# HEALTH TAXES AND THE DECLINE OF ODA: INSIGHTS FROM ZAMBIA

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KIVU INTERNATIONAL

IN PARTNERSHIP WITH

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## ABOUT KIVU INTERNATIONAL

Kivu International is a UK-based development consultancy that supports locally led policy and systems change across Africa and Asia. Drawing on deep political-economy insights and field-based partnerships, Kivu works with governments, civil society, and international organisations to design and deliver practical solutions for inclusive and sustainable growth.

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## Executive Summary

Reductions in Official Development Assistance (ODA) are raising significant questions for the global health sector. ODA has historically accounted for up to half of healthcare spending in many sub-Saharan African countries, with USAID a particularly significant contributor. At the same time, the pattern of disease is increasingly shifting across the developing world, with levels of non-communicable diseases (NCDs) rising quickly, often the result of poor diets and tobacco and alcohol consumption.

But this challenging context also opens an **important opportunity: the option of using increased health (or 'sin') taxes on cigarettes, alcohol and sugary drinks to not only tackle the burden of NCDs but also provide much-needed funding for health systems under pressure.** With African health now increasingly needing to be funded from domestic sources, there is a real chance for health taxes to play a substantial role.

It was in this context that earlier this year world leaders considered the issue of health taxes at the Fourth UN High-level Meeting on NCDs. But as the contentious debate on this topic (and on the broader promotion of healthy environments) has demonstrated, whilst the opportunity is real, exploiting it will not always be easy. To use a football analogy – there is no easy open goal. Instead, the opportunity is more like having a free kick from a distance out, which will require real skill to guide into the net.

With an eye to providing insights for the global health community as well as domestic advocates, CRUK has been supporting a project exploring how this opportunity could be best exploited across Southern and Eastern Africa. What can the global health community and local advocates do to help get the ball in the back of the net?

This sub-Saharan Africa focused project is part of a longer-term partnership between CRUK, Kivu International (which specialises in supporting locally-led policy and system change), and local researchers and civil society organisations. Starting in 2019, this partnership worked first in Nepal and Sri Lanka—for five years—and more recently in Malaysia to develop context specific, politically informed, approaches to policy influencing. In both Nepal and Sri Lanka this contributed to approximately 50% increases in cigarette excise duties, and in Malaysia this year's government budget saw the first increases in tobacco taxes for over a decade.

As part of this partnership, between September this year and March 2026, Kivu is exploring in detail how best to exploit this potential opportunity, focusing in on Zambia, Uganda, Kenya and Tanzania. This interim report considers as a case study the recent increases in health taxes in Zambia, where ODA reductions are cutting more than USD 125 million of health spending annually. The report details the increases in health taxes introduced but also highlights that the links between these measures and ODA cuts are not straightforward: the policy and political debates which shaped decision-making in Lusaka had less to do with ODA reductions than the specific local context. **Grounded in this case study, the report draws out some questions for consideration if the opportunity to use health taxes as a vehicle for sustainable health financing is to be exploited.**

The report highlights five key questions:

1. **How can the negative impacts of ODA reductions to the health sector be captured and communicated in an influential way?** The impact of cuts may

take time to be widely felt. Some impacts, such as on health sector jobs or availability of some critical health services, are already being felt (including in Zambia where job losses already have real political salience). But other impacts, for example, on commodity supply chains and wider health outcomes will only play out over time. An explicit strategy to demonstrate the negative impacts of these cuts in a politically salient way may be needed to build the case for increasing revenue allocations for public health. This could include local CSO monitoring of- and effective communication about – the impacts of cuts on essential services such as HIV, Malaria, and TB.

2. **Is there a need to strengthen the domestic political base of support for wider health sector financing to justify health tax increases, and if so, how?** If there is insufficient or only poorly organised political demand—including demand from the wider public and from organised interest groups and civil society—for general health sector financing, this will hinder Ministries of Finance in taking difficult decisions to raise health taxes and earmark funding for health. In Zambia, for example, a sufficiently powerful political base of support does not yet exist meaning ODA cuts were not part of the rationale for health tax increases. This need for there to be a sufficiently powerful political coalition in support of change is something which in the new world, post ODA cuts, moves front and centre. How global health communities can best support this is an important question.

3. **How can health tax increases be used as part of a longer-term strategy for health system financing and reform rather than just a stop-gap measure?** Without combining health tax increases and complementary efforts to, for example, strengthen compliance and enforcement, there is a risk that increases remain episodic and unsustainable. In Zambia, we have heard that recent increases in tax rates have not been commensurate with much needed efforts to build Revenue Authority collective and enforcement capacity. These challenges can undermine efficacy and reduce the credibility of health taxes as a reliable revenue source in the eyes of all-important Ministries of Finance. A related point is the need to build the longer-term case for health taxes directly achieving public health benefits; these arguments will hold sway to differing degrees depending on the tax (SSB vs alcohol vs tobacco) and across countries but should be part of underpinning a more sustainable longer-term strategy.

4. **Has careful consideration of the different politics surrounding the three major harmful products (cigarettes, alcohol, and sugary drinks) sufficiently informed the approach?** Across all three products, there are major variations in both elite-level and popular-level political contexts, including most obviously the varying strengths of the industry lobbies. In some cases, brigading these harmful products together as part of a unified “health taxes” agenda will make sense, but in certain contexts that may be ineffective or even counterproductive. In Zambia, for example, government raised concerns about SSBs taxes being particularly politically unpopular with concerns about the impact on the cost of living.

5. **Has sufficient attention been given to the framing of arguments for increasing health taxes? How will different framings resonate with policymakers in their specific contexts?** In some countries the explicit framing of “increased health taxes to pay for healthcare” will have traction, but in others it may not. In Zambia, some feel that public scepticism about the efficacy of health spending makes this framing politically counterproductive. Other framing

arguments (“sin taxes are a politically viable revenue raiser” or “health taxes are win-win for public finances and public health”) may be preferable to an explicit linking to health spending.

As the global health community meets again at the FCTC COP in November, it will rightly be eager to exploit the opportunities for health taxes to fill gaps left by ODA cuts. The potential prize is considerable: sustainable funding streams for effective health systems which protect and build on the achievements of the global public health community. But to return to the football analogy, scoring this goal will not be easy. Each country’s politics and policy landscape is unique, and success will require careful consideration of domestic political and practical realities. **In the world of ODA cuts, lasting change will have to be bottom-up and embedded in domestic political processes and government systems.** What remains clear however is that the global public health community still has a critical role to play in supporting locally led change and advocacy.

As stated above, this interim Zambia case study is just one part of a project which is also considering opportunities in Kenya, Tanzania, and Uganda. The project will continue to draw out insights from the region and will present a final report in Spring 2026.

## Introduction: ODA Cuts and Health Sector Financing

In recent years, the health sector in sub-Saharan Africa has been heavily dependent on Official Development Assistance (ODA). In many countries, as much as half of health spending has been ODA.[1] With the sharp cuts to U.S. global health funding and USAID-implemented programs, and large retrenchment of ODA by the UK, Netherlands, Germany, and Scandinavian donor countries, pressing questions about health-sector financing are coming to the fore. Bilateral donors and philanthropic funders are rightly now asking how they can ensure continued health funding and improvements in health outcomes in a world of radically cut back ODA spending.

It is not surprising that, in this context, there has been renewed interest in health taxes.[2] The notion that domestic sources of revenue, with health taxes playing a major role, can help fill the gap left by ODA cuts is understandably appealing. But what are the prospects of it happening? What may some of the barriers to realising this ambition be? In particular, what are the prospects of embedding this "health-taxes to backfill ODA cuts" strategy in local political processes in sub-Saharan African countries? With lower levels of spending the global health community and local health advocates need to consider a sometimes-challenging set of questions about how you *embed change in local political processes and systems*.

This report is part of a Cancer Research-UK supported project which seeks to provide insights on these questions, which must now be front and centre in the global public health debate. As it develops, the project will explore and compare experiences in Zambia, Uganda, Tanzania, and Kenya; this interim report starts with a case study of some recent health tax increases in Zambia. It comes with caveats: this is just one country's experience, and the full political effects of the changes are yet to play out (they only came into force on 19 August 2025). But it provides some valuable insights and raises important questions which need to be considered if health taxes are going to have any chance of playing an important long-term role in filling the black hole in health sector funding left by ODA cuts.

*The core headline finding from Zambia is that deeply embedded local political factors mean that domestically, there is no automatic and simple line between ODA cuts and increases in health taxes. But an opportunity for sustainable tax increase does exist – and greater emphasis on building the domestic political conditions higher investment in health could enable global actors and local advocates to successfully support meaningful policy change*

This report is set out in five sections:

1. Kivu and CRUK work on political-informed, locally led policy change.
2. Context of health financing in Zambia and ODA cuts
3. Health tax changes which were announced in June 2025
4. A detailed account of the domestic political and policy dynamics in Zambia
5. Key conclusions and questions of relevance for global public health debates
6. Next steps for the project

[1] Africa Centres for Disease Control and Prevention (April 2025): *Africa's health financing in a new era*

[2] E.g. Daily Telegraph (July 2025): *Inside the trillion dollar plan to replace aid with 'sin taxes' in the developing world*

## 1. Context: CRUK and Kivu's Locally Led Tobacco Tax Policy Influencing

Since 2019, CRUK has supported locally led policy influencing on tobacco taxation in low- and middle-income countries. This includes work through the Union for International Cancer Control (UICC) in Kenya and Uganda and a five-year partnership with Kivu International. This latter partnership has supported local think tanks and civil society organisations to lead policy influencing projects initially in Nepal and Sri Lanka and more recently in Malaysia.

In Nepal and Sri Lanka, the projects were tailored to the context and locally by two local think tanks; in Nepal, the Nepal Development Research Institute (NDRI) and in Sri Lanka the Institute for Policy Studies (IPS). These lead organisations coordinated with other local partners to form coalitions which, working together, had the power to influence tobacco tax policy. These coalitions were different in Nepal compared with Sri Lanka: in Nepal the coalition was larger with more pubic facing organisations, for example including a media house, the Annapurna Media Network (AMN), reflecting the fact there was a need to "raise the salience" of tobacco tax, whereas in Sri Lanka, for most of the period of the project, the coalition was smaller and more targeted at elite level, or "insider" policy influencing. This reflected the specific policy and political context of Sri Lanka.

The projects contributed significantly to large increases in tobacco taxation in both contexts. In both, approximately 50% increases in cigarette excise duties were achieved.[3]

More recently, CRUK has supported a project in Malaysia, also led by a local think tank (SERI), with Kivu support. This project started in August 2024 and contributed significantly to the first cigarette tax increase in Malaysia for over a decade.[4]

This experience in Nepal, Sri Lanka and Malaysia provides some insights into how best to support locally led policy change. But recognising that the ODA cuts of recent years and fundamental change in the global public health context will have a disproportionate impact on sub-Saharan Africa, this report is part of a rapid project assessing the potential opportunity for using health taxes to meet part of the shortfall left by ODA cuts in Southern and Easter Africa—with a focus on Zambia, Kenya, Tanzania, and Uganda.

## 2. Health Financing and ODA cuts in Zambia

Zambia's health financing landscape is marked by heavy reliance on external donor funding alongside constrained domestic resources. Despite commitments under the Abuja Declaration (2001), which urged African governments to allocate at least 15% of their national budgets to health, Zambia's budgetary allocation has averaged just 8–11% over the past decade.[5] Although the government increased its health budget by 6% in 2024, raising health as a share of the total budget from 10.4% in 2023 to 11.8%, this still remains significantly below target.[6] With health often competing against other pressing fiscal priorities, the sector remains underfunded. Donor funding

[3] Harnessing the power of thinktanks to influence policy change in Sri Lanka and Nepal: Tobacco Control Research into Policy Programme 2019-2014

[4] Post on LinkedIn by Rashaad Ali

[5] UNICEF (2023): *Zambia Budget Brief: Health 2023*

[6] UNICEF (2024): *Zambia Budget Brief: Health 2024*

has filled much of this gap, accounting for close to 50% of total health expenditure,[7] with USAID providing the largest share.

Limited fiscal space, high debt servicing obligations, and macroeconomic volatility further constrain the government's ability to increase allocations. Zambia remains at high risk of debt distress, with the public debt-to-GDP ratio projected at about 92% in 2025. Although the fiscal deficit is expected to narrow to 3.5% of GDP in 2025 compared to 6.4% in 2024, fiscal pressures continue to restrict new health investments.[8]

This chronic underfunding of the health sector by government comes despite 2022 Afrobarometer polling finding that half (48%) of Zambians cite health as a top priority – the second highest percentage on the African continent; a similar number (46%) go without health care "many times" or "always" each year – the highest in Africa; and 94% of Zambians who sought health services in 2021 found medicines or other supplies to be lacking – also the highest percentage on the continent.[9] Most recently, on 5 September 2025, new polling was released revealing two-thirds (67%) of Zambians say they worry "somewhat" or "a lot" about being unable to obtain or afford medical care when they need it.[10]

The financing challenge has been aggravated by sharp reductions in Official Development Assistance (ODA), with health funding across Africa projected to decline by 70% between 2021 and 2025, creating an unprecedented financing crisis.[11] In Zambia, average annual health ODA amounted to USD 688 million in 2022–2023 – equivalent to 2.6% of GNI and USD 33 per person – with over half of this support coming from the United States and nearly one-third directly from USAID.[12] This dependence has already been starkly illustrated by the U.S. Embassy's decision to cut USD 50 million (1.4 billion kwacha) in annual support for medications and medical supplies, citing the government's inadequate response to systematic theft of donated medicines.[13] At a minimum, Zambia now looks set to lose at least USD 125 million of health financing as a result of the USAID cuts,[14] and these losses could more than double should HIV financing through PEPFAR be further cut.[15]

In this context, domestic resource mobilisation (DRM) has become a central policy priority. Health taxes, which are targeted excise taxes on harmful products such as tobacco, alcohol, and sugar-sweetened beverages, represent a cost-effective but underutilised tool. The World Health Organization (WHO) recently launched its "3 by 35" initiative, calling on countries to raise real prices on these products by at least 50% by 2035.[16] Health taxes *potentially* provide a 'triple-win' solution: they save lives and

[7] World Health Organization (2024): *Health Financing Progress Matrix Assessment, Zambia 2024: Summary of Findings and Recommendations*
[8] International Monetary Fund (June 2025): *IMF Executive Board Concludes 2025 Article IV Consultation and Completes Fifth Review Under the Extended Credit Facility with Zambia*
[9] Afrobarometer (April 2024): *Afrobarometer Policy Paper No. 91: Africans Rate Health as a Top Priority for Government Action*
[10] Afrobarometer (Sep 2025): *Most Zambians Lack Medical Aid, Support Government Provision of Universal Health Coverage*
[11] Africa Centres for Disease Control and Prevention (April 2025): *Africa's Health Financing in a New Era*
[12] Center for Global Development (Feb 2025): *26 Countries are Most Vulnerable to US Global Health Aid Cuts*
[13] US Embassy in Zambia (May 2025): *United States to cut $50 million in medications and medical supplies support*
[14] Center for Global Development (March 2025): *USAID Cuts: New Estimates at the Country Level*
[15] New York Times (July 2025): *U.S. Quietly Drafts Plan to End Program That Saved Millions From AIDS*
[16] World Health Organization (July 2025): *The 3 by 35 Initiative*

prevent disease by reducing harmful consumption, they generate domestic revenue to offset declining aid, and they reduce long-term health system costs.[17]

Zambia's recent supplementary budget, which introduced new health tax measures through excise reforms on products such as tobacco, alcohol, and sugar-sweetened beverages, provides an important case study of how these dynamics are beginning to play out in practice.

## 3. Zambia's June 2025 Health Tax Reforms

Zambia's excise tax regime has regularly been amended, with both increases and decreases, over the last decade since baseline rates were set in 2025. For example, clear beer excise was cut from 60% to 40% after just one year in 2016 to support domestic brewers;[18] and opaque beer excise sharply increased in 2021, only to be largely reversed in 2022 after industry pushback.[19] The steepest increases came in 2024, when the duty on cigarettes was increased from K250 to K400/1,000 sticks,[20] to be followed up with a further increase to K452 just six months later.[21] It is in this context of regular but sometimes short-lived, excise reforms, that we must understand the following reforms.

On 26 June 2025, Zambia's Minister of Finance and National Planning presented an extraordinary Supplementary Budget to the National Assembly, purportedly to meet domestic and external debt service obligations and to fulfil "other critical government expenditures".

To boost revenue, the government announced a series of tax increases and new levies. These included increases in excise duty on cigarettes (from 452 ZMW to 750 ZMW per 1,000 cigarettes), spirits and wine (from 60% to 80%), and imported sugary drinks (from 1 ZMW to 2 ZMW per litre). The suspension of the 40% duty on clear beer was replaced with a 50% excise duty.[22]

**Table 1**: Timeline of 2025 Excise Tax Reforms

| Date | Event |
|---|---|
| 26 June 2025 | Supplementary Budget, including excise tax increases, formally introduced in the National Assembly |
| 8 August 2025 | The amendments to the Customs and Excise Act are signed into law |
| 19 August 2025 | New excise tax rates on tobacco, alcohol, and imported sugary drinks officially take effect |

At first glance, these measures would appear to be a significant win for the 3 by 35 initiative and wider global health agenda. Taxes on cigarettes were increased by 66%,

[17] Vital Strategies (July 2025): *The Future of Health Financing in Africa: The Role of Health Taxes*
[18] In 2025 baseline excise rates set were set 60% for clear beer, 60% for wines, opaque beer at K0.15/litre; and cigarettes taxed at 145% or K90/1,000 sticks (mixed structure).
[19] Dr Zunda Chisha et al: '*Analysing the Health Tax Landscape and Policy Development Process in Zambia*' (unpublished, forthcoming)
[20] PKF Zambia (2024): *Zambia 2024 Budget Tax Highlights*
[21] Zambia Revenue Authority (January 2025): *2025 Tax Updates: What You Need To Know*
[22] Zambia Ministry of Finance and National Planning (June 2025): *Supplementary Estimates of Expenditure No. 1 of 2025: Statement by Hon. Dr Situmbeko Musokotwane MP*

on beer by 50%, and on spirits and wine by 33%.[23] Whilst still substantially below WHO guideline rates, there is no doubt the government has taken a progressive step forward. However, informed by key informant interviews with policymakers, officials, advocates, and civil society (see Annex A) and the project team's own understanding of the Zambian political, fiscal and public health context, this case study report will demonstrate that the story is not a simple win for global health campaigners, and will draw out key lessons for campaigners advocating the health taxes agenda.

## 4. Behind the Scenes of Zambian Policymaking

Our key informant interviews, including with political insiders, offered a fascinating insight into the policymaking process that delivered these substantial excise tax increases. Whilst at times accounts contradicted, several key narratives emerged clearly from our discussions.

**Box 1: Key Informant Interviews**

The project team aimed to understand the detailed political and practical considerations which guided policymakers through this process. To understand the most significant political drivers of the decision-making process the team conducted a wide range of key informant interviews, with interviewees including from the following institutions:

- State House of Zambia
- Ministry of Finance and National Planning
- Ministry of Health
- Resolve to Save Lives
- National Health Insurance Management Authority
- Zambia Revenue Authority
- National Assembly of Zambia – Health Committee
- National Assembly of Zambia – Budget Committee
- World Health Organisation Zambia Office
- British High Commission Lusaka
- African Institute for Development Policy
- Centre for Trade Policy & Development / Zambia Tax Platform
- Southern African Institute for Policy and Research
- University of Cape Town School of Economics
- Finance Alliance for Health
- Centre for Primary Care Research
- NCD Alliance Zambia
- Campaign for Tobacco Free Kids
- Zambia Daily Mail

*Wider Fiscal Context as the Key Driver*

First, we can be certain that the primary driving force between the excise tax reforms was the need for government to fill an unexpected fiscal blackhole. This had arisen not due to ODA cuts but largely resulted from new external debt repayment obligations of more than $350 million which followed newly signed debt restructuring

[23] Zambia Ministry of Finance and National Planning (June 2025): *Supplementary Estimates of Expenditure No. 1 of 2025: Statement by Hon. Dr Situmbeko Musokotwane MP*

agreements. [24] Government also came under pressure to meet a number of unbudgeted domestic spending pressures. These included more than $460 million of fuel arrears which had built up over months, as well as approximately $250 million required to finance the e-Voucher system, the Ministry of Agriculture's flagship subsidy reform.

It is clear from conversations, too, that the Ministry of Finance and National Planning was placed under substantial external pressure by the International Monetary Fund (IMF) to increase domestic revenue mobilisation to both protect social spending and balance the national budget. What is striking, however, is despite an additional $80 million being provided for social cash transfers and $75 million set aside for education, health was the one critical social sector that did not benefit from the supplementary budget, receiving no new allocation of any kind, despite the significant financing challenges set out in the introduction.

*Little Link to ODA Cuts*

To what extent, then, did the USAID withdrawal and wider ODA spending cuts influence decision-making on the budget measures? Whilst some external public health focused stakeholders suggested that the global cuts were surely "at the back of officials' minds" as they formulated the supplementary budget, in general it seems likely that these global development cuts – and the issue of health financing more generally – had little impact on the package. This is not mean that ODA cuts will never resonate politically in Zambia; with time, the impacts on citizens will emerge more strongly as service delivery weakens and commodity supply chains falter. But it appears that if these cuts are to become a useful tool with which to advocate for drive health tax increases, further work could usefully be undertaken by both international and local actors to monitor and communicate the negative impacts of the health cuts over time in a politically salient way.

As for the decision-making on the measures themselves, informants stressed that the excise taxes were parts of a wider suite of tax measures which were already in the established policy framework, and which had "long been in the Ministry of Finance's sights". Whilst the Ministry of Health had over several years been pressing for higher rates on each of tobacco, alcohol, and sugar – and had even lobbied for outright alcohol and tobacco bans – but these requests were given little weight by the Ministry of Finance as they formulated their budget response, who dominated the process of inter-ministerial bargaining. Moreover, we heard policymakers openly lament that the evidence base for health taxation as a source of domestic revenue in Zambia specifically is too weak. Zambia has no local price elasticity data for tobacco, alcohol, or sugary drinks, relying instead on South African and international studies, raising concerns within ministries and parliamentary committees.

*No Interest in Earmarking for Health Spending*

Any talk of earmarking either all or a portion of the revenues raised for health financing – and some civil society advocates had expressed hope of such moves – was shut down rapidly by the Ministry of Finance. Specific earmarking would be "out of the question", not just due to the administrative challenges that this would create for government (and the lack of precedent upon which to design any such system), but

[24] Zambia Ministry of Finance and National Planning (June 2025): *Supplementary Estimates of Expenditure No. 1 of 2025: Statement by Hon. Dr Situmbeko Musokotwane MP*

also because in the Ministry of Finance's eyes, the health sector had already received "more than sufficient funding" in the 2024 budget and was far from the most deserving candidate for additional topping up through the supplementary budget, despite the USAID withdrawal.

The view that the health budget was adequately or even over-funded was likely shaped in part by an ongoing domestic medicines supply scandal, which dominated headlines throughout June 2025, and saw substantial public and diplomatic outrage over alleged large-scale theft of donated drugs which were being resold on the black market.[25] Following an uplift to the medicines budget in 2024, there was reluctance to dedicate further resources to the scandal-rocked sector. The extent to which this controversy reduced the Ministry of Health's credibility in the eyes of central government decision-makers, remains however contested, and it is likely that whilst meaningful, its influence should not be overstated. What Ministry of Finance officials most certainly did not mention in discussions was the latent public interest in health service delivery which is revealed by the Afrobarometer polling.

*Domestic Political Factors Were Critical*

We also heard about the role played by the international advocacy organisation Resolve to Save Lives who had been working to advocate for health tax increases in Zambia and engaging effectively with senior government actors. This was a significant and impressive part of the policymaking process, with Resolve to Save Live recommending tax increases on tobacco, alcohol, sugary drinks, and unhealthy packaged food, and supporting government with compelling modelling and revenue forecasts.

Interviewees confirmed that Resolve's advocacy played a constructive role by illustrating pathways to increasing revenue through health taxes. They also had impressive access to senior policymakers. But this did not result in straightforward adoption of their recommendations without domestic political factors coming into play.

We heard from government insiders that that the Minister of Finance personally stepped in to quickly take control of the tax agenda and shape the measures, significantly watering down proposals on taxation of sugary drinks in particular, and blocking efforts to introduce excise taxes of any kind on unhealthy packaged food.

This clearly demonstrates the different politics surrounding tobacco, alcohol and sugar. Heavily taxing sugary-drinks flashed alarm bells within the ranks of Zambia's political leadership, who balked at the idea of significantly increasing rates on food and drink products used by the vast majority of the country, and for which there was no existing national concern to tap into. It was, as one State House insider noted, "never going to see the light of day".

Despite the sugar and food manufacturing lobby appearing less well prepared and coordinated than the tobacco and industry lobbies, the supplementary budget measure only applied to imported sugary drinks, which make up only a small, high-end component of the domestic market. Even on imported drinks, excise was only increased from 1 to 2 kwacha per litre. The very different politics of tobacco, alcohol,

[25] See for example BBC News (May 2025): *Zambia says it is tackling 'systematic' theft after US slashes medical aid*; Lusaka Times (May 2025): *Minister Muchima Responds to U.S. Envoy Gonzales with Firm Action on Drug Theft Crisis*; and New Diggers (July 2025): *Health Sector Corruption is a Death Sentence*

and sugar are best illustrated by contrasting the scale of measures that were implemented (see table 2).

**Table 2**: Inside the Domestic Politics of Health Taxes

| Product | Changes Implemented | Political Dynamics |
|---|---|---|
| Tobacco | Duty increased from ZMW 452 to 750 ZMW per 1,000 sticks. | Considered "safer" politically due to the small consumer base and framed as consistent with regional norms; but strong industry lobby with institutional support from the Commerce and Agriculture Ministries. |
| Alcohol | Spirits raised from 60% to 80%; suspended 40% duty on clear beer reinstated and increased to 50%. | Popular product with stronger industry; government aware of counterfeit and smuggling risks but pressed ahead under fiscal urgency |
| Sugar-Sweetened Drinks | Only imported sugary drinks are taxed, with excise increased from ZMW 1 to ZMW 2. | Universal product consumption but with weak industry lobby; but government concerned by prospect of widespread cost of living increase. |
| Unhealthy Packaged Foods | None | Universal product consumption but with weak industry lobby; but government concerned by prospect of widespread cost of living increase. |

*Limited Political Backlash (so far).*

Once the package of measures was locked down and approved by Cabinet behind closed doors, the National Assembly was only given the statutory minimum time for consultation and debate on the measures, and there was no meaningful opposition or scrutiny from parliamentarians. Whilst we heard that the Budget Committee was quietly unhappy with the proposals, which they saw as "too fast, too soon", and expressed a general scepticism about excise tax enforcement and the revenue projection claims that had been made by the Ministry of Finance, such concerns were kept largely quiet.

The public and industry response to the budget measures has so far been relatively muted. With the new excise rates only coming into effect on 19 August 2025, it is still early to judge the full extent of industry or public reaction. For now, however, both industry and civil society actors appear to have been caught off guard by the speed of the announcement and the compressed parliamentary timeline, which limited opportunities for mobilisation. In the words of one Member of Parliament, "industry was taken completely by surprise".

Whilst the Ministry of Commerce, Trade and Industry was able to advocate on behalf of the tobacco industry internally to the Ministry of Finance, lobbying appears to have been relatively ineffective on the whole, with the greatest constraint upon the scale of the increase not being a lobbying campaign, but rather the political antennae of the Minister of Finance and senior State House figures. It was interesting that the primary coordinating body for industry in Zambia – the Zambia Association of Manufacturers (ZAM) – could not speak with us about the excise reforms, possibly having been

caught off guard by the changes, or perhaps too busy coordinating responses with their members from industry.

It was only in the weeks after implementation of the reforms, in late August and early September, that industry campaigning intensified, through a series of predominantly behind-the-scenes (albeit occasionally public) meetings at State House with the President and Senior Advisors.[26] Industry has focused on exploiting existing concerns within government about illicit trade, with the primary intent of getting the Ministry of Finance to roll back the reforms in the 2025/26 National Budget, which was ultimately presented to parliament on 26 September 2025. Whilst the budget has not yet been voted through parliament, and it remains to be seen what amendments may yet be made, there were no excise reductions in the proposals put to parliament, and it appears likely that industry's back-room campaigning has been too little too late.

More widely, there has, so far at least, been only the most muted public reaction to the changes. Two months on, public awareness of the changes remain low – and essentially negligible in rural areas. The elected politicians with whom we spoke said that they had not received complaints from citizens, who they may have expected to have raised concerns about further cost of living pressure.

A lobby group named the "Coalition Against Illegal Alcohol", established in September 2024 and coordinated by a public relations company (Langmead & Baker) on behalf of Zambia Breweries (the country's largest beer producer) published a critical piece on various online fora titled *Taxing Ourselves Into a Public Health Crisis* that argues the rises in alcohol excise duties "could unintentionally push us into a full-blown public health crisis".[27] But despite being authored by credible figures, including the Chair of the Parliamentary Health Committee, both this specific article and the wider argument it seeks to make appears received little traction locally in media and with the general public.

One contributing factor to the generally muted response was no doubt the staging of the announcements through the supplementary budget process which ensured a compressed timeline limiting opportunities for industry mobilisation and public debate. It remains uncertain the extent to which this timing was a strategic choice with the express aim of limiting pushback (versus just responding to the urgent fiscal situation), but regardless the political benefit to government was not lost upon either civil society advocates or upon officials themselves.

*No longer-term thinking on either health system funding of health taxes*

On the other hand, the compressed timeline significantly limited wider government strategic thinking across several key areas, including the (missed) opportunities to link these reforms to the NCD prevention agenda and develop a communications strategy that went beyond simply framing the taxes as a technical revenue measure, but instead highlighted equity or long-term cost savings. And of greater structural significance, is the apparent failure of the government to match the increase in sin tax rates with a comparable investment into the capacity of the Zambia Revenue Authority to increase compliance and tackle illicit smuggling.

[26] An example of a recent (and unusually publicised) meeting was on 4 September 2025 (Langmead: *Zambian Breweries Welcomes Governments Pledge to Support Industrial Growth*)

[27] Zambia Breweries (2025): *Taxing Ourselves Into a Public Health Crisis;* also on Langmead & Baker.

As one well-connected political insider explained, the clearest giveaway that these reforms are not the beginning of a new strategy or a wider transition towards excise taxes as a source of longer-term sustainable financing is the failure of government to consider strengthening the relevant excise tax teams within the Ministry of Finance and ZRA, which are particularly understaffed and underfunded, even by Zambian government standards. Instead, the insider emphasised, we should understand the excise tax measures as a one-off revenue grab, more comparable to a crisis response than a meaningful evolution of policy-thinking.

## 5. Key Lessons

The central question that this case study has sought to explore is the extent to which global aid cuts have created – or could create – meaningful opportunities for health taxes to emerge as a source of sustainable financing for healthcare in Zambia.

The most significant finding has been that despite the scale of the health financing challenge Zambia that faces, and the substantial latent public interest in health service delivery, there has not yet appeared meaningful concern at the political level to prioritise health financing. Instead, deeply embedded local political factors have created a structural disconnect between the decision-makers and the interests of ordinary Zambian citizens.

Therefore, to exploit the real opportunity that the aid cuts do provide to further the sin taxation agenda, advocates must carefully consider these political factors. The key insights that we have drawn out from our analysis of the political processes that played out in recent months, as set out above, emphasise the importance of bridging this gap between elites and the wider public on the issue of health financing, and raising the political salience of health delivery in Zambia.

**Insight #1: The domestic political conditions for health sector ODA cuts to open opportunities for health tax increases may not yet exist (and certainly do not in Zambia).**

These cuts matter, and were on some people's minds, but must not be seen as a straightforward driver of increases in health taxes. USAID's withdrawal was not, in Zambia, in any sense a trigger for health tax increases, and did not determine the scale, shape, or timing of reform. It is telling that not a single kwacha of the supplementary budget was allocated to health, with debt repayments, energy and agriculture sectors being the primary recipient. These are sectors which saw less severe ODA cuts, and this reflects an unfortunate deeper reality: there does not yet appear to be a meaningful political base for health sector spending or reform in Zambia and any politically influential concern about the ODA cuts and their potential implications for Zambia. Policymakers and political elites do not yet feel public or political pressure to replace health-focused ODA through domestic resources. In the words of one senior Presidential advisor "as a country, we are not yet at that level".

There are several possible reasons for this. There is likely a fundamental political economy problem, with an insufficiently powerful set of pro-health sector spending domestic interests (see Insight #2 for more detail on this). But in Zambia there were also some more specific points raised including several insiders suggesting that the recent scandals in the health sector (drugs budget corruption) have significantly damaged public trust. Understanding why there is an insufficiently powerful domestic political base for health system funding needs to be an important part of future work.

***Lesson**: There is a real opportunity for the global public health community to more clearly demonstrate the impacts of ODA cuts to help lay the groundwork for increasing health taxes. Moreover, donor aid cuts alone will not drive domestic health financing reforms until there develops a stronger political base for health spending; but despite fewer resources, donors nonetheless can play a critical role in supporting local actors to build that political base over time. In Zambia, such championing of locally-led change could prove catalytic in enabling future ODA reductions to begin to translate into meaningful domestic commitments.*

**Insight #2: There is a paradox of high public concern about health but limited and insufficient political pressure.**

The most likely future pathway for Zambia's health sector spending sees large ODA reductions (of potentially more than USD 350 million per year) that the Government of Zambia fails to offset with increases in health spending. But there is a paradox here: Zambians do care about health. It is, as noted in Section 1, a top concern for close to half the population. Yet this mass-level concern for the issue is not translating into political pressure. For more than a decade, Zambians have quietly endured drug shortages and weak health services, lowering their expectations of what government can deliver. This has reduced the visibility of health financing as a political issue, even though surveys show strong public support for better services, and a willingness amongst Zambians to pay more when taxes are seen to bring real improvements.

Understanding this core local political challenge is something that during the previous period of high ODA spending was able to be put on the backburner; external aid spend could "buy" health outcomes without considering how to embed them in local politics. But in the new world this is no longer tenable. Any strategy to understand and address this political challenge will need to focus on how best to bridge the gap between insufficient elite prioritisation of health and the wider public concern about the issue.

The major challenge is not convincing people that health matters but rather finding the right way to tell the story. Few journalists and agenda-setters have yet meaningfully engaged on health financing issues, and discussions of the subject are rarely packaged in clear, simple terms that resonate with everyday experience. Until advocates campaign for strengthened health financing through repeatable stories and make sure they are carried by trusted messengers such as community radio, churches, nurses, and patient groups, leaders will continue to underestimate the depth of public demand for stronger health services. This suggests the need for some longer-term "agenda setting" work.

***Lesson**: Recognise that there is a wide gap between public interest in health service delivery and political perception of salience. Whilst public support for health is already strong, it must now be made visible. Advocates need to develop strategies and coalitions to set the agenda with elites, demonstrate public demand, and raise the political salience of health policy. Advocates should work with the media to tell clear, relatable stories about how health taxes can improve daily life and highlight concrete benefits — like stocked medicines or better-equipped clinics — that people can see and trust. Some global health organisations are already leading the way, for example, with bespoke media trainings; the opportunities to engage in salience-raising advocacy are significant.*

**Insight #3: Health framing was contested—seen by some as strategy, by others as omission**

The government's decision not to present the 2025 excise increases as health taxes sparked divided interpretations. Some interviewees stressed it was a **deliberate political strategy**: scandals in the medicines budget had weakened trust in the health sector, and framing the new taxes as "for health" risked triggering public backlash or giving ammunition to political opponents. From this perspective, emphasising fiscal stabilisation was the safer route to ensure the measures passed smoothly.

Others, however, viewed the absence of health framing less as a conscious choice and more as the natural outcome of a Ministry of Finance–led process. From this angle, the omission reflected technocratic habits: the Ministry's focus is revenue, not health, and there was little institutional pressure to frame the measures differently.

***Lesson:*** *Whether by design or default, the result was the same: health was absent from the narrative. For advocates, this underlines two points. First, framing matters. How a tax is justified can shape its political durability. Second, assumptions that health arguments will automatically gain traction are misplaced. In some countries the explicit framing of "increased health taxes to pay for healthcare" will have traction, but in others it may not. In Zambia, public scepticism about the efficacy and wider management of health spending makes this framing, in the view of some, counterproductive. The most effective framings will differ from context to context and will not be static but will rather evolve over time.*

**Insight #4: Without making links to wider health-system financing, these health tax changes may not be sustainable**

One important consequence of these tax changes in Zambia being the result of short-term fiscal pressures, *not* a longer-term concern for sustainable health system financing, is that they risk being a one-off or even worse not being regarded as being effective (because they do not raise the promised revenue without, for example, sufficient investment in enforcement) which will undermine the health tax agenda in the longer-term.

Our interviews reveal government to have treated these excise changes seemingly as a one-off stopgap measure, rather than the beginning or continuation of a sustainable and long-term DRM strategy. The government has not taken steps to strengthen the ZRA's ability to collect excise taxes, nor strengthened wider policing and customs checks at borders, meaning illicit trade is a genuine concern, particularly for alcohol and tobacco. This can undermine both the intended revenue and health benefits of the changes.

A related point is the need to build the longer-term case for health taxes directly achieving public health benefits; these arguments will hold sway to differing degrees depending on the tax (SSB vs alcohol vs tobacco) and across countries, but should be part of underpinning a more sustainable longer-term strategy.

***Lesson:*** *There is real risk that weak enforcement and poor compliance reduce the appetite for further increases in the future. Moreover, if governments want to get serious about using excise as a sustainable reform, more systemic change strategies are needed, and advocates must think more strategically about how to support government tax administrations with system change, rather than simply a series of*

*one-off policy measures. This may require politically informed influencing alongside technical assistance. Health sector donors, with far less funding than in the past, will need to work more closely with government systems to achieve lasting change.*

**Insight #5: The politics of each product is different**

Despite first appearances, the measures introduced were in fact very different across the products: tobacco and alcohol taxes were raised substantially, whilst sugar was treated extremely cautiously (with the Minister of Finance, supported by State House, personally jumping to immediately rule out changes to domestically produced goods).

This speaks to very different politics across the products, with starkly different levels of public awareness of health risks, consumption, and industry power. These differences are in part caused by distributional effects – versions of sugar tax can impact much larger numbers of people than tax measures on other products such as cigarettes, significantly increasingly the scale of the political challenge.

***Lesson:*** *Recognise that products have very distinct politics – bundling them together into one package may make sense in some political contexts but may not always work, especially with sugar. Furthermore, the pace of reform across the three products will, rightly, differ given different political contexts. Understanding the local politics will be of huge benefit to global health actors seeking to support advocacy.*

**Insight #6: Industry Can Be Caught Off Guard**

Just as the popular politics of the three goods differs, so does industry power. The sugary foods and drinks lobby is weak in Zambia, alcohol somewhat stronger, whilst tobacco remains power and direct links to State House.

Whilst there is some level of coordination, through ZAM, and some consultation took place led by both parliamentary committees and the Ministry of Finance, on the whole industry was caught off guard and taxes were pushed through regardless. More powerful ministries (e.g. Finance) can dominate over weaker ones (i.e. Health on one hand, and Commerce, Agriculture on the other).

On the other hand, with the passing of time in the weeks after implementation of the reforms, industry has managed to commence a lobbying campaign at the heart of government, including meeting directly with the President and State House team, where the alcohol industry has close links. Industry has focused on exploiting existing concerns within government about illicit trade – and is actively working to reverse the excise reforms in the coming 2026 national budget – but it remains to be seen whether they have acted too late.

***Lesson:*** *Recognise that industry power is not uniform across products or countries, but even in countries with traditionally strong lobbies, opportunities may be available, and change can be forced when the conditions are right.*

**Insight #7: The Politics of Each Country is Unique**

Zambia's politics is unique, as in every country. Whilst there will doubtless be similarities, clear contrasts are already emerging. In Kenya, there is a more active popular culture of vocal protest, whilst in Zambia there was no backlash or complaint, even on wider tax measures.

Zambia and Uganda have upcoming (albeit very different) elections in 2026, which are dominating all policymaking and government activity, whilst Tanzania's are next month (October). And different albeit simultaneous scandals in the health sectors of Zambia and Kenya create very specific challenges for building public appetite for increased health spending.

***Lesson**: One size fits all strategies are unlikely to have much success across the region. Detailed political analysis is needed to understand the political economy of health and taxation. Timing advocacy campaigns and interventions within electoral cycles will be key.*

## 6. Looking Ahead

Having explored in detail the health taxes debate in Zambia, and the recent excise tax reforms, the project will conduct similar analysis of the political context and opportunities across Kenya, Uganda and Tanzania. This research will be anchored on a series of short working visits to Nairobi (October), Kampala (December), and Dar Es Salaam (January/February) with the intention of conducting 10-12 structured key informant interviews. We will test our findings and lessons from Zambia across these additional country contexts, to explore the extent to which these themes are consistent or contrast, as well as identify further lessons and opportunities for health advocates.

We will develop a wider report in Spring 2026, synthesising findings from across all four countries, to produce a final set of recommendations for CRUK, including recommendations for advocacy strategies, as well as potential avenues for further policy work in the region.

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