Financing Alliance for Health

Policy Brief by Ministry of Health, Republic of Zambia

ADVANCING SUSTAINABLE FINANCING FOR DEVOLVED PRIMARY HEALTH CARE IN ZAMBIA

Closing the Gap Between Allocation and Service Delivery in a Decentralised Health System

KEY MESSAGES

1. Zambia's health budget more than doubled from ZMW 9.36 billion (8.8% of total government expenditure) in 2020 to ZMW 21.5 billion (10.7%) in 2025, but remains below the 15% Abuja target.

2. Broader Primary Health Care (PHC) allocations accounted for 49–68% of the Ministry of Health budget between 2021 and 2025, reflecting strong policy prioritisation; however, service delivery remains constrained by delays in fund disbursement.

3.Overall PHC budget execution averaged around 80% between 2022 and 2024, but execution for drugs and medical supplies fell from 92% in 2022 to 45% in 2023 and 43% in 2024, contributing to stock-outs of essential medicines at facility level.

4. Decentralisation shifted responsibility for PHC spending to districts and facilities, but the public financial management (PFM) capacity, predictable fund flows, and integrated systems needed to make that shift effective have not kept pace - so funds are not consistently translating into timely, effective use at the frontline to optimize health outcomes.

5. Closing the gap between allocation and delivery requires four mutually reinforcing reforms: 1) institutionalising direct and predictable financing to health facilities, 2) building PFM capacity at district and Local Authority level, 3) standardising and digitising financial reporting so that spending can be tracked in real time, and 4) integrating fragmented ICT platforms into a single accountable system.

Foreword

The Ministry of Health is pleased to present this Policy Brief on Advancing Sustainable Financing for Primary Health Care (PHC) in Zambia. PHC remains the foundation of our health system and the principal entry point for care, delivering the majority of essential services across all 116 Local Authorities. As Zambia advances towards Universal Health Coverage (UHC), strengthening the financing architecture for PHC is both a strategic imperative and a national responsibility. Over the past five years, the Government has demonstrated sustained commitment to the health sector. The national health budget increased from ZMW 9.36 billion in 2020 (8.8 percent of total Government expenditure) to ZMW 21.5 billion in 2025 (10.7 percent).

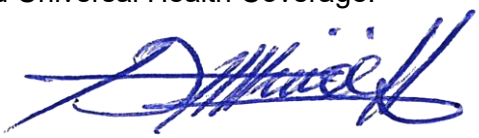
During the same period, the share of domestic financing rose from 75 percent to over 90 percent of total health expenditure, signaling progress toward greater financial sustainability. Allocations to primary health services as of 2025 accounted for 32.2 percent of the Ministry of Health budget, while the broader PHC envelope is estimated at approximately 57 percent. These trends reflect deliberate efforts to expand fiscal space for health and reduce dependence on external financing.

Notwithstanding these gains, increased allocations alone do not ensure effective service delivery. Analyses drawing on the World Health Organisation (WHO) Health Financing Framework, World Bank Public Financial Management (PFM) Framework, and Bossert's Decision Space Model expose critical bottlenecks: delays in intergovernmental fiscal transfers and disbursements to District Health Offices; uneven subnational PFM capacity; and gaps in

expenditure reporting. These constraints erode efficiency and accountability in Zambia's decentralized health system. District-level evidence from Eastern, Copperbelt, Lusaka, and Southern Provinces demands urgent action: align resource flows with institutional capacity and strengthen frontline governance.

This brief therefore proposes practical reforms to boost allocative efficiency, improve budget execution, and deepen fiscal devolution. Key measures include institutionalizing Direct Facility Financing for timely, predictable transfers to health facilities; strengthening subnational PFM via structured capacity building and routine supervision; standardizing and digitizing financial reporting systems; and reinforcing local accountability through timely, accurate expenditure reports from facilities and District Health Offices (DHOs) to track deviations between planned and executed budgets. To promote sustainable PHC financing, it further proposes a Mobile Money Levy on all transfers, airtime, and data bundle purchases to be earmarked exclusively for Primary Health Care. In addition, strengthened governance arrangements and improved Government-Development Partner coordination will be key to ensuring that additional resources translate into measurable service delivery gains.

The Ministry of Health therefore calls upon Government institutions, Local Authorities, Development Partners, Civil Society, and Communities to work collectively in advancing these reforms as a resilient and accountable PHC financing system is fundamental to improving health outcomes, protecting households from financial hardship, and accelerating Zambia's progress toward Universal Health Coverage.



Honorable Alex Katakwe, MP
MINISTER OF HEALTH

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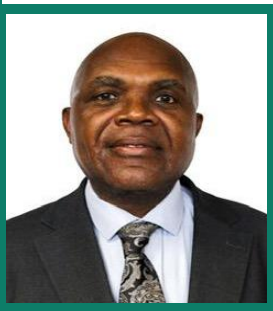

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We also recognize the Lusaka Apex Medical University, Ministry of Finance and National Planning, Ministry of Local Government and Rural Development, and University of Zambia's Department of Economics. Their unwavering commitment and diligence in generating and analyzing data significantly strengthened the evidence base, enabling well-informed, impactful policy recommendations.

Finally, we acknowledge the technical teams, experts, and partners whose insights and expertise enriched the final product. Your collaboration, dedication, and attention to detail are deeply appreciated.

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1. Introduction

Primary Health Care (PHC) is globally recognised as the cornerstone of equitable and resilient health systems and the critical pathway to achieving Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (SDGs), particularly SDG 3 (Good Health and Well-Being).[1,2]

The 2018 Declaration of Astana reaffirmed global commitment to PHC, calling for increased investment in infrastructure, financing, and workforce capacity. PHC is central to the Africa CDC's Africa Health Agenda, the Abuja Declaration (which commits signatory governments to allocate at least 15% of national budgets to health), and WHO's global strategy on Universal Health Coverage.[3,4] Most recently, in late 2025, Zambia became one of the first countries to develop a National Health Compact (2026–2030) with the World Bank, a costed, government-led reform agreement endorsed by President Hichilema that places expanding PHC access and addressing medicine stock-outs at the centre of national reform.[27]

In Zambia, PHC is not a peripheral service; it is the foundation of the national health system. It delivers over 80% of essential health services and remains the first point of contact for most citizens seeking care. The Government of Zambia has backed this priority with policy action: under the National Health Strategic Plan (2022–2026), responsibility for PHC service delivery has been devolved to 116 Local Authorities, which together oversee more than 3,500 health facilities nationwide. This decentralisation is anchored in three pieces of legislation — the National Decentralisation Policy (2002), the Public Finance Management Act (2018), and the Local Government Act (2019) — which together define the institutional framework for managing devolved health financing.[7,8]

Zambia's financing commitments for health have grown alongside this policy priority. The national health budget rose from ZMW 9.36 billion, or 8.8% of total government expenditure, in 2020, to ZMW 21.5 billion, or 10.7% of total government expenditure, in 2025. Over the same period, PHC has consistently accounted for a substantial share of the Ministry of Health budget, ranging between 32% and 57%. Zambia's overall health sector allocation as a share of total government spending has also grown, from 8–9% between 2015 and 2022 to 11.8% in 2024, though this remains below the Abuja Declaration's 15% target. In addition, the National Health Insurance Scheme (NHIS), established under the National Health Insurance Management Authority (NHIMA) Act (2018), has expanded financial risk protection for Zambian households and now covers over 5 million members.[5,6]

Despite these health financing reforms and rising allocations, funding has not consistently translated into effective service delivery at the frontline. Current health expenditure in Zambia is approximately 5% of GDP, with external sources continuing to contribute significantly to health financing. This reliance on external financing presents long-term sustainability concerns, particularly as Zambia transitions towards greater domestic resource mobilisation and seeks to achieve Universal Health Coverage (UHC) by 2030Current health expenditure stands at approximately.[9,10]

This brief examines how PHC financing functions in practice within Zambia's decentralised health system. It traces the adequacy of PHC funding, how those funds flow from national to subnational level, and how they are ultimately used at the point of care. It then identifies the key system-level bottlenecks that prevent PHC financing from reliably reaching the frontline, and proposes practical policy actions to strengthen the effectiveness, equity, and sustainability of PHC financing in Zambia.

2. Description of the problem

Zambia has a clear policy commitment to PHC and has devolved PHC service delivery to Local Authorities and District Health Offices. The central challenge is translating this commitment into effective service delivery at the point of care.

Decentralisation shifted responsibility for PHC planning and spending closer to communities, with the aim of improving responsiveness, accountability, and efficiency. However, this shift has not always been matched by comparable strengthening of the sub-national systems and capacity. Many Local Authorities and District Health Offices need the staffing, financial management skills, and integrated systems required to plan, manage, and account for PHC resources effectively. As a result, there is a persistent gap between funds allocated at national level and their timely and effective use at the frontline.

The core questions this brief addresses are therefore:

1) whether Zambia is allocating enough to PHC,

2) why allocated funds do not reliably become services, medicines, and staff at district and facility level.

Answering these two questions requires looking beyond budget totals to examine how funds actually move through the system - how they are released, how they are managed at subnational level, and how information on their use is recorded and reported.

3. Objective and scope of the project

To answer the core questions, this study examines how PHC financing functions in practice within Zambia's decentralised health system, focusing on three dimensions of the financing chain: **how much** is allocated to PHC, **how** those resources flow across levels of the system, and **how** they are utilised at district and facility level. Conducted in 2025 by the Ministry of Health in collaboration with the Financing Alliance for Health (FAH), the study covers the period 2020–2025 and aims to generate policy-relevant insights to strengthen the effectiveness and sustainability of PHC financing.

The analysis focuses on **three key areas:**

1. **PHC financing levels and composition:** assessing the scale and sources of PHC funding at national and subnational levels, and the balance between domestic and external resources over time.
2. **Public financial management performance:** examining how funds are disbursed, managed, and accounted for across levels of the system.
3. **Service delivery implications:** identifying how financing patterns and fund flows affect the availability and equity of PHC services at district and facility level.

The study seeks to identify system-level constraints in PHC financing and inform practical reforms to improve the translation of financial resources into effective and equitable service delivery.

4. Methodology

This study employed a mixed-methods design to examine how PHC financing operates in Zambia's decentralised health system. It combined secondary analysis of financial data with qualitative insights from key informant interviews and was guided by the WHO Health Financing Framework, the World Bank public financial management framework, and Bossert's Decision Space model.[20]

A desk review of national policy and planning documents, budget reports, and institutional assessments was undertaken. Key sources included the National Health Strategic Plan (2022–2026), Health Financing Strategy (2017–2027), National Health Accounts, Ministry of Health budgets, NHIMA reports, Auditor General's reports, and Joint Annual Reviews.

Secondary financial data for 2020–2025 were analysed to assess health and PHC budget allocations, PHC expenditure, NHIMA disbursements, budget execution rates, and spending on drugs and medical supplies. The analysis examined trends over time and differences across levels of the health system.

Semi-structured interviews were conducted with 25 informants across five districts in Eastern, Copperbelt, Lusaka, and Southern Provinces, including Town Clerks, Directors of Finance, District Health Directors, District Health Planners, and District Health Accountants. Interviews explored how budgeting, fund disbursement, financial management, and accountability function under decentralisation in practice.

Findings from the document review, quantitative analysis, and interviews were synthesised to identify system-level constraints affecting the flow and use of PHC financing. The analysis is descriptive and interpretive and does not aim to establish causal relationships.

5. Findings and lessons learned

Overview of Key Findings

The analysis identified three main system-level constraints that limit the effectiveness of PHC financing in Zambia's decentralised health system.

First, there is a persistent gap between budget allocations and actual execution, particularly for essential inputs such as drugs and medical supplies. This is reflected in PHC execution rates that average ~80% overall, alongside much lower execution for medicines and supplies in recent years.

Second, the way funds are managed across different levels of the system is fragmented and constrained by limited capacity. Subnational authorities face shortages of skilled finance staff, unclear roles, and multiple unaligned financial and information systems, which together weaken planning, execution, and reporting.

Third, resource allocation patterns continue to reflect inequities across geography and levels of care. Urban areas and higher-level hospitals capture a larger share of resources than rural areas and first-level facilities, despite PHC being the stated foundation of the health system.

Taken together, these findings show that the central challenge in PHC financing is not only the level of resources allocated, but how those resources are executed, managed, and distributed in practice, and whether they reach the point of care where services are delivered.

5.1 Allocation–Execution Gap

Zambia's health budget increased from ZMW 9.36 billion (8.8 percent of total government expenditure) in 2020 to ZMW 21.5 billion (10.7 percent) in 2025, representing a substantial rise in domestic investment in health.

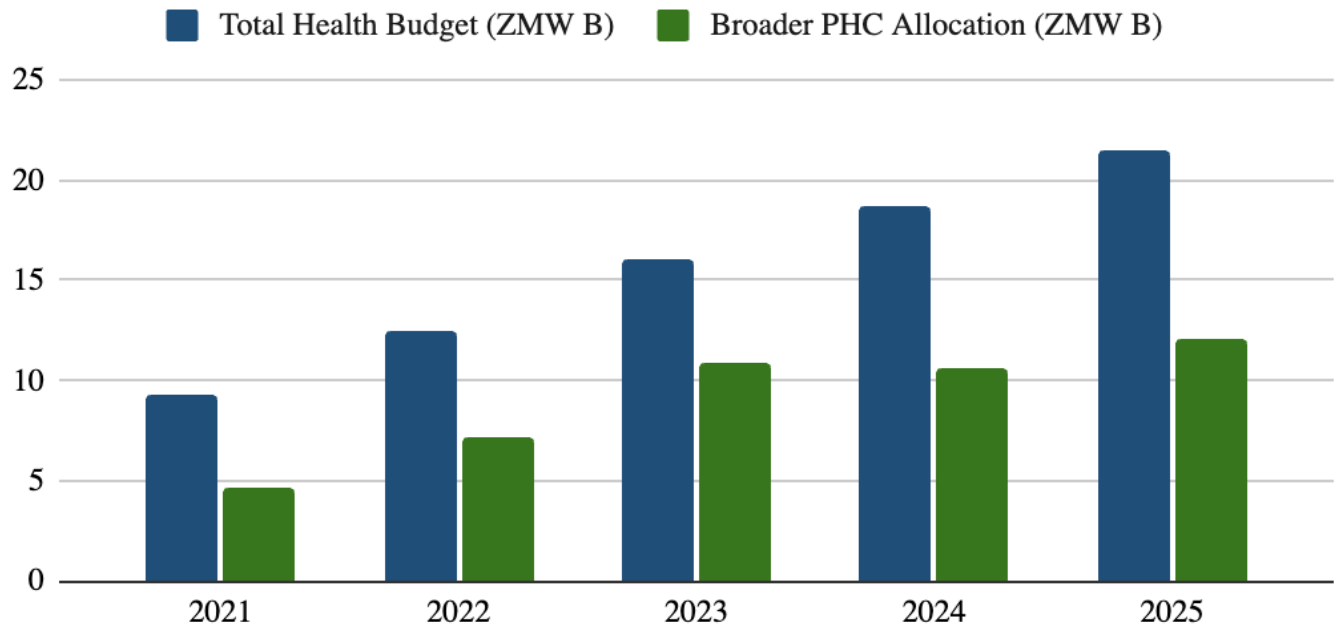

Figure 1. Share of allocations to PHC relative to the Total Health budget, 2021–2025 (ZMW). Source: Ministry of Health data

However, higher allocations have not consistently translated into spending. Between 2022 and 2024, PHC budget execution averaged about 80 percent, meaning that roughly one-fifth of approved PHC funds were not spent within the financial year. More critically, execution for drugs and medical supplies fell from 92 percent in 2022 to 45 percent in 2023 and 43 percent in 2024. In practice, this means that in 2023 and 2024 less than half of the budgeted funds for essential medicines and supplies were actually converted into expenditure.[5,9]

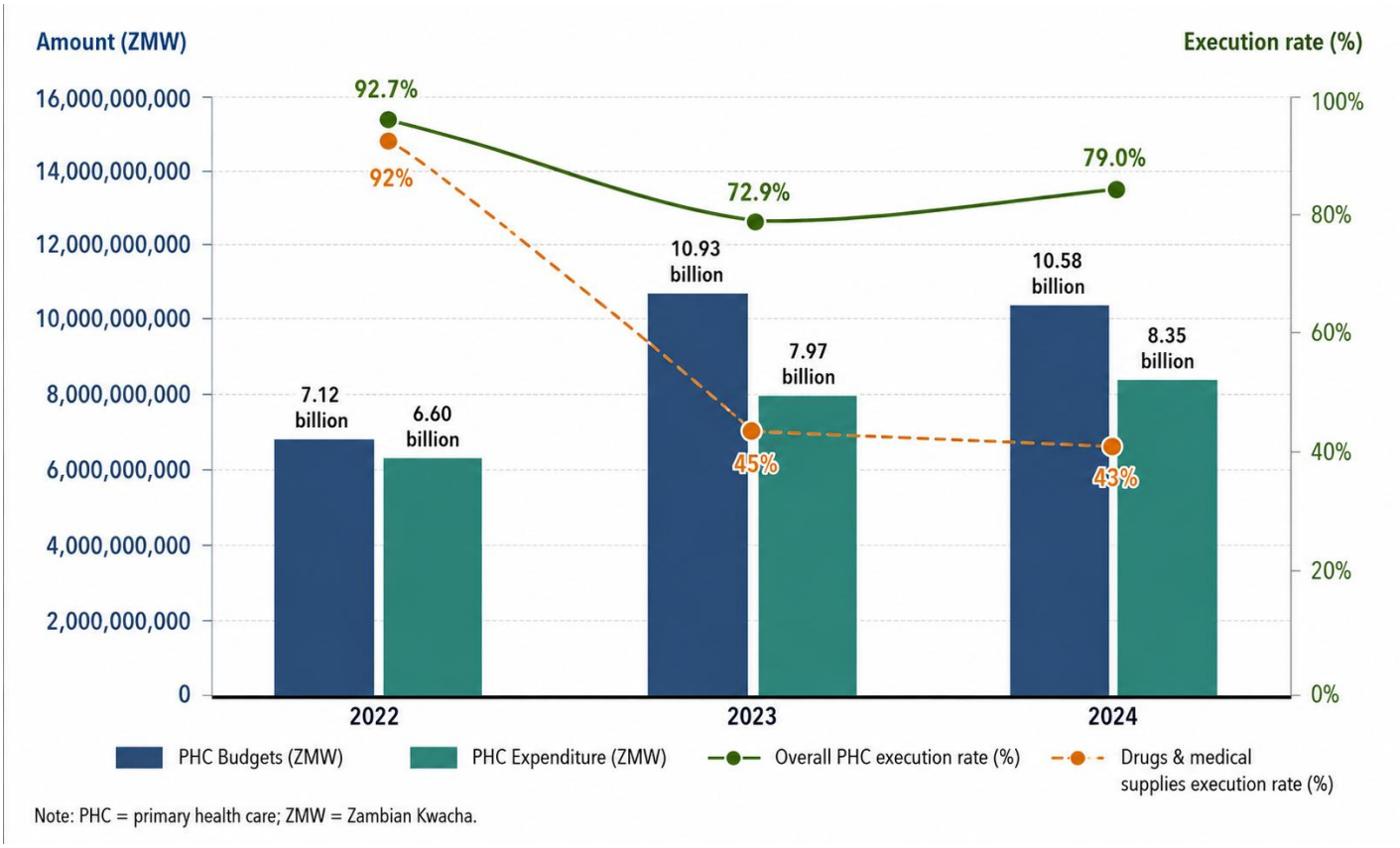

Figure 2. Annual PHC budget allocation vs expenditure, 2022–2024 in ZMW (percent of approved budget spent). % PHC budget execution overall compared to the % budget execution for drugs and medical supplies. Note: 2025 data for budget execution was unavailable at the time of data collection.

These quantitative patterns are mirrored in qualitative findings. Respondents frequently linked low execution, especially for medicines, to delayed fund releases, liquidity constraints, and procurement disruptions, including challenges at the Zambia Medicines and Medical Supplies Agency (ZAMMSA).

> ***"Delays in fund releases disrupt the execution of planned activities, with resources at times arriving after the budget cycle has already advanced."***
>
> *-District Health Director in the Ministry of Health, Zambia*

Such delays contribute directly to challenges in procurement and service continuity at facility level.[16]

5.2 Fragmented and Capacity-Constrained Financial Management

Findings indicate that the management of PHC financing across levels of the system remained fragmented and uneven.

At subnational level, Local Authorities and District Health Offices face constraints related to staffing, financial management skills, and clarity of institutional roles. In addition, multiple digital systems including Palmsoft, Navision,

DHIS2, and SmartCare, operated in parallel, requiring manual reconciliation and contributing to reporting delays and inconsistencies.

Qualitative findings reinforced these challenges highlighting the extent of fragmentation in financial management systems and practices. Respondents described the need to operate across multiple, unaligned platforms including Palmsoft, Navision, DHIS2, and SmartCare - often requiring manual reconciliation. [14,17]

> ***"We use multiple systems for the same transaction - one for the Ministry of Health, another for the council, another for donors."*** [12,13]

Differences in how PFM is understood across actors also complicates coordination. Finance officers tend to prioritise compliance with regulatory frameworks, while health managers often view PFM primarily as a tool for enabling service delivery. This divergence in focus can create misalignment in planning and execution processes, weakening the overall effectiveness and accountability of PHC financing.

5.3 Inequities in Resource Allocation

Analysis of NHIMA disbursements shows persistent disparities in the distribution of resources across geographic areas. Urban areas receive ~60 percent of total disbursements, compared with roughly one quarter for rural areas and a smaller share for semi-rural areas. Although the rural share has increased modestly over time, the pace of change remains limited.

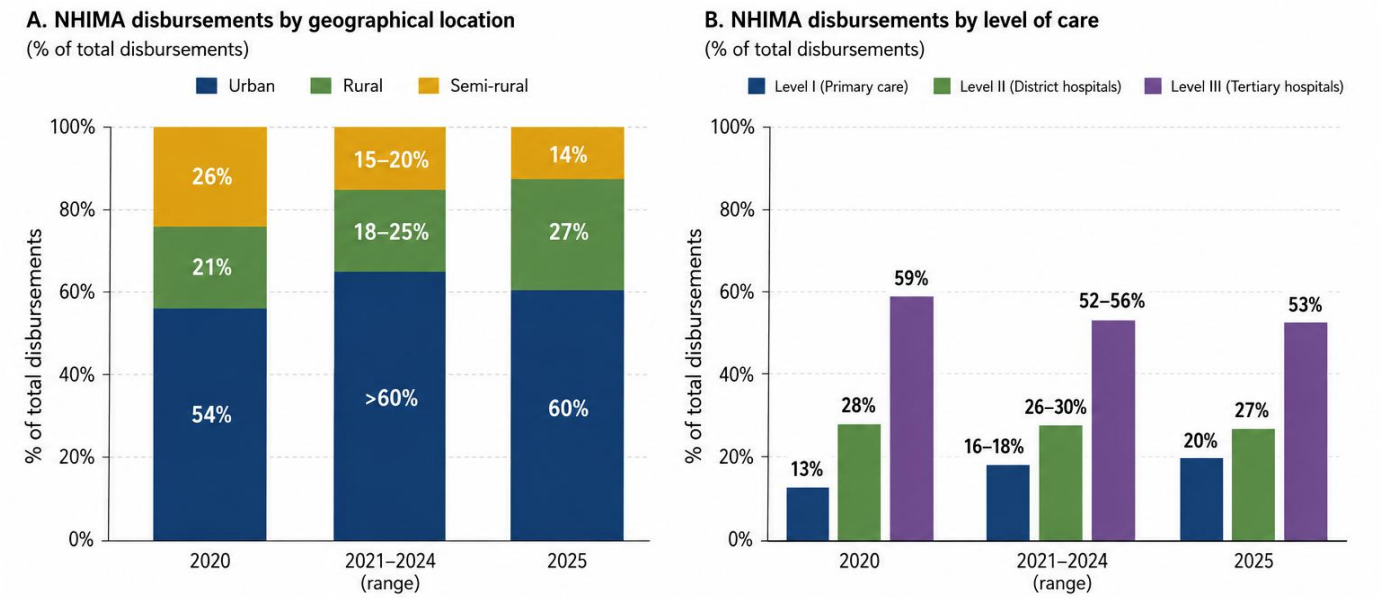

Figure A: NHIMA disbursements by geographical location (2020–2025). Figure B shows how first level services demonstrate a consistent upward trajectory. The share increases from 9 percent in 2020 to 13 percent in 2021, then rises further to 21 percent in 2022, 22 percent in 2023, 24 percent in 2024, and reaches 27 percent in 2025. The positive linear trend confirms a progressive rebalancing of NHIMA disbursements toward primary care services (Level one Hospitals). Notes: Urban, rural and semi-rural classifications follow the categorisation used in the NHIMA administrative dataset. Values for 2021–2024 represent the observed range across the period because annual values are not presented separately. Percentages may not sum to 100 due to rounding.

By level of care, third-level hospitals continue to receive the largest share of resources, while first-level (primary care) facilities, although seeing increased funding, remain comparatively underfunded. This pattern suggests that the health system remains oriented toward curative, hospital-based services, with implications for equity and access to PHC, particularly for rural and vulnerable populations.[24]

Qualitative findings provide additional context. Respondents reported difficulties in aligning technical planning priorities with local political and decision-making processes. In some cases, this led to resources being directed toward highly

visible or locally prioritised projects, rather than the interventions identified through technical planning frameworks, potentially reinforcing existing inequities.[16]

The District Health Directors echoed this concern.

"Councillors push priorities that may not align with technical needs,"

"We make requests, but final decisions rest with the council",

- District Health Director, Zambia

5.5 Lessons Learned

The findings yield key lessons for PHC financing in decentralised systems.

- Increased allocations alone are insufficient. Strong policy prioritisation of PHC and rising budget allocations do not guarantee effective service delivery without improvements in budget execution and fund-flow mechanisms.
- Financing performance depends on system capacity. Decentralisation requires parallel investments in subnational PFM capacity, clear institutional roles, and integrated systems. Without these, devolved responsibilities outstrip the ability of districts and facilities to manage resources effectively.
- Fragmentation undermines efficiency and accountability. Parallel planning, budgeting, and reporting systems, combined with unclear roles across institutions, create inefficiencies and make it difficult to track how PHC resources are used, weakening both management and accountability.
- Equity is shaped by allocation patterns. Unless resource allocation is explicitly designed and monitored with equity in mind, financing flows can continue to favour urban areas and higher-level hospitals over rural communities and first-level facilities, thereby reinforcing rather than reducing disparities in access to PHC.

6. Recommendations for policy and practice

Based on the findings, four evidence-based priority recommendations are proposed, addressing both short-term bottlenecks and longer-term structural reforms.

RECOMMENDATION 1: Strengthen Fiscal Devolution through Direct Facility Financing (DFF)

Why it matters: Delayed and unpredictable fund flows from Local Authorities to DHOs and onwards to health centres remain the primary operational bottleneck in PHC delivery. Without predictable financing at facility level, planning is undermined, procurement is delayed, and services are disrupted.

Urgency:	PHC budget execution averaged only 80% between 2021–2024, with disbursement delays preventing the remaining 20 % from reaching frontline facilities. Streamlining fund flows is critical to maximising existing allocation.
How to achieve:	Institutionalise DFF so that once funds are released to Local Authorities' sector accounts, DHOs immediately transfer allocations into each health centre's bank account. Each disbursement should be accompanied by a Facility Release Notice specifying amount, budget code, intended purpose, and reporting requirements. Health Facility Committees with designated co-signatories must oversee expenditure and publicly display quarterly allocations on facility noticeboards.
Timeline:	Short-term (0–12 months): Pilot DFF in at least two provinces. Medium-term (1–3 years): National scale-up.
Key stakeholders:	Ministry of Finance and National Planning; Ministry of Health (Policy & Planning, Finance, CCDS); Ministry of Local Government and Rural Development; Local Authorities; District Health Offices.

RECOMMENDATION 2: Invest in Subnational PFM Capacity Building	
Why it matters:	Sustainable PHC financing under decentralisation requires robust Public Financial Management (PFM) capacity at Local Authorities and District Health Offices (DHOs). Current challenges include variable PFM expertise among Principal Officers and District Health Directors, institutional knowledge gaps from staff transitions, and inconsistent training opportunities. Many officials 'sign off on budgets they barely understand because the figures come from finance officers.'
Urgency:	The pace of decentralisation is outstripping institutional capacity. Without investment now, execution inefficiencies, fiduciary risks, and accountability failures will deepen as more resources are devolved.
How to achieve:	Develop standardised PFM training modules tailored to DHD, DHO, and Local Authority roles. Complement with routine in-service mentorship and peer-to-peer learning exchanges. Integrate PFM performance reviews into regular supervisory visits. Establish subnational PFM training academies. Build financial literacy competencies including budget execution, variance analysis, internal controls, and procurement for all district-level decision-makers.
Timeline:	Short-term: Deploy training in all study districts within 6 months. Long-term: National rollout and institutionalisation within 2 years.

Key stakeholders:	Ministry of Health; Ministry of Local Government and Rural Development; Ministry of Finance and National Planning; Local Authorities; District Health Offices; development partners (World Bank, USG), the University of Zambia (SPH) and the National Institute of Public Health

RECOMMENDATION 3: Enforce Timely and Standardised Financial Reporting

Why it matters:	Facility-level financial reporting is often delayed, incomplete, or duplicated across parallel systems (councils and the MoH), reducing visibility into how resources translate into service delivery. This undermines transparency and prevents evidence-based budget adjustments.
Urgency:	The Auditor General's 2022 report found several Local Authorities failed to submit timely financial reports or comply with procurement regulations signalling systemic accountability failures that require urgent correction.
How to achieve:	Enforce standardised reporting deadlines and templates across all districts. Introduce digital reporting tools to reduce delays associated with manual submissions. Establish a PHC financing dashboard for real-time tracking of allocations, disbursements, and expenditures. Conduct quarterly performance review meetings to assess reporting compliance and provide targeted support. Publish annual budget execution reports publicly to strengthen external accountability.
Timeline:	Short-term: Standardise templates and enforce deadlines within 6 months. Medium-term: Deploy digital tools and PHC dashboard within 18 months.
Key stakeholders:	Ministry of Finance and National Planning; Ministry of Health; Ministry of Local Government and Rural Development; Auditor General's Office.

RECOMMENDATION 4: Integrate Digital Financial Systems and Strengthen Local Accountability

Why it matters:	Fragmented ICT systems (Palmsoft at council level; Navision, DHIS2, SmartCare in health) create data silos, duplicated reporting, and reconciliation burdens that consume staff time and undermine financial transparency. Political interference in audit and committee processes further weakens accountability.
Urgency:	As Zambia deepens decentralisation and devolves more resources, the cost of fragmented systems will compound. Harmonisation must begin now to prevent further entrenching of systemic inefficiency. Zambia's expanding mobile money infrastructure also presents a time-sensitive opportunity for innovative health financing through low-rate mobile money levies (0.2–0.5% on transactions).

How to achieve:	Roll out integrated digital financial management systems across districts, linking council and health office platforms. Institutionalise routine internal audits with enforcement authority. Introduce community-facing transparency tools such as public expenditure noticeboards and citizen scorecards at facility level. Strengthen Health Facility Committees to provide genuine financial oversight. Explore mobile money levy mechanisms to expand domestic health financing in a progressive and inclusive manner.
Timeline:	Short-term: Pilot integrated system in 2 provinces within 12 months. Long-term: National roll-out, mobile money levy legislation, and community accountability tools within 3 years.
Key stakeholders:	Ministry of Health; Ministry of Finance and National Planning; Ministry of Local Government and Rural Development; NHIMA; Bank of Zambia; ICT Authority; civil society organisations.

7. CONCLUSION

Zambia's decentralisation reforms present a significant opportunity to strengthen Primary Health Care (PHC) and accelerate progress toward Universal Health Coverage and SDG 3. Over the past five years, the country has demonstrated a clear commitment to PHC, with health budgets increasing substantially and PHC consistently accounting for a large share of Ministry of Health allocations. These trends reflect important progress in domestic resource mobilisation and policy prioritisation. [5,9]

However, the evidence from this study highlights a persistent gap between financing commitments and their translation into effective service delivery at the frontline in Zambia. While overall budget execution remained relatively high, critical inputs such as drugs and medical supplies have experienced sharp declines in execution, contributing to service disruptions. At the same time, fragmented financial management systems, delayed and unpredictable fund flows, and uneven subnational PFM capacity continued to limit the efficiency and coordination of resource use across the system.

Taken together, these findings suggest that the central challenge in PHC financing in the country is not only the adequacy of resources, but how funds are disbursed, managed, and aligned with service delivery needs within a decentralised context. Without addressing these systemic constraints, increases in health spending are unlikely to translate into equitable and sustained improvements in access and quality of care.

The four priority reforms outlined in this brief - (1) strengthening direct and predictable facility-level financing, (2) investing in subnational PFM capacity, (3) improving financial reporting, and (4) integrating digital systems - are mutually reinforcing and directly address the key bottlenecks identified in the analysis. Together, they provide a practical pathway for improving the effectiveness, equity, and accountability of PHC financing.[6,25]

Sustained and coordinated action across the Ministry of Health, Ministry of Finance, and Local Authorities will be essential to ensure that Zambia's growing investments in health translate into tangible improvements in service delivery, particularly for rural and underserved populations.

8. Next steps and future scope

Next Steps

- Convene a multi-stakeholder validation workshop with MoH, MoFNP, MLGRD, NHIMA, and development partners to validate findings and agree on priority reform actions.
- Develop a costed action plan for implementing Direct Facility Financing in at least two pilot provinces within 12 months, with clear accountability milestones.

- Commission a formal PFM capacity assessment across all 116 Local Authorities to inform the design of the national training programme.
- Engage the ICT Authority and relevant ministries on a roadmap for harmonising financial management platforms across councils and health offices.

Future Research Scope

Future research should conduct longitudinal evaluation of DFF pilots to measure impact on budget execution, service delivery, and health outcomes. Cost-effectiveness analysis comparing different PHC financing mechanisms including NHIS, fiscal transfers, and community-based insurance is needed, especially with disaggregation by urban-rural context. Equity analysis of resource allocation patterns affecting vulnerable groups (women, rural populations, informal workers) would strengthen the evidence base for equity-sensitive financing reforms. Feasibility studies on mobile money levies and expanded NHIS coverage for informal sector populations are also priorities.[26]

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