inter aide

Health programmes - Ongoing evaluation 2024-2026

Note on material support in Malawi

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Evaluative question 4: Does the material support of the project (donation of equipment, construction and rehabilitation of health structures) allow for a sustainable improvement in access and, secondly, in quality of health care?

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Introduction

During the first semester 2026, each team (central region and southern region) established a list of all material support provided since the beginning of the current programme in 2014. Material support included construction, rehabilitation, infrastructure maintenance or donation. The following information was provided for each item:

Date	**Area or facility**	**Support provided**	**Comment on what was done** (method, community contribution, difficulties, etc.)	**Cost** (expected vs done, in MWK and EUR)	**Current status** (usage, functionality, maintenance, etc.)	**Assessment of impact** (was it effective in its objective, was it durable, should we have done it or not, what could have been done better, etc.)

A visit to all facilities concerned was done to fill the "Current status" column. The result table for each region are provided as annex to this note. Some elements regarding planned budget and actual costs have not yet been gathered at this stage due to time constraints.

After this data collection period, discussions were held with each team regarding lessons learnt from this process, in order to evaluate the different methods used over time (duration, cost, involvement of the community or the health system, type and quality of support, durability, etc.) and to draw conclusions and recommendations for future material support.

Conclusions

An essential part of the programme

First, the inventory work undertaken **reflects the importance of material support in both programmes**. The number of items listed and their variety show that material support has been an important activity of the programme and required numerous resources (funds, human resources, time, etc.). The impact of such support is overall clearly demonstrated, with constructions and donations widely and durably used, with a clear impact on quality and quantity of care for the beneficiaries. It is the combination of this material support with capacity building activities that constitutes the full potential of the Malawi health programmes.

In addition, this support is largely appreciated by the partners (at DHO, HA, HC and community levels) and greatly helps the relationship between the programme and the beneficiaries and partners. Inter Aide is recognized as a major actors through its constructions, and its flexibility in answering to demands from partners is appreciated.

However, some nuances are emerging after careful analysis.

Comparing construction/rehabilitation of infrastructure, equipment donation and amenities

The durability of the support depends on several factors. Generally, it seems **constructions and rehabilitations are more durable than donations**. While there are always maintenance issues with constructions, due to HC teams and DHOs having little resources (or sometimes interest) in maintaining buildings and fixing little problems, the overall usage of the constructions provided does not seem hindered even on the long-term. Users accept small degradations over time due to lack of maintenance, once the infrastructure in question has been adopted.

On the other hand, **donated items are often lost, stolen or damaged after a shorter period**, without being replaced due to lack of means in the health system. This depends on the nature of the equipment donated. For instance, **furniture or strong equipment tend to last longer**. Small medical equipment is more easily lost, and electronic material is usually abandoned due to issues of batteries or fragility (BP machines, phones, etc.).

Donations of supplies (such as cleaning supplies for instance) is only temporary and should be seen as a measure to answer to an emergency (cholera outbreak for instance), or to develop good practices after a training (providing a longer-term solutions for supply provision is identified). Essential supplies that are necessary for the critical running of activities (such as stationaries needed in day to day operations to track the progress of care, through reference of notes and record keeping), cannot be considered as a one-time donation if no long-term provision can be ensured by another partner. If the Inter Aide programme starts donating supplies, it should commit to continue until the provision can be ensured autonomously (which is often unlikely, as stationary is the most ignored aspect by the Malawi Ministry of Health).

Finally, building amenities such as **electricity and running water** are particularly challenging. Their importance for the quality of care and staff motivation are undeniable, but their **need for constant maintenance can make it challenging on the long-term**, in a context where the MoH has very little upkeep capacity and budget. Durable and robust solutions with as little maintenance required as possible should be favoured: connection to ESCOM rather than solar panels (as batteries usually need frequent replacement), long-term running water systems (solar pumps are usually more durable but more expensive, electrical pumps are a good alternative when the facility is linked to ESCOM).

Importance of needs assessment

The main successes of material support are related to the assessment of the needs. Without surprise, the more critical the support is for the beneficiaries (patients or HC staff), the more likely it is a success. **Needs expressed over a long period and by a variety of different actors have a better chance to make a difference once answered.**

Good examples include the construction of Kalinde maternity or the extension of Dickson maternity, where **the need was obvious for all stakeholders** (users, HC and DHO). An interesting example of success due to a well-identified need is medical staff houses: while they do not look as a priority from a patient point of view, they prove very efficient in fixing the HC staff in a facility and avoid absenteeism. All these constructions have been swiftly adopted into the health system and are all in use.

An example of a relative failure is the maternity waiting home (MWH) in Maluwa. It was only used temporarily by expecting women and their guardian, but has quickly been used for other purposes by the HC staff. It is likely that successes with other MWHs (Katchale, Nambazo, etc.) altered our assessment of the need in Maluwa. The reason it was not used in Maluwa could be that there are less expecting women in this small catchment area (they usually fit in the maternity), or that the HC has other space issues that are given priority by the HC staff compared to the MWH. The room is therefore partially used for other services (such as HIV testing), which in itself is beneficial for the HC and therefore considered a positive impact of the programme. This is a good reminder that each HC is different and we should always **take the time to analyse specifically the need in each situation.**

Construction methods and community involvement

Inter aide construction methods have varied over time. The main principle has however remained the same: **all constructions are conducted under the community-managed approach**, and therefore not an Inter Aide initiative. This means that the community is included at all steps of the construction, including through the training and involvement of the HCMC or HAC. It also means that Inter Aide does not have to deal directly with the MoH and that **agreements can be made at District level (DHO and/or DC), which makes it much simpler and cheaper**. Communities do contribute a lot in local material (burnt, bricks, sand, quarry stones, etc.) and unpaid labour (stock management), but their capacity can vary from one area to the other. In addition, the burnt bricks are now officially forbidden as they contribute to deforestation, so this reduces the possibilities in terms of community contribution. **The involvement of the local NGO CSC has been very beneficial in helping the community** be better organize and advocate for their needs and rights in recent constructions in Phalombe district. It gives the community more power as a stakeholder among Inter Aide and the District institutions.

Initially, Inter Aide was initiating the construction, then funding all professional labour and paid material for constructions (Khuzi VC in 2015, Nambazo MWH in 2016, etc.), with community contribution in the form of local material (let us call it **the 100% IA approach**). In 2019-2020, in Mitundu, we attempted to give the leadership of the construction of two VCs (shelter with or without HSA house) to the community, as they had initiated the works themselves. We did not fund labour and only provided part of the paid material, with the community managing the actual works (let us call it **the 50/50 approach**). N'gombe and Chidangwe VC buildings were of lesser quality than VCs under the 100% approach, but much cheaper for the programme. These buildings were properly used for a long time, but later partly abandoned due to HSA lack of motivation (so not linked with the quality of the construction). Later, still in Mitundu, we attempted to let the community manage 80% of the construction of VC shelters, and only provided around 500,000 MWK of material for each, usually for roofing (let us call it **the 20/80 approach**). This allowed more shelters to be supported due to cost

reduction for the programme, with a similar yearly budget (5 to 10 shelters per year). However, it required supervision and motivational visits to each village for several months.

The 50/50 approach was then tested in Phalombe with Nthambula VC and Julius/Naminga VCs. The first one was completed in around 6 months due to high community motivation, while the one in Naminga took over 2 years and suffered many delays due to lack of ownership from the community and issues with the chief. In addition, these works created tensions with the Phalombe DHO, as they were considered not up to standard for an NGO construction (according to MoH standard for a VC). It seems the DHO was not sufficiently informed of the approach that was proposed (and how it differed from Dindi VC for instance, done under the 100% IA approach). Overall, the situation of Naminga highlights **the importance of needs assessment, including local motivation and capacity to conduct the work needed (both from the community and their leadership), and the involvement of all stakeholder including governmental to ensure acceptance.** If all criteria cannot be met, then the 50/50 or 20/80 approach should not be considered.

Cost analysis and procedure for constructions

According to our construction procedure, **we select a builder that provides a Bill of Quantity, and then we proceed to the material purchase following the general procurement procedure of Inter Aide**. This method is more cumbersome for the team, compared to selecting a constructor that would also manage the procurement. However, we favour this method as **it reduces the costs and gives us a better control over the construction** (we can monitor the quality of the material and when it is used). However, the selection of the builder remains a delicate task, as it needs to be someone that is **both qualified and accepted locally**. For instance, bringing a builder from outside the district can create frustration in the community, even though they might have more capacity than local builders might.

Finally, we have observed that **constructions were always more expensive in the Southern Region than in the Central Region**, for similar works. When we investigated the matter, we learned that the reasons for the difference were not clear. It seems to be linked with increased costs of material in the South, but also construction habits that are more costly in the South (additional material needed, for instance for foundations). In addition, over the years, due to inflation in Malawi and to issues of exchange rates, **the costs of constructions in euros have skyrocketed**. A staff house used to cost around 5,000 euros in 2017, when renovating the two Mkanda houses in 2023 cost over 12,000 euros. Similarly, the 105 m² extension of Dickson maternity in 2019 cost 6,000 euros, while Kalinde maternity construction (250 m²) costs around 60,000 euros, and Gumba maternity (219 m²) is currently budgeted at 115,000 euros. **This explosion in costs questions our capacity as an NGO project to conduct such works, until the economic situation of the country (and the exchange rate of the MWK) evolves.**

Recommendations:

- Material support is an essential part of the Malawi health programmes, with high impact on quality of care and health access, and increasing motivation for partners and beneficiary. It is essential in the initial phases of the rollout of the programme, but has to be gradually phased-out and be discontinued before exit strategies are proposed.
- Constructions and rehabilitations appear more durable than donations. However, donations of strong equipment of high quality can be considered, as they are more durable than smaller or fragile equipment, and can contribute greatly to the improvement of healthcare. For example, we can consider that a durability of 3 to 5 years is enough to be considered. Donation of short-term supplies can be considered for specific cases (such as essential stationary for instance). In any case, a discussion about the importance of the donation and its potential for sustainability need to occur before the purchase.

- Support to amenities are essential (running water and electricity), but their maintenance over time is particularly challenging. Long-term options should be favoured (connection to ESCOM for instance).
- In any case, the involvement of all stakeholder (especially the DHO) for the maintenance of the material provided (construction/donation) has to be done from the beginning of the project, and pushed for as much as possible after the material support has been finalised or as soon as maintenance problem arise.
- We have not been able to conclude on which types of buildings were more efficient and durable (between maternities, staff houses, VCs, etc.), it depends on the situation. All types can therefore continue to be considered in the future.
- For all types of material support, it seems that the needs assessment is key in ensuring the success of the project. Before starting, long-term discussions with various stakeholders should occur, to assess various points of views. Local motivation and capacity (from the community, the traditional authorities, and the medical staff) is essential, as well as support from the DHO and/or DC. Extensive discussions and signing of detailed MoUs can prevent misunderstandings in the future. The involvement of all the Inter Aide team is also important, both the HSS and community teams.
- Currently (June 2026), costs linked with material support are a major obstacle to our capacity to conduct further material support. It is likely we will need to wait for a better economical context before proposing significant material support (especially major constructions) in the future.

Annexes

Two Excel files are provided (one for each region), with the detailed list of material support provided between 2014 and 2025.

Example:

Date	**Area or facility**	**Support provided**	**Comment on what was done** (method, community contribution, difficulties, etc.)	**Cost** (expected vs done, in MWK and EUR)	**Current status** (usage, functionality, maintenance, etc.)
juil-14	Katchale	Donated 6 mattresses, 24 bedsheets, 6 blankets, 6 bed nets, 1 new-born resuscitator bed, 1 BP machine, 1 baby weighing	These items were donated to Katchale HC, to improve service delivery and comfort to clients		Most item are in use. Some mattresses need replacement because they are too torn.
juil-14	Mitundu Hospital	Donated 1 wall clock, 2 reams of paper, 2 electric power cords, 1 electric	The donation was for the opening of the kangaroo mother care room		In use.
août-14	Katchale	Construction of Khuzi Village Clinic		Estimated budget was MK 2,184,250 but actual cost was MK 2,884,250 for the house; VC shelter cost MK 2,361,350.	Functioning. The structure is turned into a Health Post. The roof is badly damaged by termites and need maintenance asap