

Dangers of Relying on Donor-Funded Procurement in the Health Sector in the Low-to-Middle-Income Countries of Africa: Lessons from a Low-Income Country in Africa

Crossman Mayavo *

IIE Emeris, Riverview Office Park, 11 Janadel Ave, Waterfall, Midrand, Johannesburg, South Africa, (PO BOX. 1686).

*Corresponding author's e-mail: mayavoc@gmail.com

DOI: [10.35898/ghmj-931346](https://doi.org/10.35898/ghmj-931346)

ABSTRACT

Background: The study focused on the dangers of heavily relying on donor-funded procurement in the health sector in low- to middle-income countries, focusing on the lessons learnt from a low-income country in Africa.

Aims: The study's objective was to critically investigate the risks associated with donor-funded procurement in Zimbabwe's health sector, with a bias towards laboratory services, a major arm of health services and provide insights that can be applied to other LMICS in Africa or elsewhere in the world.

Methods: The study adopted the use of secondary quantitative data from quantification reports for periods ranging from 2021 to 2023, with a special focus on the medical laboratory of Zimbabwe. The researcher did not doubt the data because it has been made public, which means the laboratory department is very sure of its accuracy. The quantification reports encompass laboratory commodities covering HIV/AIDS, TB and Malaria based on the list of laboratory funders.

Results: The study's key findings are that the government's funding is very low compared to the donor-funded procurements, which implies that there is a need for improved health support. Additionally, the results confirmed that the government is heavily relying on support from donors, which may not be sustainable in the long run. Furthermore, the results pointed out that the unfunded gap for all the years to have maximum service delivery from the laboratory's perspective is unsustainable, and measures must be put in place to ameliorate the situation. The results further show that Zimbabwe laboratory service is donor-dependent, with most of its commodities financed externally, creating vulnerabilities in diagnostics and surveillance.

Conclusion: The study recommended that the government should improve funding for this key health system. The study concluded that there is a genuine concern about the dangers of relying on donor-funded procurement in the Department of Laboratory Services and the Ministry of Health at large. Also, the study recommended that the government adopt the Abuja Declaration of 2001, that is, putting aside 15% of the total budget for starters to fund the laboratory services. Additionally, a resilience mechanism should be put in place to address shocks. The study implies that the government and the Ministry of Health and Child Care at large must provide an accountability mechanism, which includes a major shift in the oversight and accountability of the ministry concerned. Additionally, the implications are that these study findings extend beyond Zimbabwe to other LMICs that face similar risks of laboratory procurement fragility and donor support decline. The study further underscores the urgent need for procurement self-reliance and resilience to safeguard laboratory sustainability and strengthen health system performance globally.

Keywords: *Corruption; Donor-funded Procurement; Donor coordination; Laboratory; Health.*

Received: 15 June 2026

Reviewed: 01 July 2026

Revised: 24 July 2026

Accepted: 26 August 2026.

1. Introduction

In low- to middle-income countries (LMICS) throughout Africa, donor-funded procurement has emerged as a crucial element of supporting the health sector in recent years. This strategy seeks to improve healthcare delivery by supplying the infrastructure and resources that are required to provide services (Mothupi et al., 2022; Selviaridis et al., 2023). However, even though donor financing frequently has good intentions, failure to putting procurement procedures in place can have serious problems and unexpected repercussions. A compelling case study highlighting the risks of donor-funded procurement in the health sector in Zimbabwe, especially with a focus on laboratory services.

In relation to vulnerabilities, laboratory services are typically vulnerable to donor-funded procurement because they rely heavily on specialised reagents, diagnostic test kits and equipment that are imported from other countries, and they are also expensive (Arora & Gigras, 2018; Grépin et al., 2017; Lesego et al., 2024a). The donors always fund vertical programmes in Zimbabwe such as HIV, TB and malaria, where laboratory testing becomes central. This challenge creates dependency on external procurement cycles, donor priorities and foreign suppliers (Gilson et al., 2011). When donor funding fluctuates or declines, laboratories in Zimbabwe face immediate risks of stock-outs, delayed testing and compromised diagnostic capacity. Unlike other medical supplies, laboratory commodities cannot easily be substituted or locally sourced due to strict quality and calibration requirements. Furthermore, procurement processes for laboratory services are complex, involving international tenders and stringent regulatory approvals which local health systems normally lack capacity to manage independently (Nyabani et al., 2024; Shahzad et al., 2019). However, this structural reliance makes laboratory services disproportionately exposed to donor withdrawal compared to other medical health services, underscoring the vulnerability in Zimbabwe's health sector.

Regarding the scale of donor dependence, evidence has shown that Zimbabwe's health sector, especially health laboratory systems, is highly donor-dependent, and reports from the Ministry of Health and Child Care show that over 60% of laboratory commodities (reagents and consumables) for HIV and TB are bought through donor-funded programmes, primarily the Global Fund and PEPFAR (Gebremeskel et al., 2023; Mhazo & Maponga, 2024). HIV viral load testing is an example of tests being funded entirely by external donors with limited government or local funding and budget allocation. The reports have indicated that the donor support covers training of laboratory personnel, diagnostic equipment maintenance, including supply chain systems. The donor support accounted for more than half of the national health budget in 2019, and laboratory services were among the ones most directly supported by donor subsectors. Apparently, this dependence has created a systematic fragility, and any reduction in donor support directly threatens laboratory diagnostic capacity, treatment delays and affects disease surveillance (Saruchera & Mayavo, 2024). The reliance on donor-funded procurement highlights the need for urgent need for the government to come up with sustainable procurement strategies to safeguard laboratory resilience in the Zimbabwean context and in developing countries at large.

Zimbabwe is one country that provides key lessons for other African low- and middle-income countries (LMICS) since its health system exemplifies both the opportunities and risks of donor dependence. Zimbabwe has relied on much on external funding to sustain laboratory services; unfortunately, it has yet to develop innovative coping mechanisms such as pooled procurement, collaboration with regional peers and task-shifting in laboratory management since the country has had prolonged economic instability (Brown et al., 2023; Buse & Martin, 2012). Such strategies demonstrate how resource-constrained healthcare systems can adapt to donor funding volatility while maintaining service delivery to the general populace. Additionally, Zimbabwe's experience shows the consequences of donor exit, which include a diagnostic gap and inequitable access to health care which are challenges which are shared across most LMICS. However, in donor-funded procurement systems, corruption, inefficiency, and poor management of resources are common problems (Chimia, 2013a; Hamel et al., 2015). These issues damage public confidence in healthcare organisations in addition to undermining the efficacy of health initiatives. Additionally, concerns over the viability of donor-funded projects have been raised by reports of exorbitant prices, subpar products, and a lack of accountability in Zimbabwe (Mayavo, 2024b; Williams et al., 2020). Moreso, depending on external funding mainly from Western Countries can lead to a vicious circle of dependency that inhibits local innovation, self-sustenance and capacity building.

This study provides a clear knowledge gap that exists in procurement sustainability, supply chain resilience and donor exit risks in the context of Zimbabwe laboratory systems. Many existing studies show donor-funded procurement contributions and procurement inefficiencies (Dávid-Barrett et al., 2020; Ejughemre, 2013; Lesego et al., 2024); few studies have examined the long-term sustainability once donor funding declines (Bossert, 1990; Jaouni et al., 2026; Shroff et al., 2024). There is limited evidence on how laboratories can transition to domestic financing, diversify suppliers or build local manufacturing capacity (Greer & Méndez, 2015; Resch & Hecht, 2018; Shamu et al., 2017). Again, research studies have not adequately addressed how supply chains can absorb shocks from donor-funding withdrawal and how resilience can be provided and measured in a fragile health system like in LMICs (Dureab et al., 2021; Ejughemre, 2013). Such lack of systematic analysis of the gap leave policymakers without proper guidance on mitigating donor-funding exit risks. The study gap is critical since fully-funded laboratory services are central in mitigating HIV, TB and malaria control, and their sustainability remain certain. This study has the possibility of contributing to global health scholarship as it provides frameworks for resilience and sustainability that can support Zimbabwe and other countries in LMICs that are facing similar problems.

This research aims to critically investigate the risks associated with donor-funded procurement in Zimbabwe's health sector, with a bias towards laboratory services, a major arm of health services and provide insights that can be applied to other LMICS in Africa. This study intends to draw attention to the need for stronger procurement systems that place a higher priority on accountability, transparency, and local engagement by looking at Zimbabwe's structural weaknesses and shortcomings. In the end, the results offer insightful information to donors, legislators, policymakers and medical professionals looking to streamline procurement procedures and guarantee that donor funds result in noticeable improvements in the health of disadvantaged groups and good standing for the country.

2. The Context of Donor Funding in Zimbabwe

Donor-funded procurement has become a prominent strategy for addressing healthcare challenges in low- to middle-income countries (LMICS), particularly in Africa (Chimia, 2013a; Hamel et al., 2015; Malacina et al., 2022). While this approach aims to enhance health service delivery, it often carries inherent risks that can undermine its effectiveness. Zimbabwe serves as a critical case study, illustrating the multifaceted dangers associated with donor-funded procurement processes. This literature review examines the challenges linked to donor-funded procurement in Zimbabwe's health sector, highlighting the implications for broader applications in LMICS across Africa.

Historical Background

Zimbabwe's health sector has been heavily reliant on donor funding since the economic and political crises of the early 2000s, which led to significant declines in public health financing (Mayavo & Saruchera, 2024; Dzukey & Naude, 2017, 2015). Donors, including international organisations and bilateral aid agencies, stepped in to fill the gap left by a shrinking government budget. Additionally, this influx of funds aimed to address pressing health issues such as HIV/AIDS, tuberculosis, and maternal health, with procurement processes designed to ensure that essential medicines and services reached vulnerable populations. Furthermore, major players in Zimbabwe's health landscape that include WHO, CHAI, PEPFAR, Global Fund, UNICEF, USAID and CDC, among others (Jachi et al., 2019; Mayavo, 2024a). For the laboratory services, the CDC has been the funder of support to the laboratory services since the inception of the main laboratory, called the National Microbiology Reference Laboratory, in 2002. Moreover, the CDC presided over the establishment of this major laboratory, the procurement of equipment and ancillary accessories, and the procurement of reagents and media for bacteriology before the establishment of the laboratory services directorate, which came into effect in 2007, and has since grown, with the establishment of the logistics department. The logistics department is responsible for the provision of services such as equipment services, distribution of all procured equipment and reagents through donors and other parties, and quantification of all laboratory commodities across the country (Ministry of Health and Child Care, 2017).

The Role of Donor-Funded Procurement

Donor-funded procurement typically involves the acquisition of health goods and services through partnerships between donor agencies and local governments or non-governmental organisations (NGOs), as is the case with Zimbabwe (Harris & Sutherland, 2018). However, while this model has the potential and capacity to expedite the delivery of vital healthcare resources, it often lacks the necessary oversight and accountability mechanisms (Buse & Martin, 2012; Shen et al., 2015). Consequently, the overreliance on external funding can create vulnerabilities within the procurement process, which may not be sustainable in the long run (Mayavo & Saruchera, 2024). Currently, with the suspension of aid from the United States of America by President Donald Trump, such realities are to be witnessed soon. The donor-funders provide resources that are not readily available in countries such as Zimbabwe, and their role cannot be overemphasised; however, there is a need for both the government and the funders to be accountable and transparent in the use of the resources for the betterment of the populace that needs the services.

3. Donor-Funded Procurement Challenges

Mismanagement and Corruption

Corruption is one of the biggest risks connected to donor-funded procurement in Zimbabwe. Funds meant for health care have been misused or squandered in several reported cases of financial wrongdoing (Brown et al., 2023; Nyabani et al., 2024). For instance, kickbacks to authorities and exorbitant prices have plagued the purchase of antiretroviral medications, diverting funds from the intended recipients (Mushonga & Henneberger, 2020). In addition to draining financial resources, this kind of corruption erodes public confidence in healthcare organisations. Additionally, this leads to mismanagement of resources and no service delivery is effected without payment of kickbacks. Government funding has been elusive for the past years, and even now, which further diminishes confidence in the government's performance in the health sector (Vian, 2020). This corruption and mismanagement have seen people dying in hospitals, and employees not being adequately paid their dues, hence providing a gap that the donors have been covering for so many years. Additionally, for example, in Zimbabwe, the maternal mortality rate is staggering at 960 deaths per 100,000 live births. Moreover, in January of 2025 alone, the reports say 300 infants and 54 women died while giving birth, which are believed to be caused by a lack of qualified personnel during childbirth, mismanagement and corruption (NewsHawks, 2025).

Procurement Process Inefficiencies

The major issue with donor-funded procurement is inefficiency in the local set-up, where a country is landlocked. These delays and higher expenses are frequently caused by the intricacy of procurement laws and the bureaucratic character of donor organisations, where there are discussions between the host country and the donor funder for a prolonged time (World Health Organisation, 2019). Furthermore, in Zimbabwe, the lengthy approval processes for procurement requests have resulted in stock-outs of essential medicines, negatively impacting patient outcomes (Ejughemre, 2013; Grépin et al., 2017; Mlambo et al., 2016). Additionally, a lack of coordination between various donor agencies may result in resource waste and redundant efforts. Donor agencies are fragmented, and they do not have a lead donor to coordinate activities even if they fall within the same categories; for example, they could all be funding Hiv/Aids and TB programmes, but it's very rare to have such donors coming together to pool their funding towards the same goal (Makudza et al., 2023; Mayavo & Saruchera, 2024). This has affected the general populace since they cannot find the much-needed service delivery.

Questionable Quality of Goods and Services

Purchasing goods and services using donor assistance frequently results in variable quality, and concerns regarding patient safety and treatment effectiveness have been raised by reports of subpar medications and medical supplies (Dureab et al., 2021; Gebremeskel et al., 2021; Mostert et al., 2015). It has been noted that most donor-funded procurements and donations, in some instances, do not meet the requirements of the country they donate to, according to the World Health Organisation (2011). Public health in Zimbabwe has been seriously threatened by the importation of subpar goods from dishonest vendors, especially when it comes to the control of infectious diseases

(Mushonga & Henneberger, 2020; Walt & Gilson, 1994). Reforms are needed to improve the quality of procurement of goods and services using donor-funded programmes to avoid scenarios where reagents and chemicals used for laboratory testing end up in Zimbabwe with long-term expiries, as in certain instances, the logistics department receives them within less than six months expiry or shelf life (Ministry of Health and Child Care, 2024). This problem emphasises how crucial it is to implement strict quality assurance procedures in procurement procedures, and also that the receiving country demands a shelf life of at least 12 months and above, except for some reagents that are only made with a very short shelf life.

External Funding Dependency

A cycle of dependency that inhibits local innovation and capacity building may result from reliance on donor support. There is a dearth of investment in local health infrastructure and human resources in Zimbabwe as a result of stakeholders in the health sector being more and more dependent on outside funding to maintain operations (Mlambo et al., 2016). The creation of sustainable health systems that can operate without donor assistance may be hampered by this reliance. It has become a norm for countries in the low to middle income to depend on donor-funded procurement. The focus has been on the challenge that the health sector has been facing, which is that local governments are no longer funding the health sector, as they depend on donors and when they fund, their funding is a drop in the ocean (Ministry of Health and Child Care, 2024).

This has created a dependent syndrome which has affected service delivery, with reports of women dying while giving birth due to various challenges such as a lack of qualified employees, poor funding, and a lack of critical health materials required for the maximum functioning of the hospitals. The health sector in most low- to middle-income countries has deteriorated without signs of recovery. Furthermore, because the African governments abandoned the Abuja Declaration, where the heads of state by then agreed that health ministries should get 15% of the national budget, this is critical now more than any other time to improve health services as we move towards 2030, meeting Sustainable Development Goal number 3 (Kumurya, 2015; Olalere, Gatome-Munyua, 2020; Zimbizi, 2019). Increasing health funding by governments remove the burden of relying on external funders, as in the case of clinics and laboratories, where most of the funds are coming from external funders (Arora & Gigras, 2018; Gilson et al., 2011; Lal et al., 2021).

4. Methods

Study design

The study made use of quantitative secondary data from quantification reports produced using the ForLab quantification tool used by the laboratory services in Zimbabwe (Apuke, 2017; Franklin, 2022; Wright et al., 2004). The reports provide funding models and the various amounts committed to the coffers against the donor-funded procurements for the consecutive years 2021 and 2023 (Ministry of Health and Child Care, 2024). The study adopted a case study design based on the fact that the focus is on the laboratory services (Vasileiou et al., 2018).

Data collection

The quantification was mainly for HIV, AIDS and TB, which are mainly funded by donors. The laboratory services are a representative of the whole system, as it relies heavily on donor-funded procurement. This brought out the true and common dangers the government of Zimbabwe and other low- to middle-income countries may face by depending on donor-funded procurement in case funding ceases, as happened with USAID. On the reliability and validity of the data, the author evaluated the source of data and verified the data's credibility through the reputable Ministry of Health laboratory service and also verified the relevance of the data to this study, and found it suitable. Additionally, experts both from the laboratory services system and the Forlab quantification tool were part of the exercise. Ethical considerations were made throughout the scanning and selection of the most valuable data for this study.

Data Analysis

The author used a document review analysis where the researcher scanned through the quantification reports and selected only the relevant data that answered the research objective, and the same method was used to evaluate the dangers of donor-funded procurement and sustainability within the laboratory services set-up. This was used to address the objective and literature review, confirming or negating the claim that donors do not cause any dangers in the procurement of goods and services in the health sector (Barbier & Burgess, 2020; Panwar et al., 2022; Rout, 2010). Furthermore, the study was able to provide donor-funders who contributed and continue to contribute to support the running of the health systems in Zimbabwe. Additionally, laboratory services manage over 200 commodities, which can translate to over a thousand shipments per year.

5. Results

This section provides the results of the study based on the quantification and forecasting reports done by the laboratory team for the period 2021 and 2023. These reports are specifically focused on medical laboratory commodities only and are mainly funded by various donor agencies. The 2021 quantification report was a grant transition with less residual funds from the 2020 budget, and years 2022 and 2023 continued with some gaps in funding unmet. All the years were identical in that they had gaps in funding that were unmet and gaps created from the previous year due to a lack of funding. The researcher has provided data which directly speaks to the dangers of donor-funded procurement, with the government not coming to the party with a drop in the ocean of funds against what the donors are providing for the services in the laboratory services. Below is a table that shows the number of tests conducted in 2021.

Table 1: Expected national Tests for the year 2021

Test	Number of expected tests
Viral Load (all platforms combined)	1 156 684
EID (all platforms combined)	85 726
Syphilis	1 370 468
Rapid Hiv tests	2 498 461
CD4, Cryptococcal Antigen Test, TB LAM Testing Targets	296 856

The results of this study show that the donors are the major funders of the medical laboratory commodities and equipment, while the government provided a little of the funding needed. Additionally, the results show that there was a funding gap each year, which caused some commodities to run dry. Below is the outlook from 2021 to 2023.

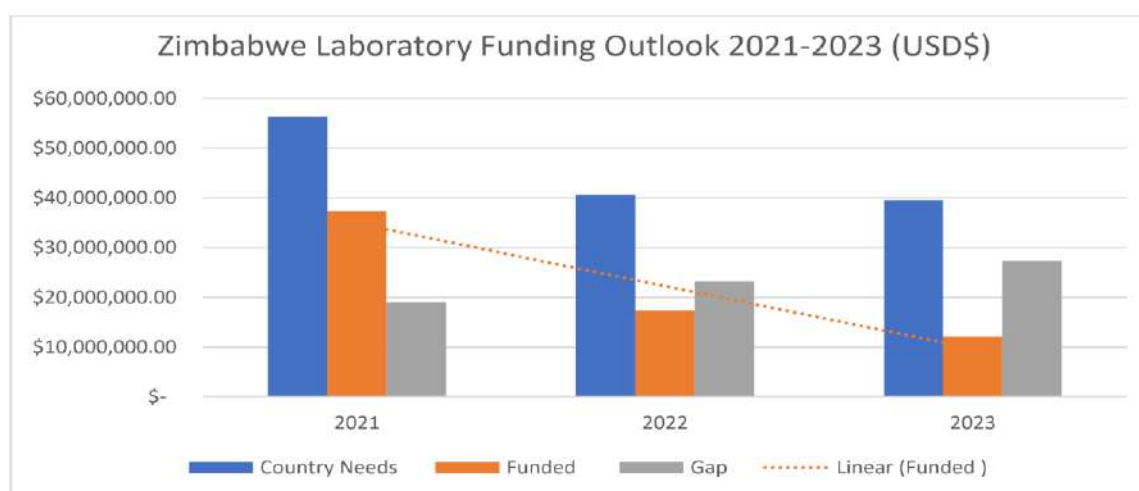


Figure 1. Laboratory funding outlook 2021-2023 in USD

Source: Ministry of Health and Child Care, 2024

The Figure 1 shows the funding outlook for the Zimbabwe medical laboratory for the period 2021 to 2023. The country's needs were always higher than the available funding, and at the same time, showed the available gap. Each year had its own projected gap from 2021 to 2023; the gap was higher than the funding, which was a different scenario in 2021, when the country's needs and funding were so close that even the funding gap was minimal. It is also important to note that country needs are always higher than the contributions made by both the government and the donors. From the above data, the study can deduce that in 2022 and 2023, the gap was higher than the contributions made.

The following results show the major funders of medical laboratory services in Zimbabwe in 2021. The results (Figure 2) show that the major funder of the Zimbabwe medical laboratory services is Global Fund (47%), followed by PEPFAR (15%), the Government of Zimbabwe (GOZ) (1%) and lastly UNITAID/CHAI/EGPAF (0%). The available gap was very high, more than what GOZ and UNITAID/CHAI/EGPAF funded. The funding gap was almost the same as that of the major funder, the Global Fund. The following results stand for the years 2022 and 2023 combined as per the quantification report.



Figure 2. Funders in 2021

Source: Ministry of Health and Child Care, 2024

The results below show the total amount that was needed to meet the testing demand for the said years. A total amount of \$ 86,407,798.06 was needed to meet all the testing demand from January 2022 to December 2023. I shall later disaggregate the number of tests projected for the same period. Figure 3 below shows the laboratory services funding outlook for 2022-2023. From January 2022 to December 2023, the projected national cost of laboratory testing was USD 86,407,798.06. However, of this amount, GFTAM (\$29 295 967.05), GoZ (\$504 833.16), PEPFAR (\$16 884 104.87), UNITAID (\$187 898.75) and the total funded was \$46 872 803.83 and the unfunded gap was \$39 534 994.23 which represented 45.6% of the total funds required. The results have shown that the government was not prepared to up its game in terms of funding the health sector, as represented by the laboratory services, where it only funded \$ 504,833.16 of the total required figure to run the laboratory. Table 2 below shows the funders and the total amount funded. The results here show the procurement risks and lack of sustainability based on the funding coming from the government against that of the donors, as shown in Figure 3.

Table 2. National Needs and Partners' Contribution (January 2022 to December 2023)

	Total 2022 to 2023	% Contribution By Partner To The Funded Total
Laboratory National Needs	\$86 407 798.06	
GFATM	\$29 295 967.05	62.5%
Govt	\$504 833. 16	1.1%
PEPFAR	\$16 884 104.87	36.0%
UNITAID	\$187 898.75	0.4%
Total funded	\$46 872 803.83	
Total Unfunded	\$39 534 994.23	45.6%

Source: Ministry of Health and Child Care (2024)

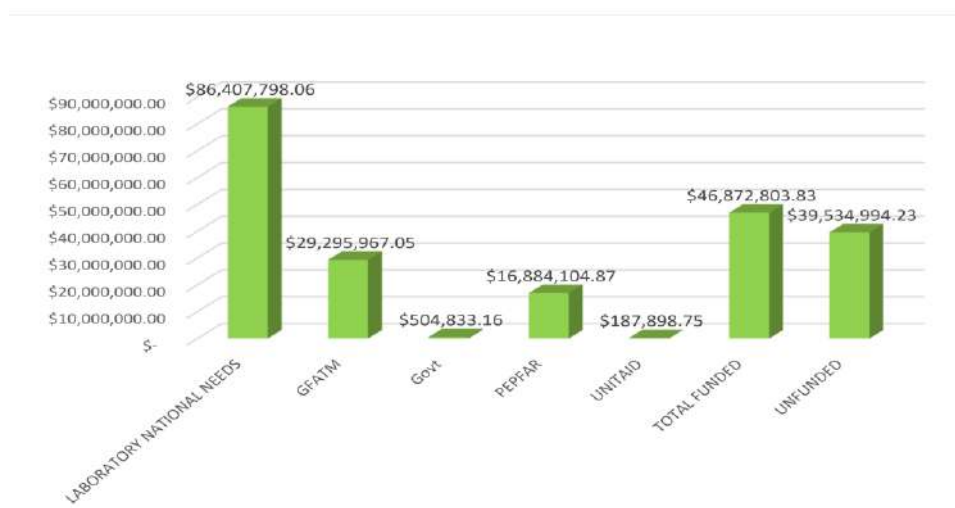


Figure 3. Laboratory funding outlook January 2022 to December 2023

Source: Ministry of Health and Child Care (2024)

As shown in the table above, the laboratory national needs were \$86 407 798.06 to fulfil the national needs, but the government offers 1.1% or \$504 833.16 in absolute figures. This figure shows that there is already a problem in the funding systems of the laboratory services. The normal thing here would be for the government to be the one providing more and the donors only complementing what the government would be funding. Additionally, this is against the percentage of donor funders who contributed more than 1.1% contributed by the government of Zimbabwe. For example, GFATM contributed \$29 295 967.05, which accounted for 62.5% of the total gap needed.

6. Discussion

This section discusses the results of the study above, focusing on the quantification reports from 2021 and 2023 (Ministry of Health and Child Care, 2024). The government of Zimbabwe, in all the years have not been putting much money into the procurement of goods and services, while the donors were the ones providing much funding in support of the procurement of goods and services (Jachi et al., 2016; Mayavo, 2024). It is evident that the government rely mainly on donor-funded procurement for the provision of goods and services, including salaries, in the health sector, and this has been the norm since the decline of the economic and political environment (Mayavo & Saruchera, 2024; Dzukey & Naude, 2017, 2015). Additionally, the results have shown that the government of Zimbabwe cannot fund the health sector. As per the quantification report above, the government only funded the laboratory to the tune of US\$ 504,833.16 for three years. The donors have become the major health players (Global Fund, PEPFAR, UNITAID, WHO, UNICEF and others). This poses a great risk as the results show that the government's funding is limited; hence, the laboratory services remain at risk.

Furthermore, the above results suggest that the unfunded gap is too huge, and the government would have provided the much-needed funding to improve the provision of essential services in the laboratory division and the health sector at large. This eventually creates vulnerabilities and a lack of accountability in the procurement process, as organisations such as these donors are always in charge since the government cannot adequately support the health sector. However, while this model (donor-funded procurement) has the potential and capacity to expedite the delivery of vital healthcare resources, it often lacks the necessary oversight and accountability mechanisms (Buse & Martin, 2012; Shen et al., 2015). Consequently, the overreliance on external funding can create vulnerabilities within the procurement process, which may not be sustainable in the long run.

The results from the above data indicate a lack of donor coordination. This system has never been good for any health system, as it may lead to the creation of a dangerous sustainability path for the country. Additionally, a lack of coordination between various donor agencies may result in resource waste and redundant efforts, as they duplicate roles. Donor agencies are fragmented, and they do not have a lead donor to coordinate activities even if

they fall within the same categories; for example, they could all be funding Hiv/Aids and TB programmes, but it's very rare to have such donors coming together to pool their funding towards the same goal (Makudza et al., 2023; Mayavo & Saruchera, 2024). This adds to the notion that a lack of coordination between these various donors creates a lack of oversight and accountability since the government do not have enough capacity to oversee the activities of the donors, as they also rely on them.

The results of this study further pointed out that laboratory services and the health sector at large cannot function at their best without the donor-funded procurement of goods and services, as witnessed by the amount of money they invest in the provision of health services in Zimbabwe. This brings back the discussion on the Abuja Declaration of 2001, which was abandoned by the SADC governments (Kumurya, 2015; Olalere, Gatome-Munyua, 2020; Zimbizi, 2019). If the government committed itself to following this noble idea of putting aside 15% of the national budget for the health sector, otherwise, the government would be singing a different tune. This ties together with investment in the local health infrastructure, which has gone down (Mlambo et al., 2016). Government funding has been elusive, which complicates things in the health sector in Zimbabwe, which has been relying on donor-funded procurement of goods and services, according to Vian (2020).

Additionally, donor dependency in Zimbabwe's laboratory systems persists even though there are known risks because of chronic fiscal constraints, lack of domestic commodities manufacturing capacity and the high cost of the required reagents and diagnostic equipment. The study has shown that donors are critically filling the national budget gap, which cannot sustain the costs, hence creating reliance on donor support. Such dependence creates a direct effect on health systems' reliance and lack of local ownership because the procurement decisions are made externally and authorities' autonomy is reduced when it comes to planning, budgeting and priorities of the health systems. Experiences from other African countries are shown in the Table 3 below, where a similar pattern of donor dependence on laboratory programmes dominates. The dangers of donor reliance are market distortion, weakened local procurement capacity and reduced capacity to incentivise domestic investment in laboratory infrastructure.

Table 3. Country comparison on donor-funded procurement reliance

Country	Donor Dependence	Impact on Resilience & Ownership	Unintended Consequences	Transition Strategies
Zimbabwe	Heavy reliance on Global Fund & PEPFAR for HIV/TB laboratory services; >60% of consumables donor-funded.	Weak national ownership; procurement cycles externally driven; fragile resilience when donors exit.	Market distortion, reduced domestic investment, weakened local procurement capacity.	Exploring pooled procurement, regional collaborations, and gradual integration of donor-funded labs into national financing.
Malawi	Significant donor support for HIV/AIDS and malaria diagnostics; donors cover the majority of lab costs.	Resilience undermined by external decision-making; limited government autonomy in supply chain planning.	Dependence discourages local manufacturing; donor-driven priorities overshadow national needs.	Adoption of pooled procurement through regional initiatives; efforts to strengthen Ministry of Health budgeting.
Uganda	Donors finance most HIV viral load testing and TB diagnostics; domestic funding remains minimal.	National ownership constrained; resilience vulnerable to donor withdrawal.	Donor dominance reduces incentives for domestic investment; weakens local supply chain systems.	Supplier diversification, regional supply hubs, and government-led financing pilots to reduce reliance.

Source: Author (2026)

7. Conclusion

The analysis of Zimbabwe's laboratory systems shows many critical risks that occur in a donor-dependent country, and among them are procurement fragility, donor withdrawal and supply chain disruptions, which directly affect laboratory services continuity and undermine disease surveillance. These risks are compounded by limited domestic financing and weak procurement systems, leaving laboratories unable to absorb shocks when external funding ends or declines. Zimbabwe's experiences offer a big understanding of the transferable critical lessons for other LMICs navigating the same donor-dependent contexts. Zimbabwe adopted and piloted strategies such as pooled procurement, regional collaborations and gradual integration of donor-funded programmes into its national financing, while donor reliance has exposed the systematic fragility of the country. Such approaches demonstrate

that resource-constrained systems can anticipate that the donor can leave and try to build resilience into their procurement planning systems. Other countries in the LMICs can learn from Zimbabwe's dual experience of vulnerability and adaptation, making use of its roadmap to balance immediate donor support and long-term sustainability plans.

Donor dependence has many unintended negative results, which include market distortion, reduced domestic investment and weakened local procurement capacity. These different risks entrench fragility rather than building resilience in the laboratory systems. The study recommends a deliberate approach that strengthens national ownership, diversifies suppliers and builds local capacity for procurement and financing to absorb the loss of the donors. A procurement system that is self-reliant and resilient is key for sustainable laboratory systems in Zimbabwe and other African countries. The study concluded that donors' contribution should remain catalytic, that is, bridging immediate gaps but must not substitute government's mandate of national investment. The study recommends building resilience through supplier diversification, domestic financing and capacity building, which aligns with continuity of diagnostics, safeguards the country's autonomy and strengthens equitable access to key health care services. Zimbabwe's case speaks to the urgency of the transition and provides relevant lessons that go beyond its borders to inform global health policy and practice in LMICs.

Additionally, reducing reliance on outside funding requires investments in local capacity building, and trying to follow the strategy of the Abuja Declaration of 2001 to maximise capacity building and strengthen health systems overall. Self-sufficiency in the health sector can be encouraged by educating local procurement officials and health managers on efficient procurement procedures (Bilan, 2023; Chimia, 2013b; Mayavo, 2024a). Moreover, the study concluded that the government could promote stakeholder engagement and make the procurement process more accountable and guarantee that health interventions are in line with local requirements by involving stakeholders, such as community people and civil society organisations.

Recommendations

Additionally, the study recommends that a balanced approach is essential, which leverages donor support for better immediate needs while simultaneously developing local transition strategies such as domestic financing mechanisms, supplier diversification, corruption elimination and capacity building for local procurement systems to support delivery services. The study further recommends a transitioned approach from donor-funded procurement to a domestically funded procurement system, which is essential to ensure the sustainability of Zimbabwe's medical laboratory health systems. This planned transition must begin with a co-funding agreement where the government budgets gradually take responsibility for a specific laboratory commodity, which can be followed by full local/domestic financing over time. The first thing should be the strengthening of local procurement systems and supply chain management capacity. Training of procurement officers, investing in digital technology to monitor inventory systems and establishing a transparent tendering system that reduces inefficiencies and eliminates corruption.

Furthermore, the study recommends increasing domestic financing of laboratory services, which requires prioritisation within the national budget, exploring innovative financing systems and earmarking funds for diagnostic services. Levies and insurance schemes can be targeted as some of the innovative financing from the laboratory services. Other complementary policies should push local and regional manufacturing of such essential laboratory reagents and consumables, which can reduce dependence on imports and stabilise supply chain systems. The government can provide incentives such as tax breaks, subsidies, and allow public-private partnerships to stimulate local investment in local production. The study further recommends risk mitigation measures, which are critical to buffer against donor-funded procurement withdrawals or funding reduction. The strategies can include pooled procurement across countries, supplier diversification and maintaining buffer stocks of key laboratory reagents and consumables. Additionally, monitoring and evaluation indicators should be provided which will allow the laboratory to track procurement sustainability and system resilience, and that can include metrics such as stock-out rates, supplier diversity, turnaround time for testing and proportion of domestic financing. The recommended measures above provide a framework for Zimbabwe and other LMICs to move forward towards procurement resilience, self-reliance, laboratory sustainability, and to strengthen overall health systems sustainability and resilience.

Study implications

Accordingly, the study implications are that the risks associated with donor-funded procurement in Zimbabwe's health sector draw attention to important issues that apply to other LMICS in Africa. Furthermore, the sustainability and efficacy of health treatments are seriously threatened by corruption, inefficiency, and reliance on outside finance, which the government of Zimbabwe should correct and ensure that corruption is dealt with once and for all. To overcome these obstacles, coordinated initiatives are needed to improve local capacity, encourage stakeholder involvement, and fortify accountability as the main basis to improve health service delivery. Moreover, policymakers and medical professionals may strive towards more robust and adaptable health systems in the face of persistent difficulties in the region by taking inspiration from Zimbabwe's experiences.

Acknowledgement

I acknowledge my family for their support

Conflict Statement

There are no conflicts of interest

References

- Apuke, O. D. (2017). Quantitative Research Methods: A Synopsis Approach. *Kuwait Chapter of Arabian Journal of Business and Management Review*, 6(11), 40–47. <https://doi.org/10.12816/0040336>
- Arora, M., & Gigras, Y. (2018). Importance of Supply Chain Management in Healthcare of Third World Countries. *International Journal of Supply and Operations Management*, 5(1). <https://doi.org/10.22034/2018.1.7>
- Barbier, E. B., & Burgess, J. C. (2020). Sustainability and development after COVID-19. *World Development*, 135, 105082. <https://doi.org/10.1016/j.worlddev.2020.105082>
- Bilan, A. (2023). Challenges for Upscaling Green Public Procurement in Romania. *Perspective Politice*, 16(Special Issue). <https://doi.org/10.25019/perspol/23.16.0.1>
- Bossert, T. J. (1990). Can they get along without us? Sustainability of donor-supported health projects in Central America and Africa. *Social Science & Medicine*, 30(9), 1015–1023. [https://doi.org/10.1016/0277-9536\(90\)90148-L](https://doi.org/10.1016/0277-9536(90)90148-L)
- Brown, G. W., Rhodes, N., Tacheva, B., Loewenson, R., Shahid, M., & Poitier, F. (2023). Challenges in international health financing and implications for the new pandemic fund. *Globalization and Health*, 19(1), 97. <https://doi.org/10.1186/s12992-023-00999-6>
- Buse, K., & Martin, G. (2012). AIDS: Ushering in a new era of shared responsibility for global health. *Globalization and Health*, 8(1), 26. <https://doi.org/10.1186/1744-8603-8-26>
- Chimia, A. L. (2013a). Donors' influence on developing countries' procurement systems, rules and markets: A critical analysis. In G. Quinot & S. Arrowsmith (Eds), *Public Procurement Regulation in Africa* (1st edn, pp. 219–260). Cambridge University Press. <https://doi.org/10.1017/CBO9781139236058.014>
- Chimia, A. L. (2013b). Donors' influence on developing countries' procurement systems, rules and markets: A critical analysis. In G. Quinot & S. Arrowsmith (Eds), *Public Procurement Regulation in Africa* (1st edn, pp. 219–260). Cambridge University Press. <https://doi.org/10.1017/CBO9781139236058.014>
- Dávid-Barrett, E., Fazekas, M., Hellmann, O., Márk, L., & McCorley, C. (2020). Controlling Corruption in Development Aid: New Evidence from Contract-Level Data. *Studies in Comparative International Development*, 55(4), 481–515. <https://doi.org/10.1007/s12116-020-09315-4>
- Dureab, F., Hussain, T., Sheikh, R., Al-Dheeb, N., Al-Awlaqi, S., & Jahn, A. (2021). Forms of Health System Fragmentation During Conflict: The Case of Yemen. *Frontiers in Public Health*, 9, 659980. <https://doi.org/10.3389/fpubh.2021.659980>
- Dzuke, A., & Naude, M. J. A. (2015). Procurement challenges in the Zimbabwean public sector: A preliminary study. *Journal of Transport and Supply Chain Management*, 9(1), 9 pages. <https://doi.org/10.4102/jtscm.v9i1.166>
- Dzuke, A., & Naude, M. J. A. (2017). Problems affecting the operational procurement process: A study of the Zimbabwean public sector. *Journal of Transport and Supply Chain Management*, 11. <https://doi.org/10.4102/jtscm.v11i0.255>
- Ejughemre, U. (2013). Donor Support and the Impacts on Health System Strengthening in Sub-Saharan Africa: Assessing the Evidence through a Review of the Literature. *American Journal of Public Health Research*, 1(7), 146–151. <https://doi.org/10.12691/ajphr-1-7-1>
- Franklin, R. (2022). Quantitative methods I: Reckoning with uncertainty. *Progress in Human Geography*, 46(2), 689–697. <https://doi.org/10.1177/03091325211063635>

- Gebremeskel, A. T., Otu, A., Abimbola, S., & Yaya, S. (2021). Building resilient health systems in Africa beyond the COVID-19 pandemic response. *BMJ Global Health*, 6(6), e006108. <https://doi.org/10.1136/bmigh-2021-006108>
- Gebremeskel, A. T., Udenigwe, O., Etowa, J., & Yaya, S. (2023). Unpacking the challenges of fragmentation in community-based maternal newborn and child health and health system in rural Ethiopia: A qualitative study. *PLOS ONE*, 18(9), e0291696. <https://doi.org/10.1371/journal.pone.0291696>
- Gilson, L., Hanson, K., Sheikh, K., Agyepong, I. A., Ssengooba, F., & Bennett, S. (2011). Building the Field of Health Policy and Systems Research: Social Science Matters. *PLoS Medicine*, 8(8), e1001079. <https://doi.org/10.1371/journal.pmed.1001079>
- Greer, S. L., & Méndez, C. A. (2015). Universal Health Coverage: A Political Struggle and Governance Challenge. *American Journal of Public Health*, 105(S5), S637–S639. <https://doi.org/10.2105/AJPH.2015.302733>
- Grépin, K. A., Pinkstaff, C. B., Shroff, Z. C., & Ghaffar, A. (2017). Donor funding health policy and systems research in low- and middle-income countries: How much, from where and to whom. *Health Research Policy and Systems*, 15(1), 68. <https://doi.org/10.1186/s12961-017-0224-6>
- Hamel, D. J., Sankalé, J.-L., Samuels, J. O., Sarr, A. D., Chaplin, B., Ofuche, E., Meloni, S. T., Okonkwo, P., & Kanki, P. J. (2015). Building laboratory capacity to support HIV care in Nigeria: Harvard/APIN PEPFAR, 2004–2012. *African Journal of Laboratory Medicine*, 4(1), 10 pages. <https://doi.org/10.4102/ajlm.v4i1.190>
- Jachi, Makumbe, & Mandongwe. (2019). Public Procurement and Public Service Delivery in Zimbabwe Local Authorities. A Non-systematic Review. *Public Policy and Administration Research*. <https://doi.org/10.7176/PPAR/9-12-05>
- Jaouni, S., Lachman, P., & Hassan, S. (2026). When donor funding ends: Reflections from Jordan's Health Care Accreditation Council on sustainable health system strengthening. *International Journal for Quality in Health Care*, 38(1), mzag033. <https://doi.org/10.1093/intqhc/mzag033>
- Kumurya, A. S. (2015). Supply Chain Management of Health Commodities and Logistics: Fundamental Components of Booming Medical Laboratory Services. *European Journal of Logistics, Purchasing and Supply Chain Management*, 3(4), 62–72. <https://ejournals.org/ejlpjcm/vol-3-issue-4-november-2015/supply-chain-management-of-health-commodities-and-logistics-fundamental-components-of-booming-medical-laboratory-services/>
- Lal, A., Erondou, N. A., Heymann, D. L., Gitahi, G., & Yates, R. (2021). Fragmented health systems in COVID-19: Rectifying the misalignment between global health security and universal health coverage. *The Lancet*, 397(10268), 61–67. [https://doi.org/10.1016/S0140-6736\(20\)32228-5](https://doi.org/10.1016/S0140-6736(20)32228-5)
- Lesego, A., Were, L. P. O., Tsegaye, T., Idris, R., Morrison, L., Peterson, T., Elhussein, S., Antonio, E., Magwindiri, G., Dumba, I., Mtambirwa, C., Madzikwa, N., Simbi, R., Ndlovu, M., & Achoki, T. (2024a). Health system lessons from the global fund-supported procurement and supply chain investments in Zimbabwe: A mixed methods study. *BMC Health Services Research*, 24(1), 557. <https://doi.org/10.1186/s12913-024-11028-6>
- Lesego, A., Were, L. P. O., Tsegaye, T., Idris, R., Morrison, L., Peterson, T., Elhussein, S., Antonio, E., Magwindiri, G., Dumba, I., Mtambirwa, C., Madzikwa, N., Simbi, R., Ndlovu, M., & Achoki, T. (2024b). Health system lessons from the global fund-supported procurement and supply chain investments in Zimbabwe: A mixed methods study. *BMC Health Services Research*, 24(1), 557. <https://doi.org/10.1186/s12913-024-11028-6>
- Makudza, F., Jaravaza, D. C., Govha, T., Mukucha, P., & Saruchera, F. (2023). Enhancing supply chain agility through e-procurement in a volatile frontier market. *Journal of Transport and Supply Chain Management*, 17. <https://doi.org/10.4102/jtscm.v17i0.847>
- Malacina, I., Karttunen, E., Jääskeläinen, A., Lintukangas, K., Heikkilä, J., & Kähkönen, A.-K. (2022). Capturing the value creation in public procurement: A practice-based view. *Journal of Purchasing and Supply Management*, 28(2), 100745. <https://doi.org/10.1016/j.pursup.2021.100745>
- Mayavo, C. (2024a). Donor-funded procurement effectiveness in the public health medical laboratory services: Examining the moderation role for government policy in donor-support. *GHMJ (Global Health Management Journal)*, 7(2), 55–65. <https://doi.org/10.35898/ghmj-72984>
- Mayavo, C. (2024b). Factors affecting adoption of green procurement in the health sector: A qualitative review of Zimbabwe's health sector. *International Journal of Business Ecosystem & Strategy* (2687-2293), 6(6), 31–45. <https://doi.org/10.36096/ijbes.v6i6.619>
- Mayavo, C., & Saruchera, F. (2024). Donor-funded procurement determinants and effectiveness of procurement in the public health medical laboratory services: Examining the mediating factors. *International Journal of Procurement Management*, 20(5), 1–19. <https://doi.org/10.1504/IJPM.2024.138755>
- Mhazo, A. T., & Maponga, C. C. (2024). 'We thought supporting was strengthening': Re-examining the role of external assistance for health systems strengthening in Zimbabwe post-COVID-19. *Health Policy and Planning*, 39(7), 652–660. <https://doi.org/10.1093/heapol/czae052>
- Ministry of Health and Child Care. (2017). National Health Laboratory Strategic Plan. Ministry of Health and Child Care, Harare, Zimbabwe.
- Ministry of Health and Child Care. (2024). National Quantification for Laboratory Commodities January 2021 to December 2023. Ministry of Health and Child Care, Harare, Zimbabwe
- Mlambo, C., Kushamba, A., & Simawu, M. B. (2016). China-Africa Relations: What Lies Beneath? *The Chinese Economy*, 49(4), 257–276. <https://doi.org/10.1080/10971475.2016.1179023>

- Mostert, S., Njuguna, F., Olbara, G., Sindano, S., Sitaresmi, M. N., Supriyadi, E., & Kaspers, G. (2015). Corruption in health-care systems and its effect on cancer care in Africa. *The Lancet Oncology*, 16(8), e394–e404. [https://doi.org/10.1016/S1470-2045\(15\)00163-1](https://doi.org/10.1016/S1470-2045(15)00163-1)
- Mothupi, T. F., Mukonza, R. M., & Khalo, T. (2022). Factors hindering the implementation of the procurement plan in a selected national research utility. *Journal of Transport and Supply Chain Management*, 16. <https://doi.org/10.4102/jtscm.v16i0.644>
- Mushonga, D. R., & Henneberger, A. K. (2020). Protective factors associated with positive mental health in traditional and nontraditional Black students. *American Journal of Orthopsychiatry*, 90(1), 147–160. <https://doi.org/10.1037/ort0000409>
- Nyabani, P., Moyo, B., & Mogotsi, K. S. (2024). Analysis of social investment in health systems reform: A case study of results-based financing in Marondera District, Zimbabwe. *The Pan African Medical Journal*, 49. <https://doi.org/10.11604/pamj.2024.49.4.43943>
- Olalere, N., Gatome-Munyua, A. (2020). *Public financing for health in Abuja: 15% of an elephant is not 15% of a chicken*. Africa Renewal.
- Panwar, R., Pinkse, J., & De Marchi, V. (2022). The Future of Global Supply Chains in a Post-COVID-19 World. *California Management Review*, 64(2), 5–23. <https://doi.org/10.1177/00081256211073355>
- Resch, S., & Hecht, R. (2018). Transitioning financial responsibility for health programs from external donors to developing countries: Key issues and recommendations for policy and research. *Journal of Global Health*, 8(1), 010301. <https://doi.org/10.7189/jogh.08.010301>
- Rout, S. K. (2010). Health Sector Reforms in Orissa: The Disconnecting Paths. *Journal of Health Management*, 12(3), 305–325. <https://doi.org/10.1177/097206341001200306>
- Saruchera, F., & Mayavo, C. (2024). Donor-funded procurement determinants and effectiveness of procurement in the public health medical laboratory services: Examining the mediating factors. *International Journal of Procurement Management*, 17(5), 10063970. <https://doi.org/10.1504/IJPM.2024.10063970>
- Selviaridis, K., Hughes, A., & Spring, M. (2023). Facilitating public procurement of innovation in the UK defence and health sectors: Innovation intermediaries as institutional entrepreneurs. *Research Policy*, 52(2), 104673. <https://doi.org/10.1016/j.respol.2022.104673>
- Shahzad, M., Upshur, R., Donnelly, P., Bharmal, A., Wei, X., Feng, P., & Brown, A. D. (2019). A population-based approach to integrated healthcare delivery: A scoping review of clinical care and public health collaboration. *BMC Public Health*, 19(1), 708. <https://doi.org/10.1186/s12889-019-7002-z>
- Shamu, S., January, J., & Rusakaniko, S. (2017). Who benefits from public health financing in Zimbabwe? Towards universal health coverage. *Global Public Health*, 12(9), 1169–1182. <https://doi.org/10.1080/17441692.2015.1121283>
- Shen, A. K., Farrell, M. M., Vandenbroucke, M. F., Fox, E., & Pablos-Mendez, A. (2015). Applying lessons learned from the USAID family planning graduation experience to the GAVI graduation process. *Health Policy and Planning*, 30(6), 687–695. <https://doi.org/10.1093/heapol/czu045>
- Shroff, Z. C., Sparkes, S. P., Paina, L., Skarphedinsdottir, M., Gotsadze, G., Zakumumpa, H., Tang, K., Perera, P. N., Yuan, M., & Hanson, K. (2024). Managing transitions from external assistance: Cross-national learning about sustaining effective coverage. *Health Policy and Planning*, 39(Supplement_1), i50–i64. <https://doi.org/10.1093/heapol/czad101>
- Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: Systematic analysis of qualitative health research over a 15-year period. *BMC Medical Research Methodology*, 18(1), 148. <https://doi.org/10.1186/s12874-018-0594-7>
- Vian, T. (2020). Anti-corruption, transparency and accountability in health: Concepts, frameworks, and approaches. *Global Health Action*, 13(sup1), 1694744. <https://doi.org/10.1080/16549716.2019.1694744>
- Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: The central role of policy analysis. *Health Policy and Planning*, 9(4), 353–370. <https://doi.org/10.1093/heapol/9.4.353>
- Williams, J., Edgil, D., Wattleworth, M., Ndongmo, C., & Kuritsky, J. (2020). The network approach to laboratory procurement and supply chain management: Addressing the system issues to enhance HIV viral load scale-up. *African Journal of Laboratory Medicine*, 9(1). <https://doi.org/10.4102/ajlm.v9i1.1022>
- Wright, B. E., Manigault, L. J., & Black, T. R. (2004). Quantitative Research Measurement in Public Administration: An Assessment of Journal Publications. *Administration & Society*, 35(6), 747–764. <https://doi.org/10.1177/0095399703257266>
- Zimbizi, G. (2019). *Zimbabwe HealthCare Financing Landscape*. Policy Brief.

Cite this article as:

Mayavo, C. (2026). Dangers of Relying on Donor-Funded Procurement in the Health Sector in the Low-to-Middle-Income Countries of Africa: Lessons from a Low-Income Country in Africa. *GHMJ (Global Health Management Journal)*, 9(3), 221–233. <https://doi.org/10.35898/ghmj-931346>