Building Resilient Communities:
Resilient Health Infrastructure (RHI)

RHI TOOLKIT GUIDEBOOK

January 2018

RHI

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Resilient Health Infrastructure (RHI) is part of MERCY Malaysia's Building Resilient Communities (BRC) initiative. It is a program focusing on advocating planned preparations in strengthening hospitals' and other capacity of health infrastructure in order to respond effectively during disasters as well as fast recovery from the impact of extreme events. Considering health infrastructure such as hospitals as complex and sophisticated organizations, hospital management and its built environment representing building and infrastructure systems within a defined boundary should perform in a predictable manner during and after a hazard and/or disaster.

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Acronyms

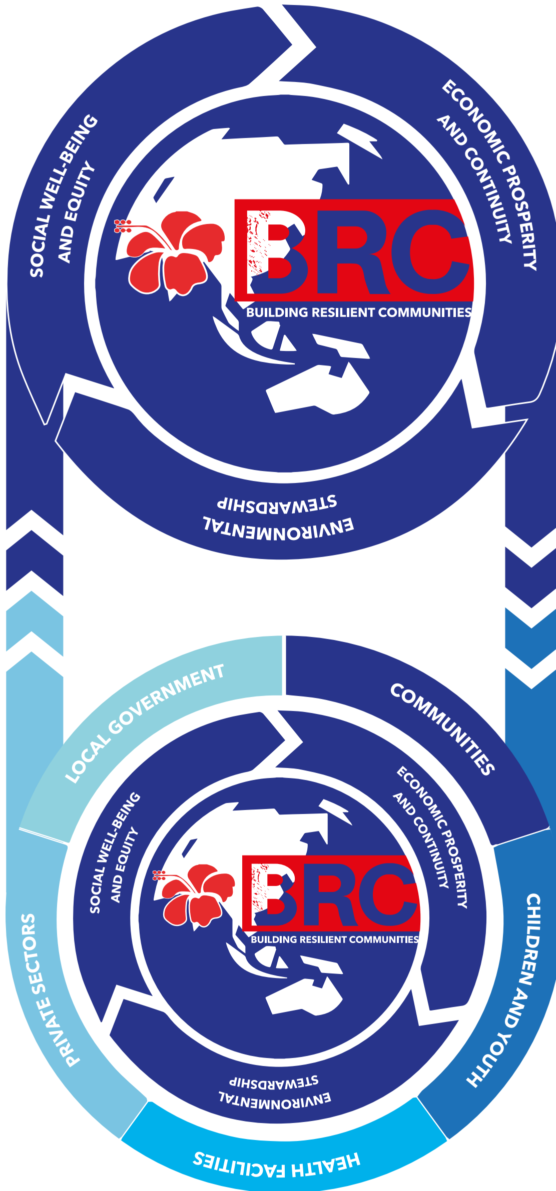
4R	Robustness, Resourcefulness, Redundancy and Rapidity
AADMER	ASEAN Agreement on Disaster Management and Emergency Response
BCM	Business Continuity Management
BCP	Business Continuity Plan
BRC	Building Resilient Communities
CBDRM	Community Based Disaster Risk Management
CFRD	Communication and Fund Raising Department
DRM	Disaster Risk Management
DRR	Disaster Risk Reduction
EM-DAT	Emergency Events Database
HFA	Hyogo Framework of Action
LGUs	Local Government Units
MOH	Ministry of Health
NADMA	National Disaster Management Agency
PDO	Program Development and Operations
PS	Private Sectors
RHI	Resilient Health Infrastructure
SFDRR	Sendai Framework for Disaster Risk Reduction
SPP	School Preparedness Program
UNISDR	United Nations Office for Disaster Risk Reduction
VMD	Volunteers Management Department
WHO	World Health Organisation

Building Resilient Communities (BRC)

A resilient community can better cope with the impact of natural disasters and is able to get life back to normal faster. To achieve this, all segments of society must be engaged - government, academic institutions, private sector, civil society, community based organizations, and the general public. Building resilience requires the direct involvement of community members at the grassroots level in all stages of DRR, from planning to monitoring and evaluation.

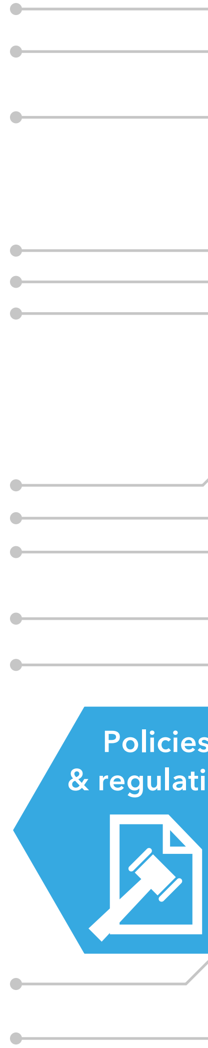
In achieving a culture of resilience, it is however not enough if only few of the civil society organizations, humanitarian actors and local government actors have disaster risk reduction and adaptation included as an inherent part of their work. Therefore, MERCY Malaysia's BRC program was developed as a way to engaged various stakeholders in a spherical and dynamic manner in addressing and responding to issues, ideas and actions that would help in increasing communities' and places resiliency.

The BRC framework is a holistic approach that includes all levels of stakeholders in a community ***(local citizens, its local government units, schools and educational units/facilities, health units/infrastructure and private sectors)*** to increase capacity and reducing vulnerability with the objective of building the community's resilience in social well-being and equity, environmental stewardship, and economic prosperity and continuity.



The BRC framework and network of stakeholders

PROGRAMS	OBJECTIVES
	To provide a platform for communities to actively participate in disaster risk reduction activities, gain knowledge, skills and competencies in DRR and indigenous early warning systems are enhanced and used.
	To generate a culture of disaster awareness and response amongst school children, teachers and staff.
	To increase and introduce hospital and its management to DRR and improve the hospital's disaster preparedness and critical infrastructure's resilience through the implementation of DRM.
	To provide DRR and DRM education for private and corporate sector through DRR for Private Sector and Business Continuity Plan (BCP).
	To educate, train and strengthen relevant LGU stakeholders on DRR and DRM.



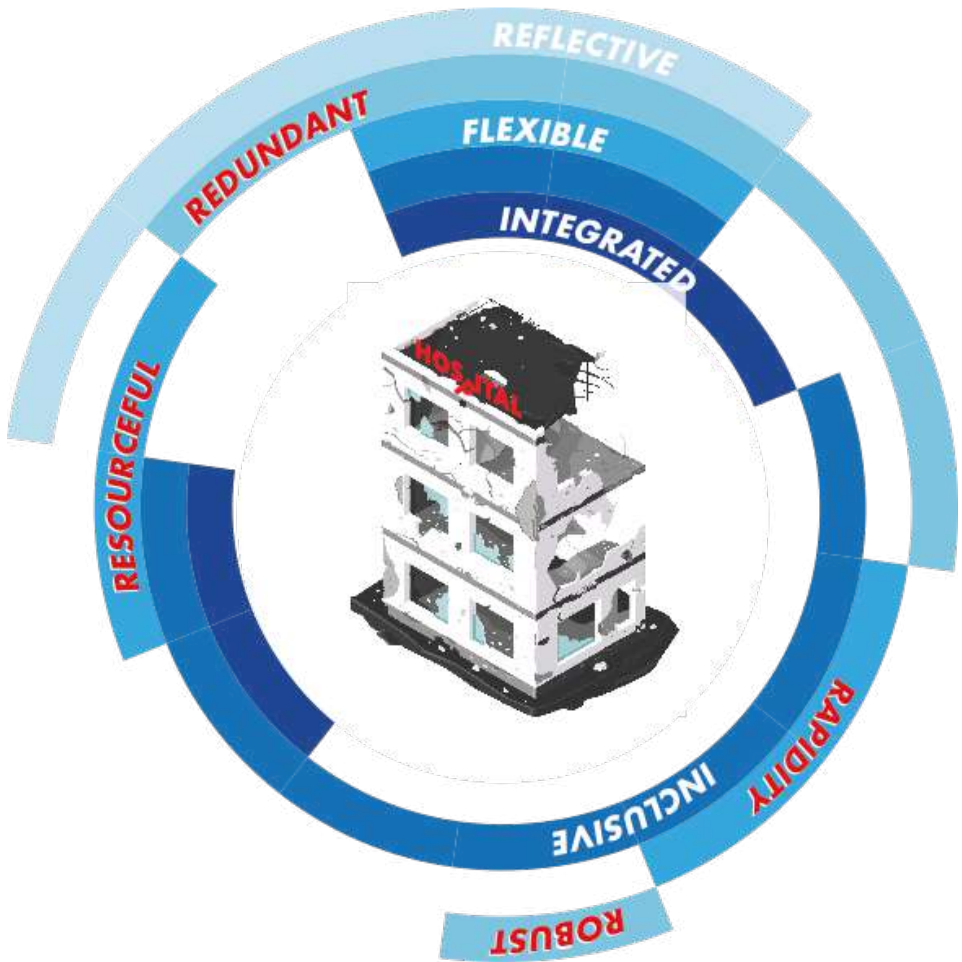
EXAMPLE ACTIVITIES

BRC programs, objectives and example of activities

Resilient Health Infrastructure (RHI)

Resilient Health Infrastructure (RHI) is part of MERCY Malaysia's BRC initiative. It is a program focusing on advocating a planned preparation in strengthening hospitals' and the other capacity of health infrastructure in order to respond effectively during disasters as well as fast recovery from the impact of extreme events. Considering health infrastructure such as hospitals as complex and sophisticated organizations, hospital management and its built environment representing building and infrastructure systems within a defined boundary should perform in a predictable manner during and after a hazard event and/or disaster.

Most hospitals were planned, designed and built without taking into account the probability of disaster. The failure of hospitals to absorb and accommodate pressures during disasters will cause performance degradation of services and health care of the hospital. Phenomenon like this had led the World Health Organization (WHO) and the United Nations Office for Disaster Risk Reduction (UNISDR) to promote 'Hospital Safe from Disaster Campaign', aiming to make hospitals more resilient and more prepared during disasters. The RHI initiative discusses strategic approaches taken to increase the level of resiliency for health infrastructure, with focus on the criteria of ***4Rs - robustness, redundancy, resourcefulness and rapidity.*** Its aim is to form clear understanding of hospital resilience, and help in the understanding in drafting preliminary conceptual framework for a more resilient health infrastructure.



Criteria framework for Resilient Health Infrastructure (RHI)

Needs Assessment and Identification

Needs assessment and identification is the first step for the whole RHI process. It is important to know and understand the needs of the local community (in this case, the health service providers, i.e. hospitals and clinics) prior to conducting the program. This toolkit is designed to help the assessment team to conduct systematic needs identification in an effective way. Needs assessment and identification results will be useful in preparing preliminary report to justify the project needs and to be used as a framing guideline throughout the whole activity process for RHI that is contextually relevant and responsive. The assessment tool is divided into two (2) sections, each focusing on general needs and an evaluation framework for hospital resilience.

Needs Assessment and Identification

General Assessment and Identification	Hospital Resilience Evaluation
A. Community types B. Community size C. Geographic location D. Disaster risk types E. Vulnerability scale F. Risk index checklist	A. Hospital safety and vulnerability B. DRR and resources C. Continuity of essential services D. Recovery and adaptation
Assessor	
1. BRC/DRR expert staffs 2. BRC project officer	1. BRC/DRR expert staffs, and/or 2. BRC technical team staffs/ volunteers

General Assessment and Identification

The earliest step involves the identification of the contextual background and its community group that require specific and strategic intervention in increasing their level of resiliency.

These checklists is to be filled based on preliminary desktop research and may not be totally accurate nor representing exact site conditions. Its purpose is to provide baseline information for further assessment.

A. COMMUNITY TYPES

- [ ] Civil society (if yes, CBDRM)
- [ ] School children and administrators (if yes, SPP)
- [x] Hospital administrators, doctors and users (if yes, RHI)
- [ ] Private/citizen organization (if yes, PS)
- [ ] Local government administrators (if yes, LGUs)

B. COMMUNITY SIZE

- [ ] < 50
- [ ] 51 - 100
- [ ] 101 - 500
- [ ] 501 - 1000
- [ ] 1000 - 2500
- [ ] > 2500

C. GEOGRAPHIC LOCATION

- [ ] West Malaysia
- [ ] East Malaysia
- [ ] ASEAN
- [ ] Asia
- [ ] Africa
- [ ] Europe
- [ ] North America
- [ ] South America
- [ ] Antarctica
- [ ] Australia

D. DISASTER RISK TYPES

- ☐ Natural hazards:
  - ☐ Geophysical (earthquakes, landslides, tsunamis, volcanic activity)
  - ☐ Hydrological (avalanches and floods)
  - ☐ Climatological (extreme temperatures, drought and wildfires)
  - ☐ Meteorological (cyclones and storms/wave surges)
  - ☐ Biological (disease epidemics and insect/animal plagues)
  - ☐ Others ______________________________
- ☐ Man-made hazards:
  - ☐ Complex emergencies/conflicts
  - ☐ Famine
  - ☐ Displaced populations
  - ☐ Industrial accidents
  - ☐ Transport accidents
  - ☐ Others ______________________________

E. VULNERABILITY SCALE

- ☐ Vulnerability as internal risk factor (intrinsic vulnerability)
- ☐ Vulnerability as the likelihood to experience harm (human centered)
- ☐ Dualist vulnerability (susceptibility and coping capacity)
- ☐ Multiple vulnerability (susceptibility, coping capacity, exposure)
- ☐ Multi-dimension vulnerability (physical, social, economic, environmental)

F. RISK INDEX CHECKLIST

- ☐ Exposure
- ☐ Susceptibility
- ☐ Coping capacities
- ☐ Adaptive capacities
- ☐ Resilience capacities

G. ADDITIONAL INFORMATION/ RECOMMENDATIONS

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PREPARED BY

☐ BRC project officer

Name ____________________

Date ____________________

VERIFIED BY

☐ BRC/DRR expert staff

Name ____________________

Date ____________________

Hospital Resilience Evaluation

The hospital resilience evaluation checklist can be used as a foundation to further understand and strategies resiliency enhancement measure for the hospital with potential measures for evaluation.

A. HOSPITAL TYPE AND CAPACITIES

- ☐ Numbers of beds: ____________ ☐ In-patient ☐ Out-patient
- ☐ Hospital type:
  - ☐ National referral hospital
  - ☐ Provincial referral hospital
  - ☐ District hospital
  - ☐ District referral hospital
  - ☐ District health center
  - ☐ Rural health center

B. HOSPITAL SAFETY AND VULNERABILITY

- ☐ Disease surveillance:
  - ☐ Surveillance procedures in place
  - ☐ Surveillance report and information sharing policy in place

- ☐ Hospital risk and safety:
  - ☐ Building code and locations of hospital critical infrastructures to meet of high risks (e.g., earthquake, fire safety, flood, typhoon)
  - ☐ Safety and security issues of architectural components to meet of high risks
  - ☐ Assessment strategies for hospital vulnerability and risks are in place
  - ☐ Strategy to evacuate and protect existing patients are in place
  - ☐ Alternative emergency energy and facilities for backup (e.g., power, water, oxygen and telecommunication) are in place
  - ☐ Area for radioactive, biological and chemical decontamination and isolation are in place

C. DISASTER PREPAREDNESS AND RESOURCES

- ☐ DRR stewardship:
  - ☐ Set-up of emergency committee or command centre (e.g. workplace, communication equipment, and staff)
- ☐ DRR cooperation and communication:
  - ☐ Center for crisis communication within hospital
  - ☐ Communication and cooperation with other community facilities
- ☐ Disaster plan system:
  - ☐ Plans for different kinds of disasters are ready
  - ☐ Hospital plans are involved within community-wide plan
- ☐ Disaster resources:
  - ☐ Stock quantity of different emergency supplies are available
  - ☐ Strategies for management of emergency supplies (e.g. logistics and distribution, contracts with suppliers and other hospitals)
- ☐ Emergency medicines administration:
  - ☐ Stock quantity of essential medicines for various disasters
  - ☐ Strategies for management of medicine (e.g. drug-distribution and management plans)
- ☐ Emergency staff and group:
  - ☐ Set-up of emergency expert group
  - ☐ Set-up of emergency rescue team
- ☐ Emergency trainings and drills:
  - ☐ Different incident types for trainings were conducted
  - ☐ Different incident drills for trainings were conducted
  - ☐ Frequency of trainings/drills ______________________
  - ☐ Period of the last trainings/drills __________________

D. CONTINUITY OF ESSENTIAL SERVICES

- ☐ Emergency surge capacity:
  - ☐ Surge capacity of emergency space (e.g., emergency beds, ICU, isolation rooms) within a limited period is sufficient
  - ☐ Surge capacity of emergency equipment, medication and resource within a limited period is sufficient
    Surge capacity of hospital staff within a limited period is sufficient
  - ☐ Strategies for surging inpatient capacity (taking physical space, staff, supplies and processes into consideration) are in place
  - ☐ Strategies for surging key staff (e.g. transfer from non-critical departments and other hospitals, volunteers) are in place
- ☐ Emergency response procedures:
  - ☐ Procedures to identify, prioritize, and maintain essential functions is in place and well sensitized with hospital staffs
  - ☐ Mass-casualty triage protocol based on severity of illness/injury, survivability and hospital capacity is in place
  - ☐ Procedures for referral and counter-referral of patients
- ☐ On-site rescue and hospital medical treatment:
  - ☐ Equipments for on-site rescue (e.g. ambulance, helicopter, communication equipment) are available
  - ☐ Hospital emergency equipment (e.g. for medical treatment, decontamination, and personal protection) are available

E. RECOVERY AND ADAPTATION

- ☐ Recovery capability:
  - ☐ Reconstruction and recovery mechanisms are in place
  - ☐ Strategies for community recovery (e.g. mental counselling, chronic disease management) are in place
  - ☐ Evaluation and adaptation report (e.g. incident summary, response assessment, risks assessment) are in place

F. ADDITIONAL INFORMATION/ RECOMMENDATIONS

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PREPARED BY

☐ BRC/DRR expert staff

Name ______________________

Date ______________________

VERIFIED BY

☐ BRC technical team staff

Name ______________________

Date ______________________

Project Proposal

Upon completion of the needs assessment and identification, a project proposal need to be prepared. A good and properly planned project need to be justified in the project proposal. Its objectives are to identify what work is to be done, explain why this project needs to be implemented and juustify the reader (funder, executive council etc.) that the project have a plausible management plan and technical approach, and have the resources needed to complete the task within the stated time and cost constraints.

Below is a guideline to prepare a BRC project proposal:

A. PROJECT COVER SHEET

- [ ] Include contact information, project director, project period and project summary

B. ORGANIZATIONAL HISTORY, MISSION, VISION AND STRUCTURE

- [ ] Include a few brief paragraphs explaining how MERCY Malaysia was established, its mission, vision and structure, as well as its record of working on humanitarian and DRR/DRM issues

C. PROGRAM BACKGROUND AND ISSUE ANALYSIS

- [ ] Provide an analysis of the field, what are the existing gaps and challenges, and what exactly is the problem to be addressed?

D. GOAL, OBJECTIVES, TARGET POPULATION AND IMPLEMENTATION PLAN

- ☐ What is the overall goal of the program/project
- ☐ What are the objectives?
- ☐ How will the project be implemented?

E. PROJECT BUDGET

- ☐ Provide a line item budget in Malaysian Ringgit (MYR) or US Dollar (USD) with short narrative explanations for each line item, which can be footnoted to the budget

F. ATTACHMENTS

- ☐ Overall organizational budget (operating budget)
- ☐ List of other potential sources of support (if any)
- ☐ Other references
- ☐ Photographs (with captions)

Note: This guideline is intended to serve as a sample to assist in the writing a BRC project proposal. The organization should feel free to use other formats, as long as all the above-mentioned elements are included in the proposal. Project proposals should be no longer than 10 pages, although shorter proposals would be preferred.

Example of needs assessment and identification

PROJECT PROPOSAL

Date: Country:	
Project name	BUILDING RESILIENT COMMUNITIES (BRC) – RESILIENT HEALTH INFRASTRUCTURE (RHI)
Project brief	
Project location	
Project description	
Project justification	
Previous experience of the organization	
Project activities	
General objectives	
Goals	
Estimated result of the project	
Risk and assumptions	
Number of beneficiaries and description	
Project's duration	
Implementing party and partners	
Project budget	
Detail budget	
Monitoring and evaluation procedures	
Timeline	
Contact information	

Project proposal template as guideline

Workshop Preparation

After the completion of Stage 1 of the BRC program, Stage 2 - 4 mark the bulk component of the program, which is the workshop with the stakeholders. This section provides guidelines and checklists in preparing for the workshop. The guideline recommend facilitators to establish a participatory and empowering tone to the workshop series. Welcome and honor the useful skills, knowledge, and experience that each participant brings to the BRC process.

A. WORKSHOP TYPES AND STAKEHOLDERS

- [ ] CBDRM (Civil society)
- [ ] SPP (School children and administrators)
- [x] RHI (Hospital administrators, doctors and patients)
- [ ] PS (Private/citizen organization)
- [ ] LGUs (Local government administrators)

B. PLANNING THE WORKSHOP

- [ ] Formulate/define workshop type and stakeholders of workshop
- [ ] Agree and set dates
- [ ] Recruit organizing working groups
- [ ] Recruit conference staff/assistants

C. FINANCIAL PLANNING

Budget to cover the following expenses need to be in line with proposed budget approved in the project proposal

- [ ] Hire of venues
- [ ] Catering – meals, lunches, tea and coffee breaks etc.
- [ ] Workshop stationery

- [ ] Workshop collaterals (banners, buntings, etc.)
- [ ] Translation services and equipment
- [ ] Evaluation report and publication of results of workshop
- [ ] Local accommodation
- [ ] Transport requirements
- [ ] Fee for Subject Matter Experts
- [ ] Media coverage expenses (additional transportation, meal, etc.)
- [ ] Other expenses. Please specify: ______________________________

D. TARGETING THE RIGHT AUDIENCE

- [ ] Prepare a brief person specification – the type of people that will benefit most from attending
- [ ] Invite chairperson
- [ ] Invite VIPs and other officials (if required)
- [ ] Invite speaker(s) for opening address
- [ ] Invite keynote speaker(s)
- [ ] Invite presenters/trainers and facilitators

E. REGISTRATION AND MAILING

- [ ] Workshop registration – set deadline
- [ ] Coordinate information with VMD Head and staffs
- [ ] Ensure all registration forms received have been processed and resolve any queries
- [ ] Send final confirmation of registration to participants
- [ ] Compile final list of registered participants
- [ ] Report updated list of participants to convener(s)
- [ ] Produce name badges with participant's first name, family name and country/organization of origin
- [ ] Produce name badges for workshop commitee members

F. FINAL CONFIRMATION

Final confirmation checklist of the planned workshop will be listed in the final mailing for all stakeholders, participants, staffs and volunteers

- ☐ Workshop title, dates, location
- ☐ Description of workshop venue
- ☐ Focal person (contact details)
- ☐ Reception arrangements and registration desk opening hours
- ☐ Hotel and other accommodation details and locations relative to workshop venue (a map is always useful)
- ☐ Any off-site workshop venues and arrangements for local transport

G. COMMUNICATION

Workshop staffs and volunteers to check with Communication and Fund Raising Department (CFRD) and to comply with MERCY Malaysia's brand and communication guideline

- ☐ Confirm all acknowledgements, including logos to be included on all material for the workshop – flyers, reports, posters etc.
- ☐ Prepare a brief description of the event and use as the basis for internal communication (within MERCY Malaysia)
- ☐ Create announcement/workshop flyer, including brief, outcome, venue, date and pre-registration deadline
- ☐ Distribute workshop collaterals (print, online, mailing lists)
- ☐ Ensure links established on appropriate websites as an outlet for news about the workshop
- ☐ Compile mailing list of people useful to invite – a 'hit list' of people desirable to have attend, e.g. international officials, national officials, specialists, etc.
- ☐ Social media communication flow (FB, Twitter, Instagram)
- ☐ Contact media agencies - TV, radio, prints (national/international)

H. DOCUMENTATION

- ☐ Photographer (staff member/professional)
- ☐ Videographer (staff member/professional)
- ☐ Rapporteur

I. PRESS RELEASE

- ☐ Draft press releases and consider means of dissemination
- ☐ Determine a lead contact (official) spokesperson
- ☐ Make arrangements for press to interview VIPs, officials, etc.

J. ADDITIONAL INFORMATION/ RECOMMENDATIONS

Note: This checklists are general guideline only. Each workshop will have its own circumstances and considerations, vary in terms of location, scale and scope.

Module Contents Preparation

The RHI modules are the core content of the program. Its delivery forms the most important component in developing stakeholders' understanding towards the needs for health infrastructure resilience. The following guidelines is intended to help develop up-to-date and relevant module contents for the workshop.

SESSION ONE

A. INTRODUCTION TO DRR

- ☐ The philosophy and concept of DRR - what is DRR?
- ☐ Positioning DRR - context and approaches
- ☐ Roadmap towards reducing disaster risk - history of DRR
- ☐ Why DRR is needed?
- ☐ Brief information on Hyogo Framework of Action 2005 - 2015
- ☐ Brief information on Sendai Framework for DRR 2015 - 2030
- ☐ Basic terminologies on disaster risk
- ☐ 'Formula' of disaster risk
- ☐ Total Disaster Risk Management (TDRM)
- ☐ How DRR can help towards RHI?
- ☐ Issues and challenges in DRR
- ☐ Summary - working together in DRR and achieving resiliency

B. INTRODUCTION TO RHI

- ☐ Context and issues - why RHI is needed?
- ☐ Positioning RHI within DRR - how RHI contributes to DRR?
- ☐ Definition of resilience and RHI
- ☐ Goals and objectives of RHI
- ☐ RHI Framework - the 4Rs (Robustness, Resourcefulness, Redundancy and Rapidity)

- [ ] RHI and the built environment and its resources
- [ ] Capacity and vulnerability of healthcare infrastructure and systems
- [ ] Healthcare infrastructure and systems' needs -pre, during and post disaster/crises
- [ ] Disaster action plan for healthcare infrastructure and systems
- [ ] Implementing disaster action plan - best practices
- [ ] Summary - working towards RHI and improving resiliency

SESSION TWO

C. HOSPITAL WATCHING

- [ ] What is hospital watching?
- [ ] Machizukuri - community planning concept
- [ ] Understanding disaster risks - capacity and vulnerability
- [ ] Methods in hospital watching
- [ ] Hospital/healthcare facilities master plan - zoning
- [ ] Techniques in collecting data from hospital watching
- [ ] Case studies and best practices
- [ ] Group distribution (based on zoning)
- [ ] Group facilitator (from MERCY Malaysia)

D. DISASTER SIMULATION

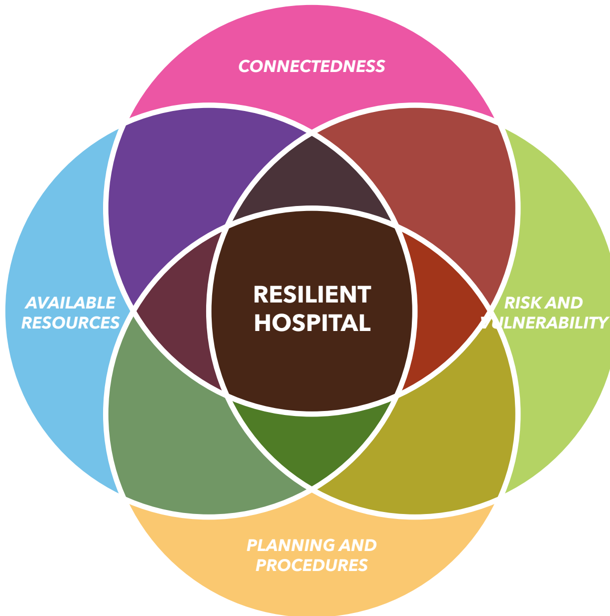
- [ ] Introduction - what is disaster simulation?
- [ ] Group distribution (Governance/ Disaster Management Plan/ NGO and Media Policy; Building and Critical Infrastructure; Continuous Medical Response and Management; and Logistic Planning, Communication and Information Control)
- [ ] Disaster scenario - simulation activities
- [ ] RHI framework - refresher
- [ ] Group activities - discussion and drafting action plan
- [ ] Presentation structure and briefing

The RHI Scorecard

This Scorecard was developed in reference to Torrens Resilience Institute's Community Disaster Resilience Scorecard Toolkit. This Scorecard is an early step towards understanding the current level of resiliency a stakeholder might be in a specific time and context. Using the Scorecard at constant intervals will allow progress tracking on selected key action areas and idenity new areas that require further action.

FOUR KEY CATEGORIES IN EVALUATING THE COMMUNITY

The evaluation looks at four categories - Connectedness; Risk and Vulnerability; Planning and Procedures; and Available Resources, which are key factors in determining how resilience a stakeholder may be.



The four categories in evaluating the community

EVALUATION SCORING METHOD

The completed Scorecard will provide a point-in-time snapshot of some key measures important to resilience, providing guidance on aspects of what should receive attention in order to increase resilience, strengthen resilience over time and reducing vulnerability. The Scorecard is then analysed to indicate whether the community's current state of resilience is at the **DANGEROUS LEVEL, CAUTION LEVEL** or **SAFE LEVEL.**

The following pages provide list of questions that form the overall evaluation items and indicators that can be used for this purpose. The lists are guidelines only and may subject to changes depending on the specific context of the project stakeholders.

CATEGORIES/LEVEL	DANGEROUS (1)	CAUTION (2)	SAFE (3)
OVERALL SCORE	25% (27 - 34)	26 - 75% (35 - 101)	76 - 100% (102 - 135)
CONNECTEDNESS	25% (6 - 8)	26 - 75% (9 - 23)	76 - 100% (24 - 30)
RISK AND VULNERABILITY	25% (8 - 10)	26 - 75% (11 - 30)	76 - 100% (31 - 40)
PLANNING AND PROCEDURES	25% (5 - 6)	26 - 75% (7 - 19)	76 - 100% (20 - 25)
AVAILABLE RESOURCES	25% (8 - 10)	26 - 75% (11 - 30)	76 - 100% (31 - 40)

Evaluation scoring method and classification of resiliency levels

A. CONNECTEDNESS

How connected are the members within your hospital and the community at large?

	QUESTIONS		
A.1	Does your hospital have access to a range of communication systems that allow information to flow during an emergency?	**1** No or very limited access	**2** Has limited access to a range of communication
A.2	What is the level of communication between local governing body and your hospital	**1** Passive (government participation only)	**2** Consultation
A.3	What is the relationship of your hospital with the larger region?	**1** No networks with other towns / region	**2** Informal networks with other towns / region
A.4	What is the degree of connectedness across your hospital?	**1** No attention to subgroups / units	**2** Little attention to subgroups / units

SCORE			JUSTIFICATION /EVIDENCE
3 Has a good access to a range of communication but damage resistance not known	4 Has very good access to a range of communication and damage resistance is moderate	5 Has wide range of access tot damage-resistant communication	
3 Engagement	4 Collaboration	5 Active participation (hosp. informs government on what is needed)	
3 Some representation at regional meetings	4 Multiple representation at regional meetings	5 Regular planning and activities with other towns / region	
3 Connected due to work requirement, formal integration	4 Connected through planned activities	5 Active involvement and integration with cross-unit initiatives; both planned and unscheduled	

B. RISK AND VULNERABILITY

What are the level of risk and vulnerability in your hospital?

	QUESTIONS		
B.1	What are the known risks of all identified in your hospital?	**1** No local focus or mapping on risk	**2** Local focus on single risk but no mapping
B.2	What is the proportion of the hospital population that has the capacity to independently move to safer place? (including the percentage of patients that can evacuate safely)	**1** <20%	**2** 21 - 40%
B.3	What is the proportion of the hospital population (both staff and patients) that refers to communication in other ways (ie those with hearing and eyesight impairment)	**1** > 20%	**2** 15%
B.4	What is the risk that your hospital could be isolated during an emergency/disaster event?	**1** Not considered in planning	**2** Map of all access routes/means available to the population

SCORE			JUSTIFICATION /EVIDENCE
3 Mapping of single local risk	**4** Widely available mapping of multiple potential sources of risk	**5** Widely available mapping includes low probability/ high impact event	
3 41 - 60%	**4** 61 - 80%	**5** >81%	
3 10%	**4** <5%	**5** None	
3 Map distributed with request to have personal plan if access is severely limited	**4** Percentage of population needing transport help identified	**5** Transport plan includes those without personal transport and support for incoming supplies/ assistance	

C. PLANNING AND PROCEDURES

What procedures support disaster planning, response and recovery?

	QUESTIONS		
C.1	To what extent and level is your hospital engaged in planning for disaster response	**1** No expectation or minimal instruction	**2** Some documentations developed, however not to all units and/or to only specific units
C.2	Are there planned activities to reach the entire hospital about all-hazards resilience?	**1** No planned activities	**2** Units are encouraged to do activities
C.3	Does your hospital meet the requirements for disaster readiness?	**1** Unknown level of awareness	**2** Readiness requirements specified but not widely known
C.4	Do post-disaster event assessments change expectations or plans?	**1** Limited only to authorities (i.e. emergency services /fire department/ police only)	**2** Post-event assessment shared at meeting with relevant authorities

SCORE			JUSTIFICATION /EVIDENCE
3 Established documentation which encompasses some units in the hospital	4 Established documentation which encompasses entire units in the hospital	5 Active participation in disaster preparedness planning, including with the larger community	
3 Translated materials to relevant units	4 Occasional activities for selected units	5 At least annual activity on disaster preparedness including building hospital resilience	
3 Units are routinely informed about readiness requirements	4 Requirements implemented when attention is called	5 Commitment to resilience is enforced-consistent evaluation for resilience	
3 Post-event assessment form circulated to all units in the hospital	4 Responses to post-event assessment collected and reported	5 Post-event action plan is based on responses includes all units and community elements (incl. authorities)	

D. AVAILABLE RESOURCES

What emergency planning, response and recovery resources are available in your hospital?

	QUESTIONS		
D.1	How comprehensive is the your infrastructure emergency protection plan? (eg water supply, sewerage, power system)	**1** No plan	**2** Infrastructures identified but no protection plan
D.2	To what extent are all units engaged in emergency preparedness education?	**1** No role known or identified	**2** Only relevant units provide emergency preparedness information
D.3	Are readily accessible other locations/health facilities including hospitals available included in resilience strategy?	**1** No inventory of places	**2** Some inventory of places, but locations are not well-publicised
D.4	What is the level of food/water/ fuel readily availability in your hospital?	**1** No idea	**2** Dependent on daily external food/ water/ fuel supply

SCORE			JUSTIFICATION /EVIDENCE
3 Most infrastructure components have plans for some emergencies	**4** All individual infrastructure components has all hazard plans	**5** Infrastructure system is integrated into an all hazards protection plan	
3 Most units provide emergency preparedness session	**4** Emergency preparedness/ response session with activities occurs in all units	**5** All units are fully aware of their responsibility should there be any emergency	
3 Inventory for all places, but not assessed for specific conditions	**4** Sites stocked and known but not sufficient for estimated need	**5** Sufficient sites with water/food/ info resources widely included in all planning	
3 Have up to 2 days supply of food/ water/ fuel	**4** Have up to 4 days supply of food/ water/ fuel	**5** Have up to 7 days supply of food/ water/ fuel	

Trainer Team Preparation

The RHI program is a comprehensive program that covers both physical built environment aspects and non-physical/operational aspects of the health infrastructure. Therefore, a strong trainer team set-up is required in order to conduct the program successfully. The basic team composition shall comprise of the followings:

BRC EXPERT STAFFS

- ☐ **Project director***
  - Oversee the whole project
  - Main stakeholders engagement
  - Facilitates workshop
- ☐ **Project head***
  - Manages project including budget and resource planning
  - Engages with stakeholders
  - Tracks the overall progress of the project
  - Review program modules
  - Facilitates workshop
- ☐ **Senior project officer***
  - Coordinate budget and resource planning
  - Coordinates and plans activities
  - Tracks project budget
  - Facilitates workshop
- ☐ **Project officer***
  - Prepare for workshop activities (project support)
  - Develops progress reports
  - Manages document filing
  - Assist on facilitating workshop
  - Assist senior project officer

BRC TECHNICAL TEAM STAFFS/VOLUNTEERS

- [ ] **Architect*/medical planner**
- [ ] **Mechanical and electrical engineer***
- [ ] **Civil and structural engineer**
- [ ] **Quantity/building surveyor***
    - Run assessments
    - Develop and/or advise on content development
    - Advise on workshop outputs and give technical recommendations
    - Facilitates workshop
- [ ] **Technical assistant**
    - Prepare drawings and 3D modellings
    - Assist in module prepatory works

BRC SUPPORT STAFFS/VOLUNTEERS

- [ ] **Medical officer**
    - Run assessments
    - Facilitates workshop
- [ ] **Data analyst**
    - Process data from workshop's activities
- [ ] **Teacher/educator**
    - Facilitates workshop
- [ ] **Translator**
    - Translation services (for required countries/programs)
- [ ] **Logistician***
- [ ] **Driver***
    - Assist/ prepare for workshop activities (project support)
    - Prepare and update inventory list
    - Mobilizing resources and items on site

* Core team set-up required for RHI

Workshop Activity Flow

Upon completion of all preparatory works in Stage 2, the RHI workshop is ready to be conducted. This section is to provide general guidelines for Stage 3 - Conducting the Workshop. It covers both the final workshop preparation work checklist and the recommended flow in conducting the workshop.

A. FINAL PREPARATION

- ☐ Program banners and buntings are in place
- ☐ Enough module copies for each of the participants and facilitators
- ☐ Enough pens or pencils and scratch paper for all participants
  Enough poster-sized paper and markers, colored pens for mapping, stickers, tape, scissors and/or whatever will be needed for prominently displaying scoring results, mapping, etc.
- ☐ Workshop venue (classroom) - room is ready and clean, toilets are clean and accessable, chairs, tables, laptops, projector, laser pointer, charger, power supply, A/C, fans, dustbin, registration/ information desk, registration book, technical assistants, etc.
- ☐ Workshop venue (field work) - transportation, GPS coordinate, latest field situation update (safety and security), walkie-talkie/ handphones, technical assistants, etc.
- ☐ Prepare suitable refreshments and organize meals for participants as appropriate
- ☐ Praying room and facilities
- ☐ Hotel and other accommodations
- ☐ Additional transportation and drivers (if required)
- ☐ Additional logistic support (if required)

B. ACTIVITY FLOWS AND BREAKDOWN LISTS - DAY ONE

- [ ] **DAY ONE REGISTRATION - *20 mins***
  - [ ] Names, contact details, attendance lists (registration book)
  - [ ] Stationeries kit

- [ ] **INTRODUCTION PRESENTATION - *40 mins***
  - [ ] Introduction to MERCY Malaysia - 5 mins
  - [ ] Introduction to BRC - theoretical framework and contextual positioning (local disaster background and contextual appraisal, DRR, TDRM, HFA, SFDRR, others) - 15 mins
  - [ ] Introduction to RHI - 15 mins
  - [ ] Distribution of scorecard questionnaire - 5 mins

- [ ] **REFRESHMENT BREAK - *15 mins***

- [ ] **WORKSHOP SESSION 1 (CLASSROOM) - *60 mins***
  - [ ] Self introduction (in group) - 10 mins
  - [ ] Discussion on resilience and context (in group) - 20 mins
  - [ ] Participatory mapping exercise (venn diagram and hazard timeline) - 30 mins

- [ ] **WORKSHOP SESSION 2 (CLASSROOM) - *60 mins***
  - [ ] Group discussion on mapping (with facilitator) - 10 mins
  - [ ] Group presentation on mapping - 40 mins
  - [ ] Summary and briefing for Workshop Session 3 - 10 mins

- [ ] **LUNCH BREAK - *60 mins***
  - [ ] Lunch - 45 mins
  - [ ] Prayer - 15 mins

- ☐ **WORKSHOP SESSION 3 (HOSPITAL WATCHING) -** ***120 mins***
  - ☐ Mobilization to site - 20 mins
  - ☐ On-site briefing - 10 mins
  - ☐ Hospital watching/assessment - 60 mins
  - ☐ Report back to base point - 10 mins
  - ☐ Mobilization to classroom - 20 mins

- ☐ **REFRESHMENT BREAK -** ***10 mins***

- ☐ **WORKSHOP SESSION 4 (CLASSROOM) -** ***60 mins***
  - ☐ Group discussion on Workshop Session 3 - 10 mins
  - ☐ Group presentation on field work - 40 mins
  - ☐ Summary - 10 mins

- ☐ **DAY ONE CLOSING -** ***60 mins***
  - ☐ Submission of scorecard questionnaire - 5 mins
  - ☐ Closing remarks - 5 mins
  - ☐ Briefing for day two - 10 mins

C. DEBRIEFING - DAY ONE (ONLY FOR TRAINERS)

- ☐ **DAY ONE ACTIVITIES REVIEW**
  - ☐ Project director/project head to conduct debriefing meeting with all BRC trainers
  - ☐ Project officer to analyze and summarized Scorecard data
  - ☐ Review on Workshop Sessions
  - ☐ Update HQ (webmaster) with latest activities' photographs and videos with captions for social media updates
  - ☐ Day Two movement and logistics planning

D. ACTIVITY FLOWS AND BREAKDOWN LISTS - DAY TWO

- ☐ **DAY TWO REGISTRATION - *20 mins***
  - ☐ Attendance lists (registration book)
  - ☐ Breakfast

- ☐ **REFRESHER SESSION - *40 mins***
  - ☐ Refresher presentation - 20 mins
  - ☐ Scorecard evaluation and discussion - 20 mins

- ☐ **WORKSHOP SESSION 5 (CLASSROOM) - *90 mins***
  - ☐ Simulation exercise - 45 mins
  - ☐ Group presentation on simulation exercise outputs - 45 mins

- ☐ **DAY TWO CLOSING - *60 mins***
  - ☐ Summary of BRC program - 30 mins
  - ☐ Closing remarks - 10 mins
  - ☐ Closing ceremony - 20 mins

E. DEBRIEFING - DAY TWO (ONLY FOR TRAINERS)

- ☐ **DAY TWO ACTIVITIES REVIEW**
  - ☐ Project director/project head to conduct debriefing meeting with all BRC trainers
  - ☐ Review on Workshop Sessions

- ☐ **BRC RHI WORKSHOP REPORT PREPARATION**
  - ☐ Data and workshop outputs compilation - prepare for report
  - ☐ Compile and select photographs and videos for record
  - ☐ Set dateline for all trainers to submit report/ photos/ recommendations/ inputs, etc.

Workshop Facilitation

As the RHI programs are practical training modules, facilitators are advised to pay a lot of attention to exercises. Facilitators alsoneed to allow sufficient time for participants to think and discuss critically. Facilitators are expected to be prepared by mastering the module content, its theories and case studies of best practices. It is also crucial that facilitators do not set the exercise and leave participants to their own devises. Facilitators need to move between groups, checking their progress, stimulate discussions and providing guidance.

A. ROLE OF THE FACILITATOR

- ☐ Ensure the more verbose do not take over, and encourage contributions, particularly from those who are introvert
- ☐ Devise non-aggressive, friendly ways to deal with difficult participants. For example with those who are over talkative, over argumentative, refusing to engage with the course proceedings, etc.
- ☐ Control conflict by stepping in if necessary to help participants learn how to deal with conflict positively
- ☐ From time to time, get the participants to summarise what has been discussed; perhaps pose a question or make a suggestion
- ☐ Assist 'weaker' participants by rephrasing their arguments
- ☐ Ensure individuals receive positive feedback from the group
- ☐ Provide feedback to the group as a whole as to its performance
- ☐ Provide information and resources for the group to function well
- ☐ Ensure that the discussion is brought to a close when the topic had achieved its intended learning outcomes or at the end of the allotted time

B. TEACHING AND LEARNING RESOURCES

- ☐ Engage attention and interest
- ☐ Reinforce key aspects of the subject matter
- ☐ Act as a focal point for learner response
- Add variety to the instructional method
- Provide organized and easy to understand content

C. INSTRUCTIONAL METHODS

- ☐ Core instructional methods:
  - ☐ Lecture:
    - Most used instructional method
  - ☐ Group Activities:
    - Cooperative learning method
  - ☐ Demonstration:
    - Effective method of teaching skills at all levels
- ☐ Supporting instructional methods:
  - ☐ Questioning (brainstorming)
  - ☐ Discussion
  - ☐ Case studies
  - ☐ Simulation exercise (role-play)
  - ☐ Field trip

- ☐ Tips for effective power-point based instructional methods:
  - ☐ Create a simple design template
  - ☐ Use appropriate font and size
  - ☐ Use good quality images
  - ☐ Avoid too many special effects
  - ☐ Limit the number of slides

Action Plan Recommendation

Upon completion of the workshop, an action plan shall be recommended for further execution. An action plan is compiled for a certain period, to be determined upon detail planning, and is presented by the domains of the development plan according to their development objectives. This section outlines the basic criteria in developing an action plan.

A. BASIS

- ☐ Planned activities for achieving the objective(s)
- ☐ Executors
- ☐ Deadline (when the activity ends)
- ☐ Resources (budget for the project/unit, necessity for additional funding, potential sources)
- ☐ Relation to RHI key indicators (i.e. which key indicator is used to assess the results of the activity)
- ☐ A specific indicator may be added to make the results more explicit and contextual

B. CRITERIAS

The action plan for the RHI initiative should meet several criteria. Is the action plan:

- ☐ **Complete?** Does it list all the action steps or changes to be sought in all relevant parts of the community?
- ☐ **Clear?** Is it apparent who will do what by when?
- ☐ **Current?** Does the action plan reflect the current work? Does it anticipate newly emerging opportunities and barriers?

ACTION PLAN IMPLEMENTATION PROPOSAL

Date: Country:			
Project name	BUILDING RESILIENT COMMUNITIES (BRC) – RESILIENT HEALTH INFRASTRUCTURE (RHI)		
Project brief			
Project location			
Project description			
Project justification			
Previous experience of the organization			
Project activities			
General objectives			
Goals			
Estimated result of the project			
Risk and assumptions			
Number of beneficiaries and description		Resources required (BRC team, SMEs, other support team)	
Project's duration		Relation to Sendai Framework for DRR (SFDRR)	
Implementing party and partners			
Project budget			
Detail budget			
Monitoring and evaluation procedures		Relation to Sustainable Development Goals (SDG)	
Timeline			
Contact information			

Action plan proposal template as guideline

Project Report Preparation

Upon completion of the workshop, a project report submission is compulsory. The content of the report shall include the following:

A. INTRODUCTION

- Project background
- Problem statement and issues addressed
- Introduction on Building Resilient Communities (BRC) and Resilient Health Infrastructure (RHI)
- Methodology

B. PROGRAM (SESSIONS AND ACTIVITIES)

- Introduction to Disaster Risk Reduction (DRR) and BRC
- Introduction to Resilient Health Infrastructure (RHI)
- Resilience mapping in hospital/clinic - venn diagram, hazard timeline and experience sharing
- Hospital watching exercise
- Presentation and discussion on hospital watching - hazard, vulnerability and capacity assessments
- Disaster simulation exercise
- Group presentation and recommended outputs

C. SCORECARD RESULT

D. RECOMMENDATIONS

E. APPENDIXES

- Resilient hospital/clinic framework
- Disaster action plan
- Drawings (i.e. site plan, floor plans, emergency plan diagrams, etc.)
- List of participants
- Others

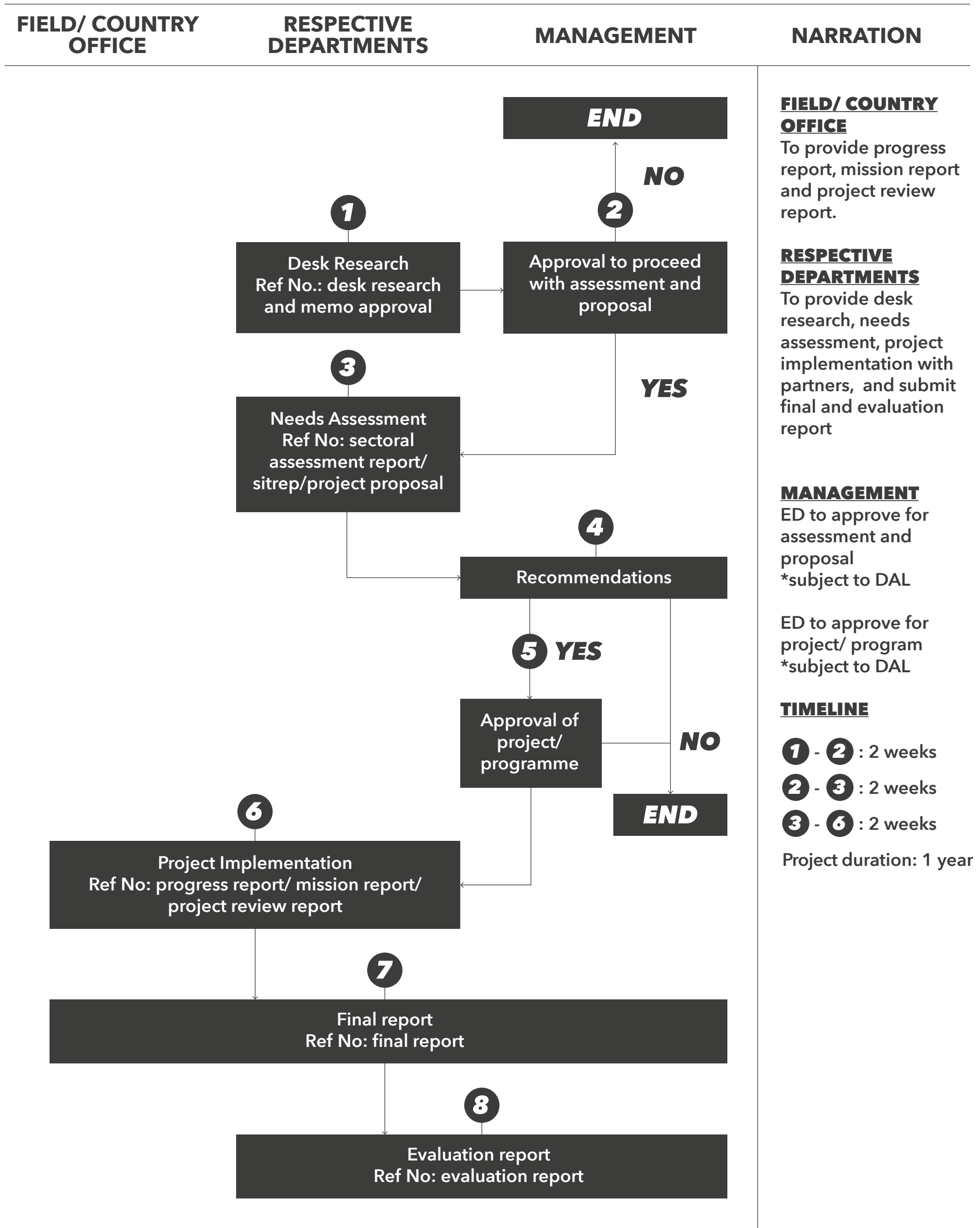
Project Report Submission

The project report shall be printed (minimum 6 copies) and submitted to the following:

1. Project beneficiary (2 copies)
2. Project sponsor (1 copy)
3. Executive Director (1 copy)
4. Head of Project, for archiving (1 copy)
5. Humanitarian Development Centre (1 copy)

Below are examples of a project report:

Action Plan Implementation Process Flow



Action plan implementation proposal process flow

FIELD/ COUNTRY OFFICE	RESPECTIVE DEPARTMENTS	MANAGEMENT	NARRATION

Project Kick-off - HAF contextualization
Ref No: LoU, MoU, meeting minutes, baseline data survey, tender document, quotation, etc.

Approved project

YES

Project Implementation
Ref No: progress report , financial report, meeting minutes, mission report, program report

Project Amendment (if any)
Ref No: memo for project amendment

Approval by ED

NO

END

Mid-term review, M&E team
Ref No: memo, revised proposal

Post Emergency & Development project/program management

Project Closure
Ref No: End of project report (include partner assessment)

YES

Project Evaluation
Ref No: evaluation report

Recommendation to extend project

NO

END

MANAGEMENT
Upon approval for project amendment, goes to project implementation

Action plan (project) implementation process flow

Action Plan Implementation Proposal

Upon submission of the project report, an action plan implementation proposal shall be submitted according to the process flow (see previous pages).

A. WHAT IS AN ACTION PLAN?

An action plan are steps to get "from here to there":

- It is a project, or part of a project
- It should be defined, developed and implemented according to good project management procedures and guidelines

An action plan shall help to:

- Define what needs to be done (action plan)
- Define how it will be done (project management plan)

B. WHAT IS PROJECT MANAGEMENT?

- Project management is the discipline of initiating, planning, executing, controlling, and closing the work of a team to achieve specific goals and meet specific success criteria at the specified time. A project is a temporary endeavor designed to produce a unique product, service or result with a defined beginning and end (usually time-constrained, and often constrained by funding or deliverable) undertaken to meet unique goals and objectives, typically to bring about beneficial change or added value.
- It is a way to develop, implement, control and deliver components of the proposed action plan. This is to be done through the preparation of a Project Management Plan (PMP), which typically consist of the following phases:

  (1) initiation; (2) planning and design; (3) execution;
  (4) monitoring and controlling; and (5) completion/closing

C. DEFINITION OF THE PROJECT MANAGEMENT PLAN (PMP)

- The Project Management Plan (PMP) is a formal, approved document used to manage project execution. The PMP documents the actions necessary to define, prepare, integrate and coordinate the various planning activities. The PMP defines how the project is executed, monitored and controlled, and closed. It is progressively elaborated by updates throughout the course of the project. The PMP is also a communication vehicle for ensuring key stakeholders share an understanding of the project.
- Components of the Project Management Plan:
  - Objectives
  - Scope
  - Milestones
  - Tasks and responsibilities
  - Schedules
  - Risk and mitigation plan
  - Budget
  - Project control
- At a minimum, a PMP should answers these basic questions about the project:
  - ***Why?*** What is the problem and/ or value proposition addressed by the project? Why is it being sponsored?
  - ***What?*** What is the work that will be performed on the project? What are the major products/deliverables?
  - ***Who?*** Who will be involved and what will be their responsibilities within the project? How will they be organized?
  - ***When?*** What is the project timeline?

Implementing The Action Plan

D. PMP PROJECT TIMELINE

NO	COMPONENTS	START DATE	FINISH DATE	SEPTEMBER				
				W1	W2	W3	W4	W1
	Component 1: Community/domestic water supply	**17-Sep-17**	**17-Oct-17**					
1	Site possession	17-Sep-17	17-Sep-17					
2	Water supply development surveys	17-Sep-17	19-Sep-17					
3	Deep well drilling	20-Sep-17	28-Sep-17					
4	Water supply pipeline laying	01-Oct-17	05-Oct-17					
5	Water points (faucets/taps) installation	08-Oct-17	10-Oct-17					
6	Installation of 3 units rainwater harvesting system	11-Oct-17	16-Oct-17					
7	Testing and commisioning	17-Oct-17	17-Oct-17					
8	Handing over	17-Oct-17	17-Oct-17					
	Component 2: Sanitation	**17-Oct-17**	**16-Nov-17**					
1	Site possession	17-Oct-17	17-Oct-17					
2	Dry pit latrines construction	18-Oct-17	26-Oct-17					
3	Ventilated improved pit latrines construction	29-Oct-17	02-Nov-17					
4	Refuse pits construction	05-Nov-17	07-Nov-17					
5	Communal latrines construction	08-Nov-17	16-Nov-17					
6	Handing over	16-Nov-17	16-Nov-17					
	Component 3: Capacity building - Community-based Resilience Development Initiative (CBRDI)	**20-Oct-17**	**27-Mar-18**					
1	Local committees trainings on water, sanitation and hygiene (WASH)	20-Oct-17	20-Dec-17					
2	WASH committee members trained on water system management	07-Nov-17	10-Jan-18					
3	Sanitation and hygiene trainings	23-Nov-17	23-Jan-18					
4	Building Resilient Communities (BRC) trainings - Community Based Disaster Risk Management (CBDRM) workshops	27-Jan-18	27-Mar-18					
	Component 4: Information base	**17-Sep-17**	**28-Feb-18**					
1	Project monitoring and project progress evaluation	17-Sep-17	28-Feb-18					
2	Updating and improvement of existing database of water points	10-Oct-17	12-Dec-17					
3	Database on rainwater harvesting points and water volume harvested	10-Oct-17	12-Dec-17					
4	Quantifying total water supply	14-Feb-18	28-Feb-18					
	Component 5: Distribution of humanitarian aid kits	**01-Mar-18**	**30-Mar-18**					
1	Distribution	01-Mar-18	30-Mar-18					
	Component 6: Project management and delivery	**17-Sep-17**	**27-Mar-18**					
1	Project director	17-Sep-17	28-Feb-18					
2	Water and sanitation specialist	17-Sep-17	16-Nov-17					
3	Project management team leader	17-Sep-17	16-Nov-17					
4	Project team	17-Sep-17	28-Feb-17					
5	Technical assistants	17-Sep-17	28-Feb-17					
6	BRC trainers	27-Jan-18	27-Mar-18					

Example of PMP's project timeline

OCTOBER			NOVEMBER				DECEMBER				JANUARY				FEBRUARY			
W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4	W1	W2	W3	W4

Project Monitoring and Evaluation

Monitoring and evaluation (M&E) is a process that helps improve performance and achieve results. Its goal is to improve current and future management of outputs, outcomes and impact. It is mainly used to assess the performance of projects being implemented and completed.

In assessing development effectiveness, monitoring and evaluation efforts aim to assess the following:

A. PROJECT RELEVANCE

Relevance of MERCY Malaysia's assistance and initiatives (strategies, policies, programs and projects designed to aid humanitarian and development gaps) to national development goals within a given national, regional or global context.

B. EFFECTIVENESS AND SUSTAINABILITY

Effectiveness of development assistance initiatives, including sustainability, value chain, partnership and financial strategies.

C. CONTRIBUTION AND VALUE PROPOSITIONS

Contribution and worth of this assistance to national development outcomes and priorities, including the material conditions of programme countries, and how this assistance visibly improves the prospects of people and their communities.

D. SUCCESS FACTORS AND SCALEABILITY

Key drivers or factors enabling successful, sustained and scaled-up development initiatives, alternative options and comparative advantages of MERCY Malaysia.

E. EFFICIENCY

Efficiency of development assistance, partnerships and coordination to control project transaction costs.

F. RISK MANAGEMENT

Risk factors and risk management strategies to ensure successful delivery to beneficiaries and effective partnerships with stakeholders.

G. IMPACT DRIVEN FOR OWNERSHIP AND CAPACITY BUILDING

Level of national and local ownership, and measures to enhance community capacity for sustainability of results.

An important goal of evaluation is to provide recommendations and lessons to the project managers and implementation teams that have worked on the projects and for the ones that will implement and work on similar projects.

The project M&E will provide opportunities for stakeholders' feedback, especially beneficiaries, to provide input into and perceptions of our work, modelling openness to criticism, and willingness to learn from experiences and to adapt to changing needs.

It als uphold accountability and compliance by demonstrating whether or not the project has been carried out as agreed and in compliance with established standards such as the Core Humanitarian Standard. For more details, please refer to the MERCY Malaysia Monitoring and Evaluation manual.

Project Delivery and Final Accounts

Upon completion and delivery of the project, final account report need to be prepared and submitted to the Head of Project. This report will form part of the project closure report. It summarize financial and auditing requirements for the project, and is required to be submitted to the project donor and MERCY Malaysia's Finance Department.

The final account report must be guided by the following fundamental principles:

A. ACCOUNTABILITY

Full accountability of all financial resources including resources internally generated from operation and those acquired externally (i.e. donations, grants, etc.).

B. TRANSPARENCY

A true and fair view of the financial position and financial performance presented by the financial statements.

Financial statements should also contain full disclosure of all material information and should be accompanied by supplementary notes to explain or qualify various accounts.

C. AUDITED

Annual project financial statements are to be audited and certified by an independent and qualified auditor as a fair presentation of the entity's financial position. This is to be done through MERCY Malaysia's Finance Department with the consent from Executive Director and Executive Council members.

Project Closure Report

A project closure report is the final report that the project team need to prepare and submit to the Head of Project. Upon verification, the Head of Project will submit this report to the Head of Department and the Executive Director.

A. WHAT IS A PROJECT CLOSURE REPORT?

A project closure report is a document which formalizes the closure of the project. The report confirms that the objectives have been met, the deliverables have been handed over to the beneficiaries, and that project closure can commence.

B. WHAT NEED TO BE INSIDE A PROJECT CLOSURE REPORT?

- A formal list of completion criteria
- Confirmation that each completion criterion has been met
- A list of outstanding project activities, risks and issues
- A set of closure actions (to hand over project deliverables / documentation, release resources and undertake closure communication)
- A request for project closure approval

C. WHAT ARE THE CONTENT OF A PROJECT CLOSURE REPORT?

- An executive summary of the project
- Background of the project
- Project objective and purpose
- Project activities and outputs
- Project results and achievements
- Lesson learnt and best practices
- Recommendations

This manual is non-exhaustive and shall be used only as a guiding principle in planning, desiging, conducting, executing action plans and closing the RHI project. It is subject to suitable amendments, depending on each project specific context and nature. This manual shall be read together with the following documents:

A. PROGRAM MODULES

Full program modules are available from the BRC project team and HDC unit. The program module set consist of the following modules:

- Introduction to BRC and DRR
- Introduction to RHI
- Venn diagram and hazard timeline
- Hospital watching and hazard, vulnerability and capacity assesment
- Resilience scorecard and questionnaire
- Disaster simulation exercise

B. PROJECT LOGFRAME

Available from BRC project team.

C. MONITORING AND EVALUATION (M&E) MANUAL

Available from M&E Department.

D. FINANCIAL MANUAL

Available from Finance Department.

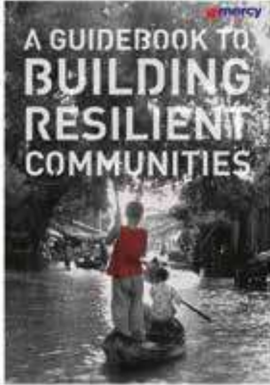
E. BRAND MANUAL

Available from Communications and Fundraising Department.

F. CODE OF CONDUCT

Available from M&E Department and MERCY Malaysia's website.

For more information on MERCY Malaysia's Building Resilient Communities (BRC) initiative, a guidebook is available from the BRC project team.



For more information on MERCY Malaysia, an organization brochure is available from the HQ and can be made available upon request.

Please visit MERCY Malaysia's website (mercy.org.my) and social media platforms for more information.

facebook.com/MERCY Malaysia

twitter.com/MERCY Malaysia

youtube.com/MERCY Malaysia

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