beverages tax, the United Kingdom's Soft Drinks Industry Levy, and South Africa's Health Promotion Levy, can generate strong health and nutrition gains when revenues are transparently reinvested in public health and nutrition programmes. Evidence from these measures points to reductions in sugar intake and childhood obesity where revenues are clearly linked to health-promoting interventions. In Zimbabwe, however, the sugar tax and fast-food levy have not yet demonstrated visible reinvestment in public health or nutrition priorities, limiting their potential impact on non-communicable diseases and malnutrition. Parliament should therefore continue to advocate for ring-fencing, supported by enabling legislation for revenue retention, and transparent reinvestment of fast-food levy proceeds in nutrition-sensitive interventions, including possible matching through the Child Nutrition Fund, to strengthen accountability and maximise health and nutrition outcomes.

Strengthening health financing will therefore require a more sustainable domestic resource mobilisation strategy, transparent earmarking of health-related revenues, and stronger accountability mechanisms to improve financial protection and safeguard essential health services for vulnerable populations.



For further information, please contact:

Pepukai Chivore
Chief of Social Policy, Research and Social Protection
UNICEF Zimbabwe
9 Downie Avenue, Belgravia, Harare, Zimbabwe
Email: pchivore@unicef.org
Phone: +263 8677 020888

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