Accountability Reporting on MERCY Malaysia's Covid-19 Response and Recovery Projects

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Also, a note of gratitude is due to the senior management of MERCY Malaysia who ensured the team had all the necessary resources and support for the preparation of this report.

Members of the Accountability Reporting team which comprises an independent consultant and two staff representatives of MERCY Malaysia assume responsibility for all opinions, recommendations and any unintended errors that may appear in this report.

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Table of Contents

Acknowledgements 2
Accountability Reporting Team Composition 5
List of Abbreviations 6
Executive Summary 7

1. Background and Context 11

2. Overview of MERCY's Covid-19 Response (April 2020 – December 2021) 13

3. Accountability Report: Purpose, Scope, and Methodology 14

3.1 Purpose and Scope 14
3.2 Methodology 15

4. Findings Against CHS Commitments and Sphere Standards 19

Commitment 1: Humanitarian Response Is Appropriate and Relevant 20
Commitment 2: Humanitarian Response is Effective and Timely 24
Commitment 3: Humanitarian Response Strengthens Local Capacities and Avoids Negative Effects 28
Commitment 4: Humanitarian Response Is Based on Communication, Participation and Feedback 31
Commitment 5: Complaints are Welcomed and Addressed 34
Commitment 6: Humanitarian Response is Coordinated and Complementary 37
Commitment 7: Humanitarian Actors Continuously Learn and Improve 41
Commitment 8: Staff are Supported to Do Their Job Effectively and Are Treated Fairly and Equitably 44
Commitment 9: Resources Are Managed and Used Responsibly for Their Intended Purposes 49

5. Lessons Identified 52

6. Overall Conclusions 54

6.1 Relevance 54
6.2 Coherence 55
6.3 Effectiveness 56
6.4 Efficiency 57
6.5 Sustainability 58

7. Recommendations 59

7.1 Broad Recommendations 59
7.2 Specific Recommendations CHW Commitments-Wise 60

8. Annex 66

Annex 1: List of Documents Reviewed 66
Annex 2: Findings According to the Sphere Standards for Health Action 67
Annex 3: Findings According to the Sphere Standards for Mental Health 72
Annex 4: Findings Against Sphere Standards for Food Security and Nutrition 76
Annex 5: Findings Against Sphere Standards for WASH 79

Medical

Accountability Reporting Team Composition

The Accountability Reporting team consisted of three members: an independent consultant and two of MERCY Malaysia's Monitoring, Evaluation, Accountability and Learning (MEAL) staff members. The two MEAL staff members were added to the team with an intent to enhance their capacity in accountability reporting and tools.

Ms Uma Narayanan specializes in evaluation, human resources, organisational development, and accountability for medium to large-scale organizations in the humanitarian sector. Ms. Narayanan has a background in International Organizational and Systems Development and worked as an Organization Development and Human Resources (HR) practitioner mostly in Southeast Asia and South Asia, for more than a decade. In her evaluation capacity, she has carried out numerous assignments on program reviews, evaluations and organizational assessments. Overall, she has conducted over 2000 interviews (face to face and virtual) with and without translators. Ms. Narayanan is committed to quality and accountability and is a Sphere and Core Humanitarian Standard (CHS) trainer and advisor. She assists organisations to conduct HR and Sexual Exploitation and Abuse (SEA) related investigations. As the team leader of the Accountability Reporting, she was responsible for the overall process, data collection, data analysis and reporting. She was responsible to build capacity of the two MM's team members in accountability reporting.

Ms Normaliza Mohd Nasir has been with MERCY Malaysia (MM) since 2016 and is the Senior MEAL Officer. She also supports the Strategic Planning and Development Department in MERCY's annual and strategic planning process. In her MEAL capacity she oversees compliance and corporate governance in the Head Office, field offices and country offices where MERCY has a presence. She was recently appointed as one of the Sphere Governing Board Members, the youngest among others with the responsibilities to oversees the formulation and implementation of strategies, policy decisions and activities of Sphere. Ms Normaliza was previously assigned to UNHCR Malaysia from 2009 to 2013, then to Yayasan Sejahtera from 2014 to 2016. From 2018 to 2019, she managed a MERCY Malaysia Comprehensive Primary Healthcare Centre (CPHCC) in Cox's Bazar, Bangladesh in collaboration with COAST Trust and Dhaka Community Hospital (DCH) Trust. As a member of the Accountability Reporting team, she supported in data collection, interviews, data analysis and input to the report.

Ms Hajar Marnisya Zulkifly is an officer with the MEAL Unit and Strategic Development and Planning Department in MM. She has been in this role for almost three years. In her MEAL role, she primarily focuses on data collection, data analysis, humanitarian accountability proficiency (including CHS) and M&E reporting for programs. She supports the Strategic Development and Planning Department in annual planning. As a member of the Accountability Reporting team, she supported in data collection, scheduling interviews and field visits, data analysis and input to the report. She took part in most of the interviews and led a few interviews. She carried out desk review of the Covid-19 situation during the Covid-19 response, specifically on the conditions of the hospitals supported by MM.

List of Abbreviations

ATM Angkatan Tentera Malaysia (Malaysian Armed Forces)

CHE Continuous Humanitarian Education

CLC The Children Learning Centre

CPRC National Crisis Preparedness and Response Centre

CRM Complaint Response Mechanism

DRR Disaster Risk Reductions

EMT Emergency Medical Training

EXCO Executive Committee

HFA Hyogo Framework for Action

HFNC High Flow Nasal Cannula

HKL Hospital Kuala Lumpur

HQ Headquarters

HTAR Hospital Tuanku Ampuan Rahimah

HWK Hand Washing Kiosks

IDEP International Day for the Eradication of Poverty

IEC Information, Education and Communication

IMARET IMAM Response and Relief Team

INGO International Non-Governmental Organization

JKM Jabatan Kebajikan Malaysia (National Welfare Society)

KL Kuala Lumpur

PERTIS Persatuan Orang-orang Cacat Penglihatan Islam Malaysia

MCO Movement Control Order

MCOH MERCY Covid-19 Operation Hub

MEAL Monitoring, Evaluation, Accountability and Learning

MHPSS Mental Health and Psychosocial Support

MM MERCY Malaysia

MoH Ministry of Health

MRA Malaysian Relief Agency

MTCP Malaysian Technical Cooperation Programme

NADMA National Agency for Disaster Management

NGO Non-Governmental Organization

OECD/DAC Organization for Economic Co-operation and Development Assistance Committee

PFA Psychological First Aid

PPE Personal Protective Equipment

PSEA Prevention of Sexual Exploitation and Abuse

QFFD Qatar Fund for Development

RMAF Royal Malaysian Air Force

SIRIM Standard and Industrial Research Institute of Malaysia

SOP Standard Operating Procedure

TDRM Total Disaster Risk Management

UNHRD United Nations Humanitarian Response Depot

VIP Volunteer Induction Programme

WASH Water, Sanitation and Hygiene

WFP World Food Programme

Executive Summary

Overview

Like other countries around the world, Malaysia too has not been spared the tragic and devastating impact of Covid-19. More than 29,400 people in the country have died to date from the illness. Hundreds of thousands more have suffered, and continue to suffer, from morbidities associated with it. The Ministry of Health (MoH) has spearheaded the government's Covid-19 Response, along with various government agencies and non-governmental organisations (NGOs). MM was among the key NGOs that was involved to support the government's efforts to mitigate the effects of the pandemic.

Costing RM 63.2 million, MM's Covid-19 Response combined strategic initiatives with a range of projects aimed at helping MoH to reduce mortality and morbidity that arose from Covid-19 among affected populations in the country.

This Accountability Report is an evaluation of MM's Covid-19 Response for the period of March 2020 – December 2021, which coincided with the most critical phase of the pandemic in the country. Using an accountability lens, it assessed MM's Covid-19 Response against international humanitarian response principles and standards. MM's Covid-19 Response are measured against first, the Core Humanitarian Standard (CHS) which outlines the broad principles of humanitarian response in a disaster or crisis. Second, MM's efforts are evaluated according to the Sphere Standards which describes the minimum standards of key sectors in a humanitarian response.

In doing so, the accountability level and quality of MM's Covid-19 Response is evaluated based on the fundamental humanitarian principle of whether it enabled people affected by Covid-19 the right to live with dignity and the right to receive humanitarian assistance.

A joint evaluation, this Accountability Reporting was prepared by a team comprising an independent consultant and two staff representatives of MM.

An evidence-based approach comprised a mix of quantitative and qualitative data such as desk review, online surveys, field visits, focus group discussions (FGDs) and a validation workshop informed this report.

Executive Summary

Performance against Core Humanitarian Standard (CHS)

Measured against the nine core commitments outlined in the CHS and Sphere Standards for international humanitarian response standards, this report concludes that overall, MM's Covid-19 Response demonstrated a high degree of accountability and a high level of quality towards affected populations. It achieved high performance in four commitments, average performance in four commitments and poor performance in one commitment as listed below:

COMMITMENT	PERFORMANCE
C1: Humanitarian response is appropriate and relevant	**High**
C2: Humanitarian response is effective and timely	**High**
C3: Humanitarian response strengthens local capacities and avoids negative effects	**High**
C4: Humanitarian response is based communication, participation, and feedback	**Average**
C5: Complaints are welcomed and addressed	**Poor**
C6: Humanitarian response is coordinated and complementary	**High**
C7: Humanitarian actors continuously learn and improve	**Average**
C8: Staff are supported to do their job effectively, and are treated fairly and equitably	**Average**
C9: Resources are managed used responsibly for their intended purpose	**Average**

Executive Summary

9 Conclusions

The Accountability Reporting makes the following overall conclusions on the relevance, coherence, effectiveness, efficiency, and sustainability of MM's Covid-19 Response.

Relevance	The Covid-19 Response from March 2020 – December 2021 was highly relevant to fulfilling MM's mandate and mission. While some challenges have been faced by MM during implementation, substantial learning has also been generated that can be used for future humanitarian response, locally or internationally.
Coherence	MM consciously adopted an approach to ensure coherence with key stakeholders whereby the Covid-19 Response complemented and significantly contributed towards the National Covid-19 Preparedness Plan. There was strong compatibility and complementarity with national and local authorities in the country, UN agencies, INGOs, NGOs and the private sector, which resulted in new partnerships and increased visibility for MM. However, the links between the various components of the Covid-19 Response was tenuous.
Effectiveness	MM's response was based on a comprehensive TDRM (Total Disaster Risk Management) model that was effective and timely in reducing and preventing further transmission of Covid-19 to others. It showed significant achievement of results in most areas of the Covid-19 Response, while the effectiveness could have been improved with continuous needs assessment and feedback system.
Efficiency	The Covid-19 Response was designed and implemented to ensure efficient use of resources, balancing quality, cost, and timeliness of each phase of the response. Funds, human resources, and material resources were adequate to provide a timely and effective response. Nonetheless, further investment in human resources and internal systems are required to maintain and increase efficiency.
Sustainability	The design of the Covid-19 Response to ensure sustainability in reducing and preventing further transmission of Covid-19 is showing lasting benefits in some areas.

Executive Summary

Recommendations

Matched against the nine specific core commitments of humanitarian response outlined in the CHS and the Technical Standards in the Sphere Standards, MM's Covid-19 Response has generally met these commitments. However, as always, there is room for improvement given the unprecedented scale and magnitude of the Covid-19 pandemic. Hence, the Accountability Reporting team would like to make the following eight broad recommendations for MM's management to follow up.

(The full and detailed version of these recommendations is at the end of this report).

1	Balance between quantity and quality. Train staff and volunteers on accountability tools, especially CHS and Sphere Standards to understand and demonstrate the balance between quantity and quality in a humanitarian response.
2	Demonstrate the TDRM model in practice by strengthening the linkage between the different components of the emergency response.
3	Continue to strengthen preparedness at HQ and MM Chapters and flexibility to increase MM's ability to rapidly respond without adding undue burden to its existing human resources. This includes enhancing the financial management system.
4	Develop a strategy and approach for partnership with various stakeholders.
5	Improve Monitoring, Evaluation, Accountability, and Learning (MEAL), and Reporting, particularly focusing on outcome levels.
6	Focus on enhancing effectiveness of emergency response and, in some cases, the design of response, by prioritizing needs assessment.
7	Improve feedback system, and thereby strengthen communication and participation of internal and external stakeholders.
8	Identify strategy and approach to new areas of response such as provision of relief items or food distribution and mental health support.

① Background and Context

The Covid-19 pandemic has been a global public health crisis of unprecedented scale and impact. Since the first identified case on 7 January 2020, almost no country has been spared its devastating effects, including Malaysia. Different countries and regions in the world have experienced, and have been overwhelmed, by surges in case numbers at different times. Much of the rapid spread of the pandemic has been driven by domestic and international transmissions and evolution of virus variants such as the Delta variant.

The pandemic has caused untold tragedy and disruption to the normal lives of communities around the world. A staggering number of people have lost their lives while countless others have fallen sick. Public health systems have collapsed. Livelihoods have been undermined. Humanitarian and recovery response systems have been severely challenged as never before.

Malaysia too has not escaped the adverse impact of the Covid-19 pandemic. As of 10 November 2021, with more than 2,500,000 confirmed Covid-19 cases, over 62,000 active cases, over 29,400 deaths, and more than 34 million tests, Malaysia was ranked third in the number of cases and deaths due to Covid-19 in Southeast Asia, behind Indonesia and the Philippines.

Every segment of Malaysian society has been adversely affected in one way or another by the pandemic. The marginalized and vulnerable groups including refugees have borne the worst brunt. While the impact wrought by the pandemic has been varied across different communities and regions in the country, it has, without exception, caused enormous strain to the nation's existing humanitarian response system.

Since January 2020, the medical response and preparedness to the Covid-19 outbreak in Malaysia has been overseen by the Ministry of Health (MoH), with the Director-General of Health leading the efforts. Meanwhile, as part of a broader humanitarian and emergency response, the Malaysian government together with the assistance of various non-governmental organisations (NGOs), businesses, and the support of foreign governments have introduced a range of relief programmes to address the impact of the Covid-19 pandemic in the country.

Among NGOs, MM has been in the forefront in working alongside MoH, relevant government agencies and other stakeholders to alleviate the impact of the pandemic on people's lives, health, and livelihoods.

MERCY Malaysia

MERCY Malaysia or Malaysian Medical Relief Society (MM) is a non-profit organisation focusing on providing medical relief, sustainable health related development, and risk reduction activities for vulnerable communities in both crisis and non-crisis situations. MM has a total of 52 staff (2020) and a total of 1,000 medical and non-medical volunteers[1]. Its management is led by an Executive Committee (EXCO) and supported by a Secretariat.

In 2020 MM launched its Covid-19 Pandemic Fund to support medical services and essential needs of marginalised groups in the country. It is a dedicated fund to implement MM's Covid-19 Strategic Preparedness and Response Plan for humanitarian assistance in a continuous cycle of TDRM that focuses on prevention, preparedness, response, and recovery. MM coordinates closely with key government stakeholders in providing aid assistance and deliverables related to Covid-19. These are: the Ministry of Health Malaysia (MoH), the National Crisis Preparedness and Response Centre (CPRC), and the National Agency for Disaster Management (NADMA).

While guided by its broad Covid-19 Strategic Preparedness and Response Plan, MM has also adapted its humanitarian response strategies on the ground to meet the needs of the rapidly evolving challenges posed by the pandemic.

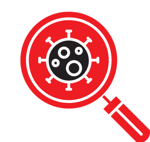
Despite risks to their own health and safety, MM staff and volunteers have responded through various ways to support the organisation's Covid-19 Response plan. At the same time, MM had to ensure its own workforce performed effectively while coping with risks to themselves and their family's health and safety.

1.
Source: MERCY Malaysia Annual Report 2020. The number of volunteers in the volunteer database (active and non-active) varies from time to time.

② Overview of MERCY's Covid-19 Response (April 2020 – December 2021)

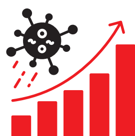
The main goals of MM's Covid-19 Response were to reduce the rate of morbidity among affected populations including refugees and provide surveillance support during the initial phase of the response and recovery. The total cost of the Covid-19 Response was RM 63.2 million.

Summary of COVID-19 Projects



Apr 20' – Jun 20'
COVID-19 Pandemic Response (Master Plan)

Jun 20' – Dec 20'
COVID-19 Pandemic Recovery Plan



Sept 20' – Feb 21'
3rd Wave COVID-19 Emergency Response

Jan 21' – Apr 21'
COVID-19 Response 2.0

Jun 21' – Dec 21'
COVID-19 Response FMCO

Figure 1: Summary of the Covid-19 Response phases.

The following components were the focus of the Covid-19 Response and recovery plan *(See Figure 1: Summary of MERCY Malaysia's Covid-19 Response)*:

- Critical preparedness, readiness, and response support actions for MoH and CPRC
- Operational supplies support and logistics
- At-risk-community's livelihood support and logistics
- Infection prevention and control
- Water, Sanitation, and Hygiene (WASH)
- Mental Health and Psychosocial Support (MHPSS)
- Risk communication and community engagement
- Information, Education, and Communication (IEC)
- Epidemics/pandemics risk reduction
- Provision of emergency response items to selected school and communities
- MERCY Covid-19 Operation Hub (MCOH)

③ Accountability Report: Purpose, Scope, and Methodology

3.1 Purpose and Scope

Report Format

This final report is divided into four main sections: Background and Context, Purpose and Methodology, Findings and Conclusions from Core Humanitarian Standard (CHS), Lessons Identified and Recommendations. The Accountability Reporting also reviewed the extent to which the Covid-19 Response Projects were adhering to the Sphere technical standards. The main findings therefore are aligned with the findings of the Covid-19 Response components against the Sphere Standards as listed in the Annex 2, Annex 3, Annex 4, and Annex 5.

Purpose and Scope

The purpose of this Accountability Reporting is twofold. First, it is to enable MM to **fulfil its accountability commitments** by providing an independent assessment of its progress in implementing the Covid-19 Response against international standards. Second, the report aims **to capture relevant learning to inform MM of potential, similar, future humanitarian responses**.

The evaluation drew evidence-based conclusions based on Organisation for Economic Cooperation and Development – Development Assistance Committee (OECD/DAC) evaluation criteria of relevance, coherence, effectiveness, and efficiency.

The Accountability Reporting process examined the degree to which MM's Covid-19 Response Projects met the CHS commitments and the relevant Sphere Standards. Findings based on the evaluation were subsequently used to understand where progress has been made and identify areas for improvement. It then used these observations to highlight the need for MM to further strengthen its policy and practice as well as internal and external accountability standards in relation to humanitarian response. The Accountability Reporting covered the period of MM's Covid-19 Response from March 2020 to December 2021.

The Core Humanitarian Standard on Quality and Accountability (CHS)[2] sets out the humanitarian sector's core commitments to people assisted by organisations. It guides organisations to take a principled and people-centred approach to the way they manage the response and adaptation to Covid-19. In this regard, the Accountability Reporting used an 'accountability lens' to reflect on how CHS commitments have informed MM's response to the pandemic.

The Accountability Reporting examined how MM has met CHS commitments during the pandemic period under study guided by the following key questions:

a. Is the response relevant and appropriate? (Commitment 1)
b. Is the response effective and timely? (Commitment 2)
c. Is the response strengthening local capacity and avoids negative effects? (Commitment 3)
d. Is the response based on feedback, participation, and communication? (Commitment 4)
e. Are complaints welcomed and addressed? (Commitment 5)
f. Is the response coordinated and complementary? (Commitment 6)
g. Is MM and partner organisations continuously learning and improving? (Commitment 7)
h. Are the staff supported to do their job effectively and treated fairly and equitably? (Commitment 8)
i. Are resources used or managed responsibly for their intended purposes? (Commitment 9)

Using the Sphere Standards[3], the Accountability Reporting also reviewed the extent to which the Covid-19 Response Projects were adhering to the technical standards and contextualisation of the response in Malaysia.

3.2 Methodology

The accountability reporting was divided into **three-phases**: inception; data collection and consultation; and reporting, as illustrated in Figure 2 below.

2.
Source: www.chsalliance.org/get-support/resource/core-humanitarian-standard/

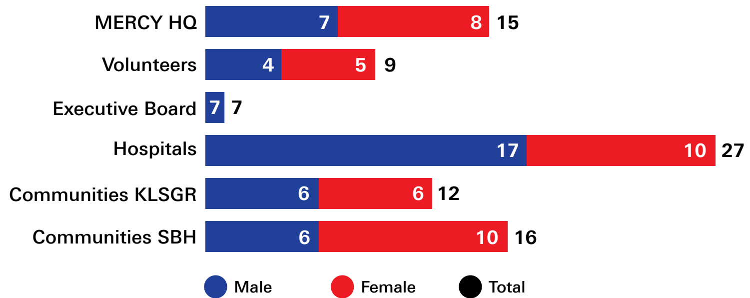
3.
Sphere Standards is based on two core principles: people affected by disaster or conflict have the right to life with dignity, and therefore the right to assistance. All possible steps should be taken to alleviate human suffering arising out of disaster or conflict. The four technical chapters in the Sphere prescribe Minimum Standards in key response sectors: Water Supply, Sanitation and Hygiene Promotion, Food Security and Nutrition, Shelter and Settlement, Health. Sphere Handbook, 2018 Edition, Switzerland.

The Accountability Reporting team employed a mixed-method approach to collect relevant qualitative and quantitative data. Data collection began during the inception phase with a desk review of pertinent documents and preliminary interviews with selected key informants.

- **The literature review** included a review of MM's policy documents, Standard Operating Procedures (SOPs), reports, reviews, updates, and project documents. The team also reviewed relevant documents from other stakeholders (Appendix 2: List of Documents Consulted).

- **Key informants** were purposively selected based on stakeholder mapping developed during the inception phase. Diverse perspectives were captured from different geographical regions, components of the Covid-19 Response, target audiences, and types of support and services received by the stakeholders. In total, 79 respondents from various stakeholder groups were consulted during the data collection phase.

Figure 3: Summary of Interviewees



- **Field Visits** were conducted by the evaluation team in Labuan, Sabah, Selangor, and Kuala Lumpur. These included visits to hospitals, communities, and schools. Criteria for the field visits were:

  - **Number of volunteers** mobilized
  - **Different levels of Covid-19 caseloads, hospitalizations, and deaths in the facilities**
  - **Engagement in activities** across the nine components (or as many components) of the Covid-19 Response. Examples of the activities are: The community has received food package, PPE, mental health support, WASH support. Or: The hospitals have received many volunteers, equipment, mental health support or setting up of test / assessment centres
  - **Level of COVID-19 impact in the states** that have received targeted support from MM
  - **Role and level of engagement with national public health authorities**
  - **Level of government engagement** and/or capacity in the Covid-19 Response
  - **Innovative practices** and **success stories** for learning, adaptation, and replication

- **Focus Group Discussions (FGDs).** A total of five FGDs were carried out with frontliners and communities. Photos below show the interviews with key informants and FGDs conducted with hospital frontliners, school student and communities (PERTIS).

Photo 1: FGD with health personnel including the team who has participated during the Labuan Field Hospital at Hospital Labuan.

Photo 2: FGD with school students from Children Learning Centre of Indonesian communities in Sabah.

Photo 3: FGD with leaders from Persatuan Orang-orang Cacat Penglihatan Islam (PERTIS) in Kuala Lumpur.

Photo 4: FGD with the Emergency Department personnel from Hospital Tengku Ampuan Rahimah (HTAR) in Klang.

Online Surveys: Data collection was also captured by two online surveys conducted among MM staff and volunteers. The surveys were based on an adapted interview guide for this evaluation. To minimise delay in response time, the surveys were designed with most of the questions to be answered in a multiple-choice format with minimal narrative.

A total of 72 staff from MM, all staff in the organisation, responded to the survey, thereby achieving a response rate of 100%. There was a low response rate from the volunteers of 1,000 as reported in the MM Annual Report 2020. The survey results were used to strengthen the evidence base and analysis in the Accountability Reporting. Data collected through the surveys helped the Accountability Reporting team to answer the Accountability Reporting guidance questions. In addition, they provided valuable input to derive a broad perspective regarding the achievements, challenges, and barriers relating to MM's Covid-19 Response.

Validation workshop: A workshop was planned with selected MM staff following circulation of this draft report in April 2023 to promote use of the Accountability Reporting results among MM management and staff. The engagement with participants of the workshop further served to validate the findings, conclusions, and recommendations in the report.

Constraints and Limitations

On top of a lack of systematised information, data on Covid-19 Response in MM was not readily available and accessible. In addition, staff turnover in MM contributed toward the constraint in access to information and data as institutional memory was not robust.

Another constraint was the low response rate of the online surveys for volunteers and frontliners. Nevertheless, the Accountability Reporting team overcame it by relying on alternative sources such as interviews, field visits, FGDs, and literature review to complement this data.

④ Findings Against CHS Commitments and Sphere Standards

Findings of the Accountability Reporting are organised according to each of the CHS commitments. MM's performance with regard to the Covid-19 Response is measured against the quality criteria of each commitment. Sphere standards are directly relevant to any public health emergency such as the COVID-19 pandemic, with WASH chapters being the most important ones. The findings below measured the extent to which MM's Covid-19 Response met the minimum health standards as stated in the Sphere Standards. The findings consider the key actions and indicators of each minimum standard. Detailed measurement of each Covid-19 Response component against Sphere Standards is available in:

Annex 2:
Findings According to the Sphere Standards for Health Action

Annex 3:
Findings According to the Sphere Standards for Mental Health

Annex 4:
Findings According to the Sphere Standards for Food Security and Nutrition

Annex 5:
Findings According to the Sphere Standards for Hygiene Promotion

The achievement of commitments are rated as high, average or poor.

HIGH PERFORMANCE indicates the response has carried out all the key actions and fulfills majority of the performance indicators of the commitment.

AVERAGE PERFORMANCE indicates the response has carried out some of the key actions and fulfilled some of the performance indicators of the commitment.

POOR PERFORMANCE indicates the response has carried out minimal key actions and failed to fulfill performance indicators.

Commitment 1:
Humanitarian Response Is Appropriate and Relevant

Commitment 1 stresses the importance of understanding the context and needs of different populations affected by a humanitarian crisis, and how these needs might change over time. It also emphasizes the necessity to recognize the capacity of different groups of people. Further, it highlights the role of policies and processes to drive on-going assessment of needs, to provide impartial assistance, and to acknowledge gender and diversity in the response.

Commitment 1 Indicators

Key Indicators		Organizational Responsibilities	
1.1	Conduct a systematic, objective and ongoing analysis of the context and stakeholders.	1.4	Policies commit to providing impartial assistance based on the needs and capacities of communities and people affected by crisis.
1.2	Design and implement appropriate programmes based on an impartial assessment of needs and risks, and an understanding of the vulnerabilities and capacities of different groups.	1.5	Policies set out commitments which take into account the diversity of communities, including disadvantaged or marginalised people, and to collect disaggregated data.
1.3	Adapt programmes to changing needs, capacities and context.	1.6	Processes are in place to ensure an appropriate ongoing analysis of the context.

4.1.1 Initial needs assessment was conducted and used to inform Covid-19 Response planning

Based on initial assessment through literature review, World Health Organization (WHO) guidelines, consultations with MoH, and internal consultation within the organization, MM developed a comprehensive Master Plan for the Covid-19 Response[4]. The Master Plan included nine components to support MoH to address the Covid-19 challenges. Subsequent Covid-19 Response phases referred to the guidelines in the Master Plan and used it as a road map to address the challenges of the pandemic.

4.1.2 Rapid needs assessment was carried out to inform the humanitarian support

Interviews with the Programme Development and Operations (PDO) staff of MM and stakeholders affirmed that rapid needs assessment was carried out to identify the needs, risks, and capacities of affected people. The assessment was predominantly carried out using WhatsApp text messages. Given the travel restrictions and limited movement of staff to the office as well as to hospitals, interview respondents determined the use of WhatsApp as the most effective channel to identify needs. Once the needs were established and agreed upon, MM issued a donation letter (*Surat Sumbangan*)[5] to each recipient to confirm the aid and assistance.

4.1.3 Efforts were made to conduct impartial assessment and include 'at-risk' people

Interviews with communities suggest that efforts were made by MM to assess the needs of people in 'hard-to reach' locations and groups who were 'at-risk'. For example, MM rendered support to schools such as Sekolah Kebangsaan Desa Aman. Although located in city area of Kuala Lumpur, the status of the school is rural with many children from lower income groups. Another example is the identification of medical and relief items as primary needs of the Somalia Refugees Centre. In addition, members of the visually impaired community were identified as recipients of aid through the Persatuan Orang-orang Cacat Penglihatan Islam Malaysia (PERTIS). Further, stateless individuals in Sabah were supported directly or through hospitals in Sabah. Interviews with hospitals in Sabah confirmed that stateless people from rural areas in the state were more likely to engage with NGOs like MM than the public hospital authorities.

4.
Source: COVID-19 Pandemic Response, Strategic Preparedness and Response Plan, MERCY Malaysia, April 2020

5.
Source: Online copies of donation letters *(surat sumbangan)*

4.1.4 Policies exist in MM that commit to impartial assistance; however, practices do not adequately consider diversity of communities and disaggregated data

There are policies in MM that commit to impartial assistance and consider the diversity of communities. MM's values and principles clearly define the importance of impartial assistance. Relevant policies include the Gender Policy (March 2016), Partnership Policy (May 2017), Child Protection Policy (May 2017), and Protection Policy (January 2016) based on Sphere Protection Principle.

Disaggregated data, however, is not evident in the needs assessment. For example, older people and people with disabilities and chronic diseases face further risks and consequences, anxieties, and a threat to their autonomy during a crisis. There is no disaggregated data to show how the needs of such vulnerable were supported during MM's Covid-19 Response. There is actual data available of support provided to the beneficiaries which indicate that various vulnerable groups were targeted.

4.1.5 Processes and practices are not in place to ensure ongoing analysis of context and adaptation of Covid-19 Response

Desk review and interviews with staff and field visits confirmed there was an absence of ongoing analysis of the specific context that was carried out systematically and periodically during the Covid-19 Response. The lack of an ongoing analysis has resulted in a gap to 'redesign or improve' the implementation of a few components in MM's Covid-19 Response. For example, refugee communities stated that instant noodles in the relief items were unsuitable for them, and they would have preferred food items that were more appropriate to their culture. All respondents who received relief items stated that the quantity was insufficient both in terms of the duration and the number of food packs to cover the number of beneficiaries in the location[6].

Due to a lack of ongoing analysis, it was not possible to increase the distributed items, adjust the content of the delivery items or inform the recipients the reasons for a one-off distribution. Similarly, the hotline for the stateless communities, especially school children, was not effective as the children were apprehensive about calling the hotline. Meanwhile, the stateless community in Sabah was not accustomed to psychosocial support.

Staff of hospitals who were interviewed, especially Hospital Kuala Lumpur (HKL), also stated that there was inadequate ongoing analysis of the needs and context resulting in aid that was not relevant to Covid-19 needs. Nevertheless, the needs assessment challenges should be viewed in the context of pandemic restrictions and bureaucracy within MoH and hospitals. Interviewees in hospitals stated that the reasons for a lack of comprehensive and on-going needs assessment were due to their own fear of 'by-passing' the chain of command. MoH policy stipulated that any request for needs assessment had to go through the ministry. Furthermore, hospitals were unclear of MM's own capacity to provide aid and support. (See section on Sphere Technical Chapters for further detail).

6. MERCY Malaysia has a list of core items in the food pack and instant noodles was not in the list. However, due to request from the community, PDO decided to include instant noodles in the food pack.

Commitment 1: Conclusion

The Accountability Reporting concludes that MM's performance on Commitment 1 is high, with a few areas for improvement.

The indicators for Commitment 1 can be broken down into three main areas: the existence of policies; information collection and analysis; and the use of information in the design and implementation of the Covid-19 Response.

Overall, communities and people affected by Covid-19 received assistance appropriate to their needs from MM during the Covid-19 Response. The purpose of the Covid-19 Response was fulfilled as it alleviated the hardships and suffering of affected people, upheld their right to assistance and ensured their dignity as human beings.

Accountability Reporting findings suggest that policies, practices, SOPs, and procedures for needs assessment, stakeholder analysis and context analysis exist.

One area that requires further improvement, however, is the consistent application of SOPs and practices throughout the response period. Rapid needs assessment was carried out successfully to ensure relevance of the Covid-19 Response. But there were challenges to obtain information based on the specific needs of marginalised people, and particularly on how needs change over time which affected the improvement of the response.

Commitment 2:
Humanitarian Response is Effective and Timely

Commitment 2 relates to how good an intervention is and the need for systems and structures that ensure effective systems, timely, evidence-based decision-making and adequate geographical coverage of both assistance and protection needs. It recognizes the challenges that are often faced in terms of access, security, funding, logistics, agency and donor priorities and capacity. At the same time, the commitment requires the humanitarian community acting together to find ways to overcome the challenges so that a comprehensive response to people's needs can be provided.

See Sphere Standards for effectiveness of the Covid-19 Response components.

Commitment 2 Indicators

Key Indicators	Organizational Responsibilities
2.1 Design programmes that address constraints so that the proposed action is realistic and safe for communities.	2.6 Programme commitments are in line with organisational capacities.
2.2 Deliver humanitarian response in a timely manner, making decisions and acting without unnecessary delay.	2.7 Policy commitments ensure: a. systematic, objective and ongoing monitoring and evaluation of activities and their effects; b. evidence from monitoring and evaluations is used to adapt and improve programmes; and c. timely decision-making with resources allocated accordingly.
2.3 Refer any unmet needs to those organisations with the relevant technical expertise and mandate, or advocate for those needs to be addressed.	
2.4 Use relevant technical standards and good practice employed across the humanitarian sector to plan and assess programmes.	
2.5 Monitor the activities, outputs and outcomes of humanitarian responses in order to adapt programmes and address poor performance.	

4.2.1 Covid-19 Response was delivered in a timely manner

Interviews with staff, volunteers, hospital authorities and communities evidenced that the response was timely, despite the challenges faced in travel restrictions and delays in procurement. All communities interviewed affirmed that MM was one of the first agencies to deliver food packs and hygiene kits. Interviewees from schools visited in Sabah confirmed that hygiene kits were received at the right time. Hospitals in Labuan, Tuaran and Hospital Tengku Ampuan Rahimah (HTAR) in Klang confirmed that the Emergency Medical Team (EMT) was deployed in a timely manner. The field hospitals were set up at a crucial time when the hospitals needed support *(See List of Abbreviations Annex 2: Findings According to the Sphere Standards for Health Action)*

4.2.2 Delay in service delivery resulted in changing needs

Under the Covid Response, HKL received hospital expansion support for the Covid-19 patients worth 4.8 million ringgit. Interview with HKL respondents suggested that the support for the expansion was delayed. By the time the hospital expansion was completed, the need was no longer relevant. Instead, the expansion in the hospital facility was used for diabetic patients instead of Covid-19.

4.2.3 Relevant standards were used to plan and implement response

The quality of service and assistance of the Covid-19 Response rendered by MM largely complied with international humanitarian and WHO standards. Interviews and field visits affirmed that MM provided high quality products and equipment, which were superior to many other donations the recipients received. Some examples of high-quality products cited were Personal Protective Equipment (PPE), hospital equipment, food packs, and hygiene kits. Hospital equipment was compatible with the needs and use of the hospitals. On the downside, one of the relief distributions that was not of sufficient quality was tents[7]. According to interviewees from Tuaran Hospital, the tents tended to get blown away by strong winds. Furthermore, after the pandemic, the hospital had challenges in storing the tents.

7.
The type of tent received by Hospital Tuaran during Covid-19 was 1 unit of canopy tent of size 20x20 and 2 units of canopy tent of size 15x20.

4.2.4 Capacity of volunteers, especially non-medical volunteers was sufficient to support Covid-19 Response

The Covid-19 Response enabled MM to mobilize and reignite its volunteer base, especially non-medical volunteers. New volunteers were on-boarded and orientated through the online Volunteer Induction Programme (VIP). Interviews and observations of Sabah volunteers noted that they were highly motivated and agile to support the response in Sabah. One of the factors that ensured effective management of volunteers was strong leadership demonstrated by relevant MM staff, with clear direction on the goals and purpose of the Covid-19 Response in Sabah.

On the other hand, there was a shortage of medical volunteers for immediate deployment. Some of the doctors who were hired on a contract-basis with MoH were unable to 'break their service' to be part of MM's deployment, even if the deployment was only for two weeks. Moreover, MoH was paying doctors approximately a daily fee of RM150.00 to RM200.00 while MM utilized their services on an unpaid, voluntary basis. The shortage negatively impacted the objective of building capacity of the hospitals and frontliners.

4.2.5 Policy commitment ensured timely decision-making with resources allocated accordingly

During the Covid-19 Response, numerous internal changes were made to support timely decision- making and allocation of resources. These changes were discussed during regular internal coordination meetings[8] and external coordination meetings.

4.2.6 Covid-19 Response commitments were not fully aligned with organizational capacity

MM successfully increased its financial capacity at a significant level during the pandemic period. Financial support received were mainly from public and private donors in Malaysia. Enlarged financial support allowed MM to design a comprehensive response with wide outreach in Malaysia. The additional funds were used mainly for direct implementation of the Covid-19 Response. They were not used to cover the core costs of MM. Many vacant staff positions were not filled quickly due to lack of funding for Human Resources (HR) functions. Hence, organizational capacity[9], specifically human resources at MM's HQ, was inadequate to support the Covid-19 Response.

In the early stage of the Covid-19 Response, the procurement department and emergency response team were under-staffed. Existing staff had to work long hours and be on standby throughout the week. Inadequate number of staff and medical volunteers resulted in the inability of MM to respond effectively and access resources at inter-state levels. Requests by hospitals for additional human resource support from MM was not fulfilled due to the lack of medical volunteers. In addition, interviews with MM staff suggested that it was a challenge to prioritize their work due to competing priorities, including requests from MM's EXCO.

Capacity constraint was however somewhat mitigated in the later part of the Covid-19 Response by hiring of staff on a contract basis to support existing teams.

8. Source: MM internal coordination meeting minutes.

9. Organisational capacity typically focuses on governance and institutional capacities, programmatic response capacity, co-ordination and partnership capacity, human resources and financial capacity.

4.2.7 MM's systems and processes were inadequate to efficiently meet the needs of Covid-19 Response

Interviews with staff and review of MM's system, policies and procedures indicated they were inadequate to meet the emerging needs of the Covid-19 Response. In particular, there was limited financial management capacity to manage financial requirements and flow of funds for the Covid-19 Response. For instance, there was non-existence of MEAL function[10] until mid- 2021. Moreover, the role, purpose and focus of MEAL was unclear pre-post Covid Response.

Also, HR functions in emergency situations were not fully mobilized in MM. Knowledge management systems and practices were inadequate. Formal records and data of the Covid-19 Response were not easily found. Most of the data available were at output level, with limited outcome level information. Recipients of MM support, from small to big, were not expected to demonstrate accountability to MM.

Finally, the evaluation team did not find any evidence of progress reports or updates, or utilization report of equipment received. The hospitals confirmed there was no follow up and requirements to formally update to MM.

10. Monitoring, Evaluation, Accountability and Learning (MEAL) function typically is responsible for planning, monitoring, evaluation, reporting and accountability.

Commitment 2: Conclusion

The Accountability Reporting concludes that MM's performance on Commitment 2 was high, with a few areas for improvement.

MM's Covid-19 Response was timely and effective and adhered to minimum Sphere Standards in most aspects. Frontliners who were the primary recipient of aid and assistance, along with the affected communities, considered the timing of the assistance and protection they had received as adequate, except in a few instances. Frontliners and affected population considered their needs met, in most cases. The quality of aid and assistance was considered high and consistent throughout the Covid-19 Response, except in minor cases.

MM worked closely with a wide range of partners to provide comprehensive assistance and protection to frontliners and the affected population. MM had a wide outreach in Malaysia, to effectively cover remote areas and marginalized communities that were often not reached by others.

While MM's Covid-19 Response was overall timely and effective, it is noted that MM's systems, processes and practices were not sufficiently revised and updated to support effective implementation of the response. MM lacked the capacity to monitor the activities, outputs, and outcomes of the Covid-19 Response to adapt preparedness and address poor performance.

At the same time, it is acknowledged that the constraints in capacity did not significantly affect the success and effectiveness of MM's overall Covid Response.

Commitment 3:
Humanitarian Response Strengthens Local Capacities and Avoids Negative Effects

This commitment recognises the need to acknowledge and build on local and national capacity in response to disasters. Badly planned and executed responses that do not properly understand the context, or work alongside local organisations or consider potential risks, can cause more harm than good. Both programme interventions and organisational policies should seek to mitigate the unintended negative consequences of aid.

Commitment 3 Indicators

Key Indicators	
3.1	Ensure programmes build on local capacities and work towards improving the resilience of communities and people affected by crisis.
3.2	Use the results of any existing community hazard and risk assessments and preparedness plans to guide activities.
3.3	Enable the development of local leadership and organisations in their capacity as first-responders in the event of future crises, taking steps to ensure that marginalised and disadvantaged groups are appropriately represented.
3.4	Plan a transition or exit strategy in the early stages of the humanitarian programme that ensures longer-term positive effects and reduces the risk of dependency.
3.5	Design and implement programmes that promote early disaster recovery and benefit the local economy.
3.6	Identify and act upon potential or actual unintended negative effects in a timely and systematic manner, including in the areas of: a. people's safety, security, dignity and rights; b. sexual exploitation and abuse by staff; c. culture, gender, and social and political relationships; d. livelihoods; e. the local economy; and f. the environment.

Organizational Responsibilities	
3.7	Policies, strategies and guidance are designed to: a. prevent programmes having any negative effects, such as, for example, exploitation, abuse or discrimination by staff against communities and people affected by crisis; and b strengthen local capacities.
3.8	Systems are in place to safeguard any personal information collected from communities and people affected by crisis that could put them at risk.

4.3.1 Covid-19 Response significantly contributed to the capacity and resilience of hospitals and front-liners

All sources indicated that MM's Covid-19 Response significantly contributed to building capacity and resilience of hospitals and frontliners. The hardware provided were particularly useful to support hospitals in management of Covid-19 caseloads. Equipment, beds, PPE were utilised fully by hospitals. In turn, hospitals were able to increase their capacity to meet future contingencies *(See Annex 2: Findings According to the Annex 2: Findings According to the Sphere Standards for Health Action).*

4.3.2 Covid-19 Response contributed towards community resilience and capacity, with minor negative effect

The support to hospitals directly contributed towards community resilience, particularly Covid-19 patients and their family members. MM's food distribution programme supported numerous B40 (lower income) groups and marginalised communities in Malaysia. A minority view stated that the aid provided caused negative effect in the community *(Refer to 4.4.3 and Annex 2: Findings According to the Sphere Standards for Health Action).*

4.3.3 Covid-19 Response was an opportunity to build MM's internal capacity and strengthen MM's position as a medical relief organization

MM's Covid-19 Response has created opportunities for the organisation to strengthen its internal capacity in various forms. They include strengthened partnerships with government authorities at all levels ranging from the Ministry of Health (MoH), public hospital authorities, and the military. MM demonstrated the ability to work efficiently with MoH as well as other partners during the pandemic. There was strong support from the local donor community, especially the private sector for MM's Covid-19 Response, which led to enhanced partnership with the private sector. Further, MM had the leverage and credibility to speak on behalf of vulnerable communities and fill the gaps of government hospitals.

MM's Covid-19 Response escalated MM's response scale and contributed to new learning in the organisation. MM has explored and delivered new programmes such as mental health services. It also had the opportunity to engage with community-based health services.

On the other hand, MM's resources were not adequately in place to respond to a large-scale emergency such as the Covid-19 Response. Much more investment was needed to enhance internal human resources (volunteer management particularly), upgrade of financial systems and procedures, increase capacity in procurement, and increase capacity in MEAL and strengthen the process of management.

Commitment 3: Conclusion

The Accountability Reporting concludes that the performance on Commitment 3 was high, with a few areas for improvement.

The Covid-19 Response strengthened local capacities and avoided major negative effects. This commitment highlights the need to acknowledge and build on local and national capacities in response to the Covid-19 pandemic and forge strong links particularly with government stakeholders. As a result of MM's support, frontliners and communities considered themselves better able to prepare and manage the effects of the pandemic. Additionally, local authorities, affected population, MM staff, MM volunteers and MM leadership found that their capacities had been increased.

In terms of areas for improvement, recipients of aid and assistance from the Covid-19 Response identified only a minor negative effect that resulted from MM's Covid-19 Response.

Commitment 4:
Humanitarian Response Is Based on Communication, Participation and Feedback

This commitment emphasises the need for the inclusive participation of crisis-affected people. This requires a willingness to allow and encourage people that receive aid to speak out and influence decisions. Information and communication are critical forms of aid, without which affected people cannot access services, make the best decisions for themselves and their communities or hold agencies to account.

Commitment 4 Indicators

Key Indicators	Organizational Responsibilities
4.1 Provide information to communities and people affected by crisis about the organisation, the principles it adheres to, how it expects its staff to behave, the programmes it is implementing and what they intend to deliver.	4.5 Policies for information-sharing are in place, and promote a culture of open communication.
4.2 Communicate in languages, formats and media that are easily understood, respectful and culturally appropriate for different members of the community, especially vulnerable and marginalised groups.	4.6 Policies are in place for engaging communities and people affected by crisis, reflecting the priorities and risks they identify in all stages of the work. External communications, including those used for fundraising purposes, are accurate, ethical and respectful, presenting communities and people affected by crisis as dignified human beings.
4.3 Ensure representation is inclusive, involving the participation and engagement of communities and people affected by crisis at all stages of the work.	
4.4 Encourage and facilitate communities and people affected by crisis to provide feedback on their level of satisfaction with the quality and effectiveness of the assistance received, paying particular attention to the gender, age and diversity of those giving feedback.	4.7 External communications, including those used for fundraising purposes, are accurate, ethical and respectful, presenting communities and people affected by crisis as dignified human beings.

4.4.1 MM is far more widely known in Malaysia now as compared to before its Covid-19 Response

The Covid-19 Response provided the opportunity for MM to be more visible and extend its presence in the whole of Malaysia, especially in far flung areas. More than 60% of external stakeholders interviewed were not aware of MM's role and purpose prior to the Covid-19 Response.

Nevertheless, although the interviewees had better knowledge of MM's work after its Covid-19 Response, they still asked basic questions[11] about MM during the interviews. It indicated that systematic, consistent communication and information-sharing about MM among the stakeholders was somewhat lacking. In addition, organised, sustained communication and systematic information- sharing about MM was much more effectively handled in Sabah and Labuan as compared to Kuala Lumpur and Selangor.

4.4.2 Limited participation and engagement of stakeholders in the Covid-19 Response design and need for further improvement

Community visits and hospital visits affirmed the limited participation among grassroots population and medical staff in hospitals in the design and delivery of the Covid-19 Response components. In fact, the interviews conducted by the Accountability Reporting evaluation team was the first ever opportunity for interviewees to provide feedback about MM and its Covid-19 Response.

4.4.3 Covid-19 Response support was not consistently communicated in languages, formats and media that are easily understood and culturally appropriate

MM was part of a hotline service to share information to the public on Covid-19. The hotline was available in two major languages; Malay and English. However, this initiative was unable to reach out to minorities or other groups that were not proficient in either language *(See Annex 3: Finding According to the Annex 3: Findings According to the Sphere Standards for Mental Health).*

An example of the gap in communication and feedback was with regard to relief distribution to stateless children. Stakeholders in two schools attended by stateless children stated that some aspects of MM's relief distribution programme were insufficient and caused problems to the community. Although the quality of the relief items was rated as high, not all the items were found to be suitable. Whereas, for the refugee community particularly, they preferred not to have instant noodles. As for the Persatuan Orang-orang Cacat Penglihatan Islam Malaysia (PERTIS), there were no instruction on the content and organization of the relief items in a format that can be understood by visually impaired persons. For instance, some of them were confused between 'flour and soap powder' as both items were placed in the same plastic bag or box.

11.
Questions such as: What services does MM offer? Has MM worked in Malaysia before? What is MM's outreach? How does MM fund itself? Who can we contact if we need more information? What is the role of MM during Covid-19 Response vis-à-vis MoH?

Overall, all communities interviewed feared any critical feedback from them to MM may lead to loss of Covid-19 relief assistance from MM or other negative repercussions. Moreover, there were also cultural reasons as to why criticism or negative feedback was not forthcoming during the delivery of relief items and services.

The evaluation team did not find any evidence of a coherent policy in MM for communication and information sharing as well as promotion of participation and listening to feedback from stakeholders. 70% of MM staff and volunteers interviewed, especially those who are new to MM, confirmed the absence of formal training and orientation on how MM should be presented to external stakeholders. In most of the cases, staff and volunteers used their own knowledge about the organization to present information on MM to stakeholders.

Access to the MM Covid-19 Response website at the time of this reporting was denied due to internal issues. Information channels for Covid-19 Response used was not available. Further, it is unclear who has access to MM's general feedback email and how the feedback was managed (info@mercy.org.my.).

Commitment 4: Conclusion

The Accountability Reporting concludes that the performance on Commitment 4 was average.

Frontliners and communities were partially aware of their rights and entitlements about MM's Covid-19 Response support. Effective and inclusive communication was indeed used in most cases. However, there were instances where communication and information-sharing were not organized, systematic and sustained. It also failed to consider cultural appropriateness and context.

At the same time, affected communities and frontliners were not fully satisfied with the opportunity for them to influence the design and implementation of the Covid-19 Response as the feedback loop was not wholly effective. Policies for information sharing and feedback loops were outdated and staff and volunteers were not formally and consistently trained to share information and communicate effectively. Thus, there was a lack of systematic engagement and representation of affected population at some stages of the Covid-19 Response.

Commitment 5:
Complaints are Welcomed and Addressed

People affected by crisis have a right to complain to an agency and receive an appropriate and timely response. Formal mechanisms for complaints are an essential component of an agency's accountability and can alert organisations to serious misconduct or failure in the response.

Commitment 5 Indicators

Key Indicators		Organizational Responsibilities	
5.1	Consult with communities and people affected by crisis on the design, implementation and monitoring of complaints-handling processes.	5.4	The complaints-handling process for communities and people affected by crisis is documented and in place. The process should cover programming, sexual exploitation and abuse, and other abuses of power.
5.2	Welcome and accept complaints, and communicate how the mechanism can be accessed and the scope of issues it can address.	4.6	An organisational culture in which complaints are taken seriously and acted upon according to defined policies and processes has been established.
5.3	Manage complaints in a timely, fair and appropriate manner that prioritises the safety of the complainant and those affected at all stages.	4.7	Communities and people affected by crisis are fully aware of the expected behaviour of humanitarian staff, including organisational commitments made on the prevention of sexual exploitation and abuse.
		4.8	Complaints that do not fall within the scope of the organisation are referred to a relevant party in a manner consistent with good practice.

4.5.1 Complaint Response Mechanism (CRM) policy is available in MM

MM's Complaint Response Mechanism (CRM) policy was developed in 2017. The CRM does provide some channels that allow feedback from affected populations and stakeholders to raise concerns. For example, communities could use MM's Facebook (FB) to raise concerns. Other channels to share feedback and complaints were coordination meetings, staff meetings, feedback box, and staff survey.

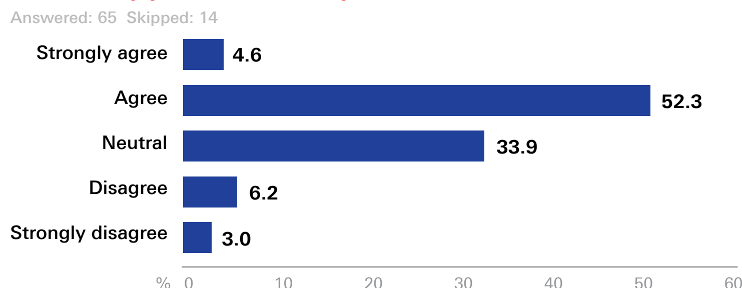
On the other hand, it is unclear if comments and messages posted on the FB were being systematically addressed and analysed. An internal CRM exists (email and complaint box); however, it is not utilized.

4.5.2 Communities were not consulted in the design, implementation, and monitoring of complaints-handling processes.

Interviews with communities, frontliners and MM staff revealed the absence of consultation on the design, implementation, and monitoring of complaint-handling processes in the different components of the Covid-19 Response. Desk review showed no evidence of resources, whether financial or human resources, being allocated to set up an effective complaint response mechanism specific to Covid-19 Response.

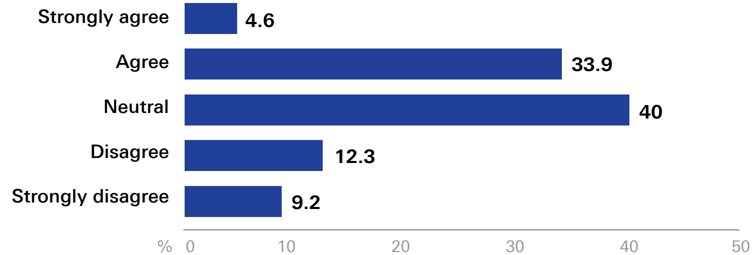
According to staff survey results, less than 50% staff agreed that MM encouraged staff to share ideas during the Covid- 19 response, whereas 44% remained neutral to this statement. A minority of staff strongly disagreed that MM encouraged staff to share ideas and opinions during the Covid-19 Response. As shown in Figure 4, more than 50% of the staff knew where to go if they had a problem or complaint while 40% remained neutral in their response. 6% of the staff disagreed and 3% of the staff strongly disagreed that they knew where to go if they had a problem or complaint.

Figure 4:
Staff survey results



Based on staff survey results shown in Figure 5 below, 12.3% disagreed and 9.2% strongly disagreed that their concerns and complaints will be addressed effectively, confidentially and in a timely manner.

Figure 5:
Staff survey results



According to volunteer survey results, the response rates suggest that most of the volunteers knew where to go in case of problems or complaints. A high majority of more than 90% strongly agreed their concerns and complaints will be addressed in MM effectively, confidentially and in a timely manner. For the same question, only a minority of the volunteers, 3%, disagreed.

Commitment 5: Conclusion

The Accountability Reporting concludes that the performance on Commitment 5 was poor, with major areas of improvement.

People affected by crisis have the right to complain to an agency and to receive timely and appropriate responses. Communities, frontliners, staff and volunteers did not have access to safe and responsive mechanisms to handle complaints or feedback. MM was not alerted in the gaps of the Covid-19 Response and did not take timely action to improve response quality in some cases due to a lack of a CRM. MM does not have a workable CRM. There is an absence of a dedicated system, processes, and resources (financial and human resources) for external CRM.

Commitment 6:
Humanitarian Response is Coordinated and Complementary

Adequate response coverage and timely, effective humanitarian response require collective action. Coordination mechanisms are required to establish clear division of labour and identify gaps in coverage and quality of response.

Commitment 6 Indicators

Key Indicators		Organizational Responsibilities	
6.1	Identify the roles, responsibilities, capacities and interests of different stakeholders.	6.5	Policies and strategies include a clear commitment to coordination and collaboration with others, including national and local authorities, without compromising humanitarian principles.
6.2	Ensure humanitarian response complements that of national and local authorities and other humanitarian organisations.	6.6	Work with partners is governed by clear and consistent agreements that respect each partner's mandate, obligations and independence, and recognises their respective constraints and commitments.
6.3	Participate in relevant coordination bodies and collaborate with others in order to minimise demands on communities and maximise the coverage and service provision of the wider humanitarian effort.		
6.4	Share necessary information with partners, coordination groups and other relevant actors through appropriate communication channels.		

4.6.1 MM's Covid-19 Response was coherent with national and international standards and frameworks

MM Covid-19 projects were designed based on a TDRM approach. They were in turn aligned to international frameworks such as the Hyogo Framework for Action (HFA). In addition, MM's Covid-19 Response plan was in line with national standards and framework such as the National Pandemic Response (2020) and Recovery Plan (2021)[12].

4.6.2 MM effectively coordinated with key stakeholders to ensure effective humanitarian response

Using rapid needs assessment and literature review, MM identified the roles, responsibilities, capacities, and interests of different stakeholders. The key stakeholder was MoH, followed by district health authorities and public hospital authorities. Specifically, in setting up the EMT, MM coordinated with the military in the areas of logistics, transport, and communication. In addition, MM participated with relevant coordination bodies such as the National Welfare Department (JKM), Ministry of Health Malaysia (MoH) and Malaysian Armed Forces (ATM) to maximize the coverage and service provision throughout Malaysia, with a focus on highly affected areas.

4.6.3 MM's Covid-19 Response evidently complemented that of national and local health authorities, while on the other hand shows some gaps in timely and accurate information- sharing

MM played an essential and commendable role to support Malaysia's Covid-19 pandemic response and coordination function. All interviewees from hospitals and MoH acknowledged the crucial and valuable role MM played during this response and greatly appreciated its contribution towards the National Pandemic Response Plan.

> As far as I concerned, MM will go to the hardest-to- reach areas and this is what we need. We have a high number of cases of unregistered people and illegally employed migrants who would not come to the government hospitals. We want to reach out to them, however it would be difficult for us to approach them due to the fear of getting caught. We are able to reach out to this group through MM.

12. National Pandemic and Recovery Plan, MKN portal; www.mkn.gov.my/web/ms/sop-perintah-kawalan-pergerakan/

At the same time, gaps in information-sharing and communication at various levels among the health authorities affected the speed of MM's Covid-19 Response in a few cases. Interviews with all the hospitals stated that there was information-sharing gaps especially between MoH and the hospitals. Given that MM deals directly with MoH and not the hospitals, most information sharing, especially deployment of manpower is done at that level. In line with government coordination protocols, MM does not have direct communication channels with the hospitals and needs to go through MoH. This created a big information gap between the hospitals and MM.

Absence of a direct and more effective information-sharing mechanism between MoH and the hospitals caused challenges and limited the opportunity to improve MM's Covid-19 Response. Numerous examples were cited by frontliners interviewed that pointed to the lack of an information- sharing mechanism. For example, hospitals wanted to extend MM's medical volunteers' deployment but were unable to do so and speak to the right person in MM. In this case, the feedback from medical volunteers was not received by the hospital or vice-versa (*See Technical Standards for detailed findings*).

4.6.4 MM was committed to coordination and collaboration with others, however formal agreements were not in place

MM did have a Partnership Policy and related procedures. However, the Partnership Policy focuses on medium to long-term partnerships. It does not provide adequate guidance on short-term partnerships such as those that might arise in an emergency like Covid-19.

Relationships with the partners and stakeholders during the Covid-19 Response were governed by agreements. But these agreements were not always consistent and clear. Further, the evaluation team was unable to access the agreement or memorandum of understanding (MoU) between MM and the MoH or the hospitals. Only *'surat sumbangan'* was available.

According to MM's Partnership Policy, verbal contracts (WhatsApp, Phone Calls) are acceptable during an emergency response. The verbal contracts should be followed up with an email to indicate the nature, type of support and the subsequent costs. It is further endorsed by a formal agreement or Letter of Understanding (LoUs) within 72 hours.[13] Signed copies of agreement or LoUs were not found by the evaluation team. LoUs were available for outsourced partners such as Thrive Well and WC Park. Partnership Policy and Fund Raising does not describe the different types of partnership where MM provides in-kind support.

13. Source: Partnership Policy, May 2017, page 3

Commitment 6: Conclusion

The Accountability Reporting concludes that MM's performance on Commitment 6 was high, with a few areas for improvement.

The humanitarian response was coordinated and complementary.

Adequate programme coverage and timely, effective humanitarian responses require collective action. MM's Covid-19 Response was well coordinated through formal and informal mechanisms. Different roles, capacities and interests of stakeholders were identified during the Covid-19 Response. The response significantly complemented the efforts of national and local authorities and that of other aid providers. MM participated in relevant coordination bodies and maximized the coverage and service provision of the wider humanitarian effort. Practices exists to suggest a clear commitment to coordinate and collaborate with others. Attempts were made to share necessary information with partners, coordination groups and other relevant actors through appropriate communication channels.

However, the coordination strategy was unclear. Relationships with partners were not always governed by clear and consistent agreements that respect the mandate, commitments and constraints of each partner.

Commitment 7:
Humanitarian Actors Continuously Learn and Improve

Commitment 7 is important as learning from success and failure and applying these insights to modify and adapt current and future work is a cornerstone of accountability and quality management.

Commitment 7 Indicators

Key Indicators		Organizational Responsibilities	
7.1	Draw on lessons learnt and prior experience when designing programmes.	7.4	Evaluation and learning policies are in place, and means are available to learn from experiences and improve practices.
7.2	Learn, innovate and implement changes on the basis of monitoring and evaluation, and feedback and complaints.	7.5	Mechanisms exist to record knowledge and experience, and make it accessible throughout the organisation.
7.3	Share learning and innovation internally, with communities and people affected by crisis, and with other stakeholders.	7.6	The organisation contributes to learning and innovation in humanitarian response amongst peers and within the sector.

4.7.1 MM strengthened its remote planning, monitoring and implemented changes based on feedback

MM strengthened its remote planning, implementation and monitoring during the Covid-19 Response. This was one of the major shifts in MM's MEAL processes. Due to the Movement Control Order (MCOs), travel restrictions and COVID-19 SOPs, MM's HQ remotely guided and built capacity of MM State Chapters and volunteers, especially in planning and implementation of the response.

A specific example of how feedback has improved the delivery of hygiene promotion activity may be seen in the hygiene promotion training. Following the feedback, MM improved the hygiene promotion sessions, thereby increasing its effectiveness (*See Technical Chapter: Hygiene Promotion*)

The Covid-19 Response presented numerous learnings for MM, including the use of innovative practices in its response.

4.7.2 Lessons were identified, and decisions were taken to adapt the Covid-19 Response interventions during internal coordination meetings, although these were not systematically captured for organization- wide sharing

Document review[14] and interviews with MM staff indicated lessons and changes to the interventions were captured during daily coordination meetings, external meetings including daily briefings and debriefings. Decisions taken during these meetings guided HQ and MCOH to adapt the Covid-19 Response. On the other hand, the lessons learned and justification for changes and adaptation were not systematically documented and analysed for organisation-wide use.

4.7.3 Learning and sharing was shared with other stakeholders

There is inadequate mechanism to systematically capture the lessons learned and analysis of feedback and complaints in MM. Lessons learnt were mentioned in internal progress or closure reports for projects. For external stakeholders or donors, the contents were more focused on deliverables, success stories and financial statements.

One drawback was the absence of a section on lessons learned in most of MM's progress or donor reports. Such lessons could be drawn from updates on coordination meeting held externally with key stakeholders involved in Covid-19 Response such as local NGOs (IMARET & MRA), donors, government agencies on COVID-19 situation, progress, assistances given, challenges, recommendations, etc.

It is noted that lesson learnt that were gained during daily coordination meetings, external meetings, including daily briefings and debriefings, did guide MM HQ and MCOH in programme design. However, it was not systematically documented. Such useful lessons learned just remained in the reports and verbal discussions.

14. Source: Summary of MoM Coordination Meeting / Internal Coordination Meeting MoM

Commitment 7: Conclusion

The Accountability Reporting concludes that the performance on Commitment 7 was average, with some areas of improvement.

Learning from success stories and failures and applying the insights gained to modify and adapt current and future work is a cornerstone of accountability and quality management. MM attempted to continuously learn and improve its Covid-19 Response as it rolled out the implementation. There was obvious application of lessons learned but it was done intuitively and not systematically. Nor were the lessons learned properly documented.

There was an absence of a rigorous and robust MEAL system and practices at the start of the Covid-19 Response that could lead to changes in programme design and implementation. The purpose of MEAL and the role of managers in monitoring and evaluation is unclear, thus affecting the systematic practice of learning and continuous improvement. Learning was not systematically documented although some systems and networks were used to share the learning with relevant stakeholders.

Commitment 8:
Staff are Supported to Do Their Job Effectively and Are Treated Fairly and Equitably

The actions of the staff are the foundation of each of the Nine Commitments and are the basis for an effective response. An organisation's capacity to recruit, train, and manage staff and volunteers is at the heart of adherence to the CHS.

Commitment 8 Indicators

Key Indicators	
8.1	Staff work according to the mandate and values of the organisation and to agreed objectives and performance standards.
8.2	Staff adhere to the policies that are relevant to them and understand the consequences of not adhering to them.
8.3	Staff develop and use the necessary personal, technical and management competencies to fulfil their role and understand how the organisation can support them to do this.

Organizational Responsibilities	
8.4	The organisation has the management and staff capacity and capability to deliver its programmes.
8.5	Staff policies and procedures are fair, transparent, non-discriminatory and compliant with local employment law.
8.6	Job descriptions, work objectives and feedback processes are in place so that staff have a clear understanding of what is required of them.
8.7	A code of conduct is in place that establishes, at a minimum, the obligation of staff not to exploit, abuse or otherwise discriminate against people.
8.8	Policies are in place to support staff to improve their skills and competencies.
8.9	Policies are in place for the security and the wellbeing of staff.

4.8.1 Policies and processes are in place in MM to support effective volunteer management and deployment

During the Covid-19 Response, MM volunteers were involved in numerous ways such as in the vaccination programme of kids and outreach community, mobile clinic, sewing of PPEs, swabbing tests, working at Covid-19 Assistance Centres, food pack and hygiene kit distributions, and attending to the Covid-19 mental health hotline.

Survey results with volunteers showed 72% of volunteers responded by saying they attended the Volunteer Induction Programme (VIP) and 72% found it useful. Less than 20% of the volunteers did not attend the VIP.

Conducted online due to the travel restrictions during the pandemic, the VIP covered the following aspects[15]: Introduction to Humanitarianism, Introduction to MM, Understanding the TDRM, Volunteering with MM, Standards and Policies, and Sharing Session.

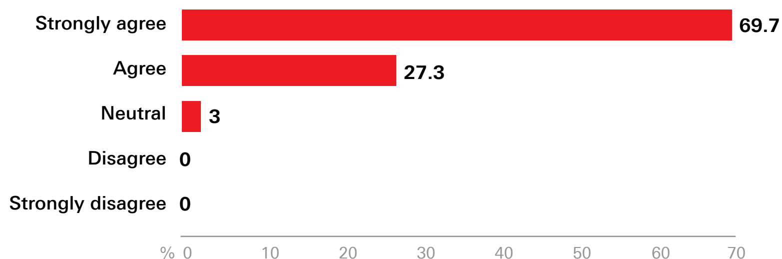
In the survey, 90% of the volunteers stated that MM was always supportive when needed. 90% of the volunteers stated there was effective communication throughout the pre-during-post Covid-19 Response from MM.

Almost 100% of the volunteers surveyed strongly agreed they were proud to represent MM during the Covid-19 Response. Interviews with volunteers further reaffirmed the immense pride they experienced to represent MM. They stated they could relate to and identify with MM's mission and vision.

Figure 6: Volunteers' survey results

I felt proud to represent MERCY Malaysia in the COVID-19 Response efforts mission

Answered: 33 Skipped: 0



15. Source: Interview with Volunteer Management Staff, VIP Presentation, Interviews with Volunteers

4.8.2 Policies are not in place for the security and wellbeing of staff; however, safety and wellbeing practices are visible although not consistently applied

There was no formal policy in place for the security and well-being of MM staff. However, practices did exist to support staff security and well-being. Measures were taken to minimize risks during the pandemic. This included ensuring safe distance, provision of PPE for staff, and the establishment of an Operation Hub that was managed with safety precautions. In addition, staff who had additional workload were provided with a monthly allowance.

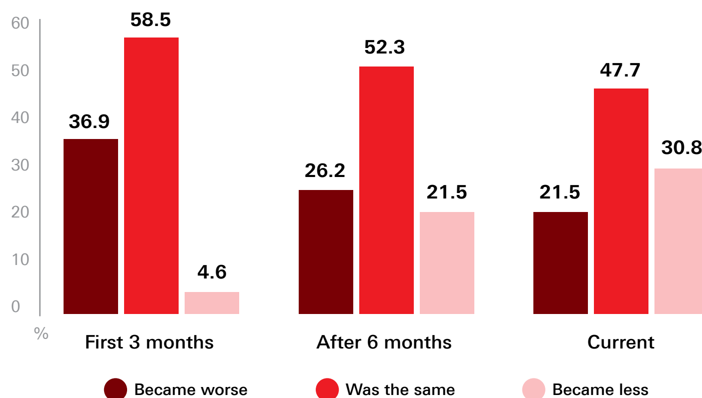
The staff survey results showed that 55% of the staff in MM were directly involved in the Covid-19 Response while 28% were indirectly involved, and 18% were not involved in the response. While there were attempts to mobilize as many staff members as possible to support the response, 20% of the staff interviewed stated that there was an imbalance in workload. Some staff were over-worked to the point of burnout while there were some staff who were underworked. Workforce planning was perceived as not strategic and systematic to ensure competent staff are available to support the Covid-19 Response. Moreover, a clear HR policy and processes in emergency situations was not evident in MM.

Mental Health and Psychosocial Support (MHPSS) consultation was made available to the staff. But this service was discontinued due to a low turn-up rate as staff felt insecure to join the MHPSS webinars and therapy sessions.

On the question of staff stress level, 20% of the respondents stated that there was a clear reduction in the stress level from the first three months of Covid-19 and the current level as shown in the below figure.

Figure 7: Volunteers' survey results

My stress level for the first 3 months, 6 months and current period of COVID-19 Response



4.8.3 Majority of MM staff were clear of what was expected of them by the senior management

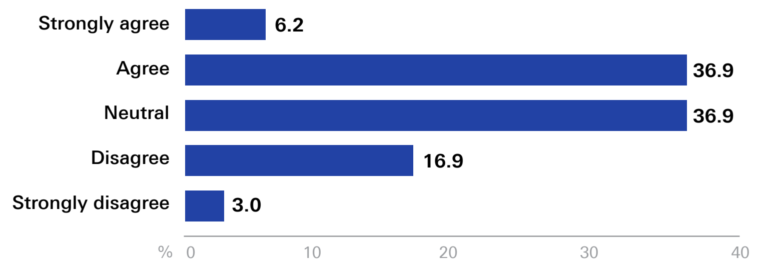
The staff survey results showed that 38% of the respondents agreed while 14% strongly agreed that they had proper briefing and information about their roles and responsibilities. A minority stated this was not the case. More than 50% of staff stated they had clear communication from their supervisors on their role during the Covid-19 Response, while a minority strongly disagreed. Interviews with staff suggest that there was miscommunication or delay in communication from different channels that caused confusion. This included direct communication from MM's EXCO to the staff.

50% of the staff agreed they had the necessary resources (tools, equipment, systems, direction, decision making process) to do their work effectively during the Covid-19 Response period. 15% disagreed that they had the necessary resources to do their work effectively during the same period.

4.8.4 Mixed results on the question of fair and equitable treatment of MM staff

42% of MM staff responded positively saying they were treated fairly and equitably while 37% neither agreed nor disagreed with this question. 20% of the staff respondents disagreed that MM staff were treated fairly and equitably. MM witnessed high staff turnover immediately after the Covid-19 Response period.

Figure 8:
Staff survey results



Commitment 8: Conclusion

The Accountability Reporting concludes that the performance on Commitment 8 was average, with some areas of improvement.

The actions of staff are the foundation of each of the Nine Commitments and the basis for an effective response. Although communities and frontliners received the required assistance they required from competent and well-managed staff and volunteers, MM staff particularly were not fully supported to do their job effectively. They also perceived that they were not consistently treated fairly and equitably.

Overall, the volunteers were managed and deployed effectively and had positive feedback on their contributions. Volunteers in Sabah particularly demonstrated relentless and high-principled assistance under the leadership of the Sabah chapter.

MM staff, and especially volunteers worked according to the mandate and values of MM. MM did not fully have the management and staff capacity to deliver the response, especially at the start of the Covid-19 Response. On the one hand, volunteer policies, procedures and practices were consistently perceived as fair, transparent, or non-discriminatory. On the other hand, staff policies, procedures and practices were not always perceived as fair, transparent, or non-discriminatory.

Commitment 9:
Resources Are Managed and Used Responsibly for Their Intended Purposes

Being accountable is intrinsically linked with being responsible for the effective and efficient use of resources donated to and managed by the organisation.

Commitment 9 Indicators

Key Indicators	Organizational Responsibilities
9.1 Design programmes and implement processes to ensure the efficient use of resources, balancing quality, cost and timeliness at each phase of the response.	9.6 Policies and processes governing the use and management of resources are in place, including how the organisation:
9.2 Manage and use resources to achieve their intended purpose, minimising waste.	a. accepts and allocates funds and gifts-in-kind ethically and legally;
9.3 Monitor and report expenditure against budget.	b. uses its resources in an environmentally responsible way;
9.4 When using local and natural resources, consider their impact on the environment.	c. prevents and addresses corruption, fraud, conflicts of interest and misuse of resources;
9.5 Manage the risk of corruption and take appropriate action if it is identified.	d. conducts audits, verifies compliance and reports transparently;
	e. assesses, manages and mitigates risk on an ongoing basis; and
	f. ensures that the acceptance of resources does not compromise its independence.

4.9.1 Resources were largely managed and used to achieve their intended purposes, and minimized wastage

MM's Covid-19 Response comprised a large component of hardware and software resources. The hardware included hospital equipment, relief items, Emergency Medical Training (EMT) while the softer components mainly consisted of technical advice, capacity building and related services. Interviews with hospitals confirmed that the hardware provided by MM was used to achieve their intended purposes, and minimized waste.

The cash limit for payment of hardware resources was changed to speed up the processes of purchasing goods and equipment.

4.9.2 Wastage seen in a few components of Covid-19 Response

There were however a few types of aids that could be seen as wastage and not achieve their intended purposes. This was evident in relief distribution and hospital expansion *(See Annex 2-5: Findings Against Sphere Standards).*

4.9.3 Apparent gap in monitoring and reporting expenditure against budget

A review of staff interviews and desk research revealed significant gaps in monitoring and reporting expenditures against the budget. Financial progress was generally monitored by managers only when required for reporting purposes. Responsibility for tracking expenditures against the budget primarily rested on a single key staff member within the Emergency Response team.

That said, it is commendable that MM's senior management has acknowledged these gaps and is actively taking steps to enhance the organization's financial management systems. However, it is important to note that the organization faced substantial challenges in managing the funds received during the COVID-19 response. Travel restrictions and limited access to banking facilities during the Movement Control Order (MCO) further compounded these difficulties[16].

16.
MM has carried out process improvement initiative starting mid_ April 2022 to address some of the process related gaps.

4.9.4 Key policies and procedures to manage risk of corruption and take appropriate action are available

Policies and processes governing the use and management of resources in MM include:

- Anti-Money Laundering
- Ethical procurement
- Acceptance and obligations of gift-in-kind
- Conflict of interest

One exception is the absence of a specific policy on risk management, although MM had incorporated MACC Act into the procurement policy including vendor due diligent process as well as connected party declaration form.

Commitment 9: Conclusion

The Accountability Reporting concludes that the performance on Commitment 9 was average, with some areas of improvement.

Being accountable is intrinsically linked with being responsible for effective and efficient use of resources donated and managed by the organization. Aid recipients, particularly hospitals, were aware of the costs involved in the assistance they received. Most of the aid provided was used for their intended purpose. In only a minority of cases was there wastage and where aid was not used for the intended purpose.

At the same time, it was a challenge to understand if the resources obtained for the response were used according to stipulated budgets. This constraint was due to a lack of accessible data that could compare budget and expenditure data in a user-friendly manner.

5 Lessons Identified

Tailoring and adapting the humanitarian response based on the specific contexts and needs increases the effectiveness of the Covid-19 Response. Such customization of the response includes understanding the context and culture of different communities to adapt responses. The hesitancy from communities is mainly because they do not trust outsiders. Whereas MM, on the other hand, has built trust with the affected communities during the Covid-19 Response.

MM is seen as a key source of assistance in the Covid-19 Response by key stakeholders. MM has leveraged its position as a medical service provider and has gained the trust and respect of government authorities and other partners and affected population. MM was awarded by MoH for its performance during the Covid-19 Response.

Outsourcing when internal capacity is lacking is an effective model and approach, provided there is a clear follow up and exit strategy. Outsourcing expertise still requires internal capacity to oversee, facilitate and monitor progress.

Timely and continuous assessment is key to ensuring relevant response that meets the emerging and evolving needs of government authorities and affected population. Needs assessment is a process and not a single event wherein the needs of the communities should be identified and not assumed.

Common goals are met when there is a coordinated approach to the Covid-19 Response and complementarity of roles and responsibilities between the different actors. The sharing of information between the actors in the Covid-19 Response has ensured MM to better manage the outcomes of the response.

A four-pillar approach based on the TDRM model (response, recovery, prevention-mitigation and preparedness) to provide a combination of hardware and software support increases the resilience of hospitals and frontliners. The coherence among the pillars would have increased the effectiveness and impact of the response.

Use of informal communication means such as WhatsApp has increased the speed of Covid-19 Response, however a formal follow-up through email is necessary for accountability and tracking purposes.

Having standby options for getting community feedback during such emergencies that are community based would help improve delivery of the Covid-19 Response. Feedback systems require proper management and follow through.

MM was successful in reaching out to remote communities. Lack of access to remote communities, whether through lockdowns, natural disaster meant that "easy to access" communities, often in capital cities, had a much greater voice than remote communities resulting in lack of accountability to them. MM initiated additional programmed named "House to House" visit and obtained information from the community head on "bedridden patients".

6 Overall Conclusions

6.1 Relevance

CONCLUSION: The Covid-19 Response March 2020 – December 2021 was highly relevant towards fulfilling MM's mandate and mission. While some challenges have been faced during implementation, substantial learning has been generated that can be used for future humanitarian response locally or internationally.

Findings from the Accountability Reporting, particularly findings corresponding to Commitment 1 and Commitment 3, confirmed that **the Covid-19 Response was relevant to MM's mandate and mission**. Substantial and significant outcomes were noted in many components during the period covered by the response, notably in contributing towards the reduction of mortality and morbidity rate in Malaysia during the pandemic.

The Covid-19 Response also proved **flexible enough to accommodate an unexpected effect of the global COVID-19 pandemic** so that MM managed to adapt its working arrangements relatively quickly to a unique situation. A few components of the Covid-19 Response, namely the relief distribution and MHPSS, faced more challenges in adapting to some planned changes. Efforts were made to capture learning during the implementation of the Covid-19 Response, including a series of internal and external coordination meetings.

The Accountability Reporting suggests that MM's organisational culture, a lack of skilled staff, and a lack of systems for disaggregating data on marginalised groups all acted as constraints. The challenge for the future may be as much around harmonising data from different sources, and then using it in programming, as it is about collection and analysis.

6.2 Coherence

CONCLUSION: MM adopted an approach to ensure coherence with key stakeholders whereby the Covid Response complemented and significantly contributed towards the National Covid-19 Preparedness Plan. There was strong compatibility and complementarity with national and local authorities, UN agencies, INGOs, NGOs and private sector, resulting in new partnerships and increased visibility for MM. However, the links between the various components of MM's Covid-19 Response was tenuous.

Findings from the Accountability Reporting, particularly findings related to Commitment 6, indicate coherence between international and national, and the Covid Response goals, targets, and indicators were aligned to meet the common goal. At the national and local levels, the Covid Response components and activities were coordinated to achieve a common goal of reducing mortality and morbidity rate of Covid 19. Integrating processes and actions related to international frameworks and national frameworks were crucial to achieving common respective goal and the Covid Response was successful in contributing towards a common goal.

MM experienced a significant boost to its visibility and profile at a national level during the Covid Response, proving itself critical to the MOH, frontliners and affected population. MM was also able to strengthen and form new partnerships with government authorities and other partners working in the humanitarian field to support this response and serve as a trusted channel for information to and from communities. Adequate programme coverage and timely, effective humanitarian response require collective action, and this was seen through the Covid-19 Response. Overall, there was coordination internally in MM between the relevant functions, programmes and EXCO.

On the other hand, the integration among different components of the Covid Response could have been better where each component was delivered as activity-project based instead of programmatic approach. Although there was strong coordination between MM and the stakeholders through formal and informal sharing and networks, there was a gap in information sharing between MM and MoH as well as among the MoH and hospitals. It resulted in minor delays and missed opportunities to provide improved service. While MM was able to demonstrate its value as a medical organization, particularly in health, there was no evidence of an exit strategy with the stakeholders or clear strategy and plan for sustaining the partnerships.

6.3 Effectiveness

CONCLUSION: MM provided a comprehensive TDRM response model that was effective and timely in reducing and preventing further transmission of Covid-19 to others and showed significant achievement of results in most areas of the Covid Response. At the same time, the effectiveness of the response could have improved with continuous needs assessment.

The Covid Response was one of MM's largest national humanitarian response, covering both large geographical scale, long term (duration of response almost 2 years), with a diverse outreach covering urban, rural, remote, and targeting multiple groups of Malaysians and non-Malaysians.

The response showed significant positive achievements of results in almost all the components. Mixed results however were seen in MHPSS, supply of manpower, relief distribution and internal capacity. The Response successfully delivered immediate assistance to reduce the burden on the Malaysian healthcare sector and personnel. It was effective to ensure continuity of health services and surveillance in controlling any outbreak during the emergency period.

Nonetheless, the response showed mixed results in reducing the burden of vulnerable groups in Malaysia including the B40 community, refugee communities, elderly people, detainment centre and those at risk losing their source of income due to the MCO. Mixed results were also indicated in the delivery of high-quality emotional support or Psychological First Aid (PFA) through diverse avenues to communities in need to increase and support emotional resiliency.

There was excellent alignment between the response and the needs of the Malaysian government and the health sector and the affected populations. It reflected the quality of pre-existing relationships between MM and MoH at individual and institutional levels, investment in establishing robust plans at the outset (and subsequently adjusting them as required and high levels of trust and mutual respect).

Collaboration with the private and non-profit sector was effective in ensuring there was an improved focus on understanding and addressing the needs of vulnerable groups at all stages of the response. MM was flexible and agile to respond to evolving needs and was particularly able to provide aid and assistance in a timely manner. The quality of hardware and capacity-building services provided was of high standard, meeting the specific needs of the affected population.

Still, the only weakness that appears to have been of significant concern to several stakeholders was the lack of manpower supply and the lack of continuous needs assessment and feedback loop to support continuous improvement and learning.

6.4 Efficiency

CONCLUSION: The Covid-19 Response was designed and implemented to ensure efficient use of resources, balancing quality, cost, and timeliness of each phase of the Response. Funds, human resources, and material resources were adequate to provide a timely and effective response. However further investment in human resources and internal systems are required to maintain and increase efficiency.

The Covid-19 Response was designed and implemented to ensure efficient use of resources, balancing quality, cost, and timeliness at each phase of the response.

The funding received afforded MM the possibility of designing a comprehensive response based on a TDRM model. However, the implementation was inefficient in some areas due to lack of staff capacity, competencies, internal systems, and processes.

Procurement was central to the Covid-19 Response. Despite some delays, aid and assistance was provided in a timely manner, except in some cases when the supply chain was under stress. The quality of equipment and relief items provided were of a high standard. Overall, the AR has found that procurement, including the focus on the quality of goods and probity of processes was an important strength in the response.

Significant gaps existed in the financial management system and practices that profoundly affected the efficiency of the Response. Being accountable is intrinsically linked with being responsible for the effective and efficient use of resources donated to and managed by the organization. The poor financial management system could pose a potential risk and missed opportunity to MM. Significant gaps also existed in MEAL where the tendency is to focus on the quantity (data based) and not the quality of the interventions.

Volunteer management and deployment was efficiently carried out which contributed to the effectiveness of the Response. Staff capacity and competencies while was inadequate to implement all the phases of the Response effectively. Needs assessment and MEAL areas severely lacked staff capacity. It will be a challenge to maintain and increase efficiency with the existing number of team members and the gaps in the systems. Until and unless further resources are dedicated in terms of human resources and formalization and systematization, efficiency levels may be at status quo level or compromised.

6.5 Sustainability

CONCLUSION: The design of the response to deliver epidemic/pandemic risk reduction efforts based on the TDRM cycle to ensure sustainability in reducing and preventing further transmission of Covid-19 to others is showing lasting benefits in some areas.

Significant benefits are seen in cases where hardware was provided to the hospitals and use extended beyond Covid-19 patients. Also, capacity building support provided especially around new knowledge shared and new skills shared is showing lasting benefit.

Lasting benefits are also seen in internal capacity, new partnerships, experience of responding to a large and uncertain public health emergency such as the Covid-19 pandemic. That being said, the lack of strategy and plan to manage and sustain these partnerships and relationship may affect the sustainability in the long run.

It should be noted however that staff turnover (senior management and middle management) and loss of institutional memory in PDU particularly will affect the sustainability of the response due to lack of knowledge management system in MM. Recognising this gap, in early November of 2022, MM established a new function namely “Knowledge Institutionalization Management” to curb the loss of enterprise knowledge.

7 Recommendations

This section presents the broad and specific recommendations of this Accountability Reporting. Recommendations are targeted at MM EXCO, senior management and staff. They have been structured as follows.

Implementation of these recommendations will be subject to a review process to determine their urgency and level of priority, both from the perspectives of the EXCO and staff. Where additional financial and human resources are required, these may be sourced either by restructuring staffing and budgets, sourcing from external budgets.

7.1 Broad Recommendations

1	Balance between quantity and quality. Train staff and volunteers on accountability tools, especially process refresher courses, CHS and Sphere Standards.
2	Demonstrate the TDRM model in practice by strengthening the linkage between the different components of the emergency response.
3	Continue efforts to strengthen preparedness at MM HQ and Chapters and flexibility to increase MM's ability to mobilize surge capacity and rapidly respond.
4	Review and revise the strategy and approach for partnership with various stakeholders.
5	Improve MEAL and Reporting, particularly focusing on outcome level.
6	Focus on enhancing effectiveness of emergency response and, in some cases, the design of response by prioritizing needs assessment.
7	Improve feedback system, in so doing strengthen communication and participation of internal and external stakeholders.
8	Define strategy and approach of new areas of response such as -hygiene kits, mobile clinics and mental health.

7.2 Specific Recommendations

Recommendations for Commitment 1: Humanitarian response is appropriate and relevant

- Enhance activities around participation to give people in the government agencies and affected communities more say on the assistance and protection they receive.
- Increase the diversity of MM staff and representation in the Secretariat and governance bodies to ensure that organisational conversations reflect the views of groups such as disabled, elderly, minorities, and socially marginalised groups, and make these population groups more 'visible' in operational design.
- Ensure the collection and use of Sex, Age-And Disability-Disaggregated Data (SADDD), and the use of guidance and standards such as Humanitarian Inclusion Standards (HIS) for older people and people with disabilities.
- Revise and update SOPs for needs assessment and retrain MM staff and volunteers on needs assessment (initial, rapid, and in-depth needs assessment).

Recommendation for Commitment 2: Humanitarian response is timely and effective

- Hospital authorities and MoH would like to know the next steps after the response and have indicated strong interest in preparedness interventions by MoH. MM is expected to advise the government bodies to develop a health preparedness unit in the MoH. MM to consider if this recommendation is feasible to support in any way.
- MM to increase medical personnel and create a roster system to deploy medical personnel for more than the current two-weeks. The roster system should target to build medical personnel capacity and preparedness in mostly affected states such as Sabah.
- Revisit the MHPSS model and ensure consistent implementation across all levels of MHPSS pyramid to prevent distress from exacerbating and requiring higher forms of support. Hire internal MHPSS technical expert (at senior level) to facilitate and monitor progress of MHPSS, especially if the services are outsourced.
- Determine the strategy and approach for food delivery taking into consideration quality over quantity.
- Design interventions that are culturally appropriate/better suited for different population.

Recommendation for Commitment 3:
Humanitarian response supports local capacities

- Identify key potential risks or negative effects of common assistance types (relief distribution for example) and build in systems to monitor and address these effects where they occur.
- MoH and hospital authorities are keen, open and willing to build their resilience and capacity in health preparedness. MM could leverage this interest and commitment to initiate or support the process of health preparedness plan.
- MM's role to reach the most marginalised groups is highly appreciated and should be continued especially in Sabah where access to hospitals is not easy for the marginalised groups. Types of services include health education; essential health screening; anti-vaccination campaign, anemic children etc.
- Study the model of Malaysian Red Crescent Society (MRCS) and their ways of working with MoH and identify areas where MM could improve in collaboration and positioning itself.
- Identify MM's role and strategy for health areas in Sabah and other states in Malaysia.
- Arrange basic medical education, procedure, and give credentials to empower non-medical volunteers to do medical procedure.

Recommendation for Commitment 4:
Humanitarian response is based on communication, participation and feedback

- Have clear policies on what should be communicated to MM's stakeholders including MoH, hospitals and people affected by crisis, and how it should be communicated. These policies should particularly emphasize the rights and entitlements of people affected by crisis. They should also ensure that these policies are known and understood by all staff and volunteers, and that their implementation is a standard element of response design and implementation.
- To better understand on MM roles during pandemic emergency response and recovery movement at the national level.
- Ensure that the design of communication and feedback mechanisms are undertaken by staff closest to the communities, and that efforts are made to ensure that the media and language used are both accessible to the communities and culturally appropriate.
- Take steps to increase the ability to use feedback. Key actions include review of decision-making processes, and building flexibility into structures, partnerships, and Human Resources (HR) and logistical processes (see Commitment 8 for more detail).

- Consider what 'participation' means for MM in practice; how participation relates to their organizational mandate and what would have to change – in staffing, funding, processes, and other areas, to implement participation as a default.
- Use IT to increase efficiency. For example, use of real-time dashboard and tracker to keep provide information / update and track of progress and measure outcomes.

Recommendation for Commitment 5: Complaints are welcomed and addressed

- Work to build programme-or system-wide internal and external complaint mechanisms or feedback loop to ensure assistance is reaching the intended target audience.
- Review the internal CRM process and activate existing channels for CRM internally such as the complaint box, Facebook, grievance procedures, etc. Re-sensitize staff on CRM process.

Recommendation for Commitment 6: Humanitarian response is coordinated and complementary

- Ensure coherence among the different components of the humanitarian response.
- Develop partnership strategy and revise the existing partnership policy.
- Include exit strategy for the partnerships.

Recommendation for Commitment 7: Humanitarian actors continuously learn and improve

- Move away from being data-driven and provide equal focus on the quality of the response.
- Clarify the role of MEAL and the priorities of short, medium, and long-term including the capacity required to implement a comprehensive MEAL.
- Ensure that the design of monitoring and evaluation (M&E) activities is an integral part of project design, rather than being added on when the design is completed.
- Identify systems for capturing lessons at various levels of the organization.

- Ensure that decision-makers, programme managers and donors clarify the information that they need from MEAL systems, so systems can be designed to provide this information and do more than just donor reporting.
- Similarly, ensure that decision-makers are involved to a certain degree in the analysis of information. This is often the exclusive preserve of M&E staff and means that knowledge and information become 'siloed' in the MEAL department of the organization.
- Continue to invest in a knowledge management system to mitigate loss of institutional memory.

Recommendation for Commitment 8:
Staff are supported to do their job effectively, and treated equitably and fairly

- Invest in systems that could support staff in their performance.
- Develop HR in emergencies procedures to speed up HR processes during emergency. Develop staff and volunteers' well-being policy and implement practices to promote staff well-being especially during emergencies.
- Empower state MM Chapters to make more decisions and take the lead to increase speed of response.
- Activate and strengthen the roster system to deploy medical personnel – medical vs non-medical personnel what volunteers can do now and in the future. Increase number of medical volunteers in the state that is most affected by disasters or crisis.
- Identify and implement different ways of recognizing staff and volunteers.
- Include strategic HR as part of MM's strategic planning. Include workforce planning to determine the size and type of staff required for future responses.
- Keep track of staff and volunteer data using HR dashboard / HR metrics that can be easily accessed by senior management and EXCO.
- Ensure staff are well supported during the Response period, especially in getting sufficient direction and technical input from supervisors or Technical Advisors.

Recommendation for Commitment 9:
Resources are managed and used responsibly for their intended purposes

- Harmonize MM's internal systems, especially the financial management system to allow programme managers and senior management have better understanding and comparison of expenditure data.
- Identify potential risks, wastage and redundancies and keep track of these.

Medical
HAND

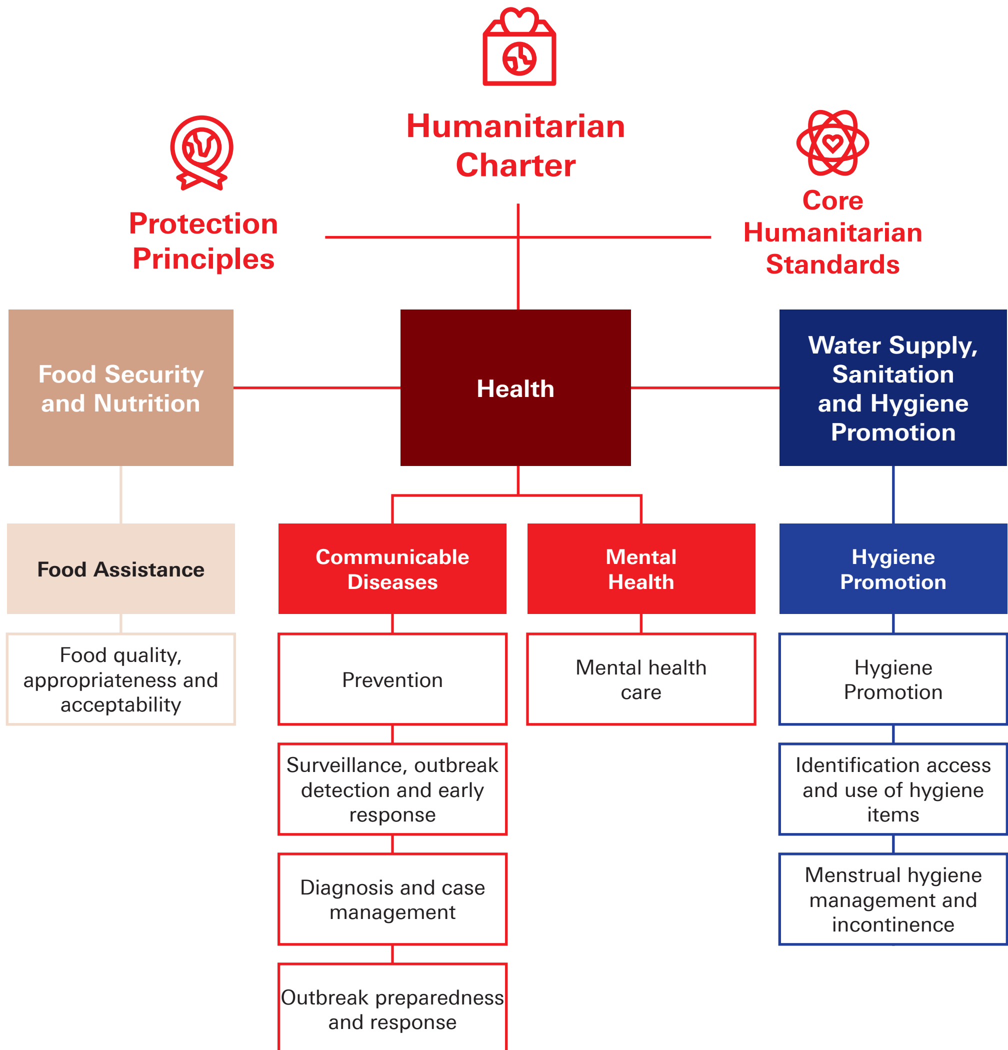
⑧ Annexe

ANNEX 1:
List of Documents Reviewed

1. MERCY Malaysia Project Proposals
2. MERCY Malaysia Strategic Work Plan for Covid-19
3. MERCY Malaysia Project Amendments
4. MERCY Malaysia Policies
5. MERCY Malaysia Reports
6. MERCY Malaysia SOP and Manuals for Covid-19
7. Job Descriptions of Staff
8. Online Copies of Donation Letters (Surat Sumbangan)
9. Interview Guide
10. Survey Results
11. Interview Results
12. MERCY Malaysia Internal Coordination Meeting Minutes
13. MERCY Malaysia Monitoring Reports
14. External Evaluation Reports

ANNEX 2:
Findings According to the Sphere Standards for Health Action

Sphere standards are directly relevant to any public health emergency such as the COVID-19 pandemic, with the Health, and Water, Sanitation and Hygiene Promotion (WASH) chapters being the most important ones.



Health Chapter

Overview

As stated in the **Sphere Health Minimum Standard on Communicable Diseases**, the primary objective in a humanitarian crisis is to prevent the transmission of communicable diseases such as Covid-19 right from the beginning. If it escalates into a pandemic, the aim should be to manage any cases, and ensure rapid and appropriate response. Interventions to address Covid-19 included prevention, surveillance, outbreak detection, diagnosis and case management and outbreak response.

The findings below measured the extent to which MM's Covid Response meets the minimum health standards as stated in the Sphere Standards. The findings consider the key actions and indicators of each minimum standard.

A snapshot of assistance provided by MM to hospitals in KL and Selangor is listed in Table 1.

CATEGORY: HOSPITAL		COMPONENT	CONT. AMT.	REMARKS
FEDERAL TERRITORY OF KUALA LUMPUR				
1	Hospital Kuala Lumpur	• Food Pack Distribution • Hospital Expansion	• 5,459 deliverables • RM5,064,205	HB: **71.2%** (1,565 beds) ICU: 58.7% (46 beds)
2	Hospital Tunku Azizah (Women Child ICU Dept)	• Hospital Expansion	• 21 deliverables • RM42,990.00	HB: **95.8%** (547 beds) ICU: 20% (5 beds)
SELANGOR				
1	Hospital Tuanku Ampuan Rahimah	• Food Pack Distribution • Hospital Expansion • Operational Support • PPE • MHPSS	• 8,252 deliverables • RM990,201	HB: **81.3%** (1,229 beds) ICU: 106.3% (32 beds)
2	Hospital Sg. Buloh	• Food Pack Distribution • Hospital Expansion • Operational Support • PPE	• 21,488 deliverables • RM1,566,020	HB: **65.3%** (729 beds) ICU: 83.3% (42 beds)
3	Hospital Serdang	• Hospital Expansion	• 408 deliverables • RM94,250	HB: **84.3%** (814 beds) ICU: 0% (20 beds)
4	Hospital Ampang	• Food Pack Distribution • Hospital Expansion • PPE	• 22,144 deliverables • RM545,330	HB: **80.9%** (675 beds) ICU: 87.5% (16 beds)

Other hospitals that received surge capacity support to enhance their ability to manage increased demand during critical periods include the following:

1. Hospital Umum Sarawak, Sarawak
2. Hospital Miri, Sarawak
3. Hospital Melaka & Jabatan Kesihatan Negeri Melaka, Melaka
4. Hospital Kulai, Johor
5. Hospital Bukit Mertajam, Penang
6. Hospital Seberang Jaya, Penang
7. Hospital Sultanah Nur Zahirah & Jabatan Kesihatan Negeri Terengganu, Terengganu
8. Hospital Temenggong Seri Maharaja Tun Ibrahim, Kulai, Johor

Findings

People have access to healthcare and information to prevent communicable diseases

In its Covid-19 Response, MM worked with the relevant stakeholders in the public health sector, including health regulators and frontline medical personnel to support prevention measures and establish integrated health promotion programmes at the community level. In total, MM's outreach covered 142 hospitals (including field hospitals) in 14 states, mainly focusing on states severely affected by the pandemic. MM also implemented hygiene promotion activities at the community levels, especially targeting marginalized groups. (See standard on Hygiene Promotion).

Vaccination measures program named "Outreach Vaccination" and obtained info from the community head on the bedridden patients were implemented in several states. MM also collaborated with MoH in setting up hotlines, providing information regarding Covid-19. Its Covid-19 Response plan was developed in consultation with the nation's health partners namely MoH, JKM, military, and NGOs, as well as UN Agency such as UNICEF.

Pandemic response and recovery were adequately implemented in a timely and effective manner

MM developed an integrated preparedness, response, and recovery plan in partnership with relevant government stakeholders across key public sectors. Support provided included supply of essential medical devices, rapid tests, PPE, and ventilators. Operational support in the form of manpower capacity for screening, vaccinating, and monitoring, as well as aiding medical personnel treating Covid-19 patients was provided to hospitals that had low capacity to respond during the pandemic.

Essential medical devices complied standards in most cases

Based on interviews with staff of public hospitals and MM, essential devices and equipment that were provided complied with national and international safety and health standards. This included safe use of devices, regular maintenance, and spare parts supply that were available locally. MM had sought guidance from Standards and Industrial Research Institute of Malaysia (SIRIM) and WHO to ensure compatibility and compliance to standards.

A few of the medical items were, however, not compatible in meeting the needs of the public hospitals. Examples of items that were not compatible was monitors. High flow nasal cannula (HFNC)[17] was not compatible and was not utilised by HKL.

MM significantly contributed to hospitals in Malaysia to reduce the burden on the public health sector

Due to the unprecedented scale of the pandemic, major public hospitals in Malaysia were severely burdened and had limited capacity in terms of resources and personnel. Hospitals were overwhelmed with the needs for basic infrastructure such as, laptops, fans, air-cooler, trolleys, limited bed capacity, limited medical equipment or medical equipment that had reached its lifespan, and lack of medical and non-medical personnel. Medical personnel had to use own personal equipment for work such as mobile phones and laptops. Also, medical personnel were infected by Covid-19, and family and friends of hospital staff were also affected. There were also deaths of medical personnel in hospitals that needed to be dealt with.

Key actions taken by MM to reduce the burden on public hospitals included providing essential hardware and software support to them. Provision of basic items such as laptops, fans, and food packs relieved the medical personnel and increased their efficiency and motivation to work. The fans were particularly useful for the hospitals that set up car parks as additional space for working. The provision of laptops was useful to keep track of data management and observe the trends.

"MM stepped in when the situation was already dire and although efforts were being made, the underlying issues remained unresolved."

Frontliner — KL

17. **High flow nasal cannula** HFNC is a device that delivers warm and humid air at a high flow rate through the nose

MM aid supported public healthcare workers to operate in a safe and comfortable working environment

Typically, the health care workforce includes medical doctors, nurses, matrons, clinical officers, technicians, pharmacists, as well as management and support staff. All staff of hospitals interviewed stated that at the onset of the pandemic there was shortage of PPEs. MM's assistance in providing significantly assisted the hospital personnel to stay safe and continue to provide their services to the affected population. Field visits to hospitals and interviews conducted by the Accountability Reporting team revealed that PPEs and protective gear from MM was the first to arrive. In Hospital Tuaran located in Sabah for example, the first batch of 7000 units of PPE were received in June 2020. Within six months of the early stage of the pandemic, the hospital was able to contain infection within the staff. All staff wore full PPE suits of high quality, approved by CDC. PPE helped with the physical and mental health. Medical personnel felt protected and safe using the PPE.

HKL confirmed that the beds provided by MM were of ICU quality. Oxygen tanks helped the Covid-19 positive patients, and ventilation masks provided were also helpful as it used electricity instead of oxygen pressure.

Provision of these essential items significantly contributed to the well-being of the hospital staff in the hospitals that received MM's assistance and support. In the case of HTAR in Klang, the provision of a 'safe space' for the personnel was a big relief to their personnel physical and mental health.

Emergency Medical Training (EMT) deployment and field hospital set up significantly contributed to continuity of health services provisions and surveillance in controlling any outbreak during the MCOs, although it was insufficient in some cases

EMT is equipped with a pool of specialized and skilled medical and non-medical volunteers. EMT assets are pre-positioned in United Nations Humanitarian Response Depot (UNHRD), Subang. Transport arrangements are established with Royal Malaysian Air Force (RMAF) and World Food Programme (WFP). During the Covid Response, EMT was deployed to a total of seven locations. Field hospitals were set up in HTAR, FGD Interviews with HTAR and Tuaran hospitals affirmed that MM's field hospital profoundly decreased the burden of the hospitals and contributed to the continuity of their provision of health services and surveillance to control the spread of Covid-19 during the MCO.

However, EMT deployment was insufficient to meet the demands and needs of hospitals especially in Sabah and Labuan. Interviews with staff of hospitals in Sabah and Labuan confirmed that the EMT deployment was insufficient to meet the demands and needs of the hospitals.

ANNEX 3:
Findings According to the Sphere Standards for Mental Health

Mental Health

The findings below measured the extent to which MM's Covid Response meet the minimum mental health standards as stated in the Sphere Standards. The findings consider the key actions and indicators of each minimum standard.

People of all ages have access to MM's healthcare that addresses mental health conditions and associated impaired functioning

The MHPSS component of MM's Covid-19 Response aimed to prioritize mental health awareness and interventions from both non-specialized and specialized aspects. In tandem with the objective, several programmes were developed to provide mental health awareness based on the MHPSS pyramid. Refer to the chart below for more details:

Intervention pyramid

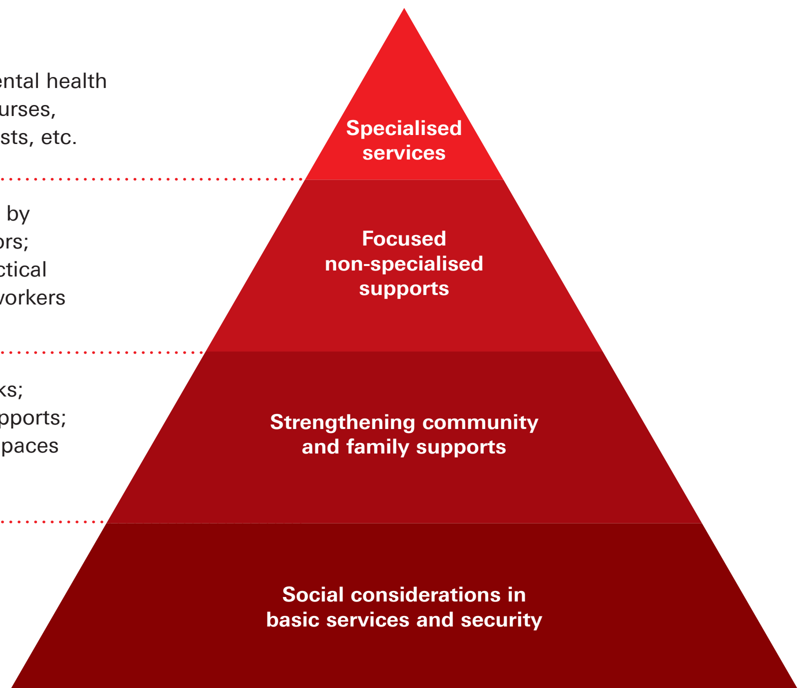
Examples

Mental healthcare by mental health specialists, psychiatric nurses, pyschologists, psychiatrists, etc.

Basic mental health care by primary healthcare doctors; basic emotional and practical support by community workers

Activating social networks; communal traditional supports; supportive age-friendly spaces

Advocacy for basic services that are safe, socially appropriate and that protect dignity



Source: IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2010)

The MHPSS programme design covered multiple sectors of the MHPSS pyramid, but lacked consistency in implementation and demonstrated inadequacy in coordination

Interviews with stakeholders and beneficiaries evidenced that various activities were planned for each level of the MHPSS pyramid. All programmes were implemented concurrently. At the same time, interviews with staff indicated that training on MHPSS was insufficient which resulted in inability to accurately assess the needs and prioritize subsequent actions. Both members of the MHPSS team shared that they struggled to adapt to their roles and relied heavily on expertise from MM's EXCO members and research through their own initiatives. They rated their subjective well-being as six to seven from a scale of one to ten, one being good and ten being not so good.

MHPSS considered existing resources and pre-existing mental health conditions which might have been exacerbated by the pandemic

At time of reporting, there were two people in the MHPSS team with limited clinical experience in mental health. Consequently, resources were outsourced to two private mental healthcare facilities in the form of Thrive Well and WQ Park who provided psychological and behavioral interventions.

Furthermore, 22 online webinars were conducted via Facebook which covered a range of topics centered around the impact of the pandemic on mental health. Subject matter experts were also outsourced as rotating speakers.

MHPSS lacked consultation with respective beneficiaries such as frontliners

Initially, psychotherapy sessions were focused on frontliners to support their well-being. A total of 250 clients were targeted for the sessions. The observed outcome entailed 35 frontliners who registered. Owing to the low response and considering the worsening of mental health within locals, this initiative was then opened to the public, particularly the lower income B40 families who were not financially able to afford services. Out of this group, a total of 377 individuals, comprising 232 adults and 145 children, received mental health therapy.

Thorough orientation and follow-up on PFA to manage acute stress after traumatic events were carried out

Sources interviewed for this report indicate that a detailed training programme was conducted for health and non-health actors nationwide whereby 20 sessions were conducted from March 2020 to December 2020, building into 2021. Based on post-training feedback, a majority of participants felt they were better equipped to listen and reported an increase in confidence in provision of PFA.

Models of mental healthcare were available but not easily accessible and lacked personalization

One primary programme initiated by MM was the MHPSS Hotline which was attended to by staff and volunteers trained in PFA. It aimed to provide emotional and mental health support, conduct brief assessments, and make necessary referrals. Desk reviews indicate that volunteers were the linkage between partners and beneficiaries. This was affirmed by stakeholder interviews.

The operations consisted of four domains and connected several partner organizations, see details in table below.

NO	SERVICE	PARTNERS
1	Mental Health	Volunteers
2	Food aid	National Welfare Department (JKM)
3	Covid-19-related	Malaysian National Security Council (MKN) and Crisis Preparedness and Response Centre (CPRC)
4	Incidences of Sexual and Gender Based violence (SGBV)	Women's Aid Organization (WAO)

Psychological interventions were made accessible through remote platforms.

Based on the interviewed sources, the frequency of calls to the MHPSS hotline ranged from 120 to 140 per day and was subsequently expanded to other states beyond KL. There was an increase of 72.9 % of callers in 2021 compared to 2020.

Desk review indicated that in West Malaysia, 48.5% of callers called in for emotional support while about 33.5% requested information pertaining to Covid-19. The remaining 18.0% were directed towards facilitation of food aid. Progress and coordination reports indicate that most callers from Sabah contacted for guidance on where to obtain food aid while a small number requested mental health support.

In terms of self-care for staff, five individuals received psychological and behavioral interventions, and completed all five sessions in the programme. Additionally, four workshops on mental health and well-being were conducted in December 2020 for staff and volunteers. The Accountability Reporting team was unable to measure the medium-term outcome for these workshops.

Efforts were taken to design a sustainable mental health system during the early recovery planning and protracted crises.

Thrive Well and WQ Park centers relied heavily on psychological assessment tools for monitoring of mental health status and recovery. See list below on the progress of the services provided by both service providers building up to the fifth session:

NO	SERVICE PROVIDER	TOTAL NUMBER OF CLIENTS	RECOVERED BEFORE 5 SESSIONS	RECOVERED AFTER 5 SESSIONS	CONDITION DID NOT IMPROVE/ WORSENED
1	Thrive Well	40 Adults	8	20	12
2	WQ Park	192 Adults	39	148	5
		145 Children	25	111	9

Overall, 88.8 percent of clients reported a decrease in depression and anxiety, as well as an increase in well-being through psychological assessment tools. Many clients indicated an increase in awareness of mental health symptoms faced, leading to good health literacy and health promoting behavior. For instance, a frontliner presented with depressive symptoms was accurately diagnosed with functional autism while a student struggling with working from home realized she had displaced symptoms of anxiety.

ANNEX 4:
Findings Against Sphere Standards for Food Security and Nutrition

Food Security and Nutrition

The findings below measured the extent to which MM's Covid-19 Response meet the minimum food security and nutrition standards as stated in the Sphere Standards. The findings consider the key actions and indicators of each minimum standard.

NO	GROUPS OF RECIPIENT (FGD AND KII INTERVIEWEES)	STATES	NUMBER OF FOOD PACKS
1	Somalian Immigrants	Kuala Lumpur and Selangor	900 packs
2	Children Learning Centre, Cerdas	Sabah	138 packs
3	Children Learning Centre, Stairway to Hope	Sabah	120 packs
4	Sekolah Kebangsaan Desa Aman	Selangor	100 packs
5	PPR Desa Tun Razak	Kuala Lumpur	63 packs
6	Persatuan Orang-orang Cacat Penglihatan Islam (PERTIS)	Kuala Lumpur	40 packs

Food quality is safe and conforms to local standards

Through interviews with volunteers, it was learned that beneficiaries expressed satisfaction with the quality of groceries and health items. This finding was further validated during interviews with beneficiaries who expressed similar sentiments.

Relief item packaging lacked accessibility and personalization

Based on interviews with beneficiaries, food items did not include proper labels. Several families suggested that a list of the items given could have been outlined to prevent any allergic reactions. Additionally, several beneficiaries who were blind noted that the flour and detergent was mixed and compromised the overall food aid.

Briefing conducted with beneficiaries on ground

During instances where teachers and schools aided with distribution, staff sensitized them on proper distribution including an explanation of the items. Several volunteers also shared that a session was conducted with at- risk beneficiaries such as stateless groups and refugees prior to distribution.

Needs assessment was inadequate, especially among the at-risk population

About half of the staff noted that the distribution of food aid lacked an appropriate assessment of needs, particularly among the vulnerable groups. This was attributed to the lack of access and capacity constraints because of the pandemic.

In addition, interviews with volunteers reinforced this concern whereby a volunteer who was asked to facilitate 200 packs of groceries to a stateless community learned that the number of beneficiaries outweighed the resources.

All volunteers reported that the allocated amount per community was almost always insufficient. This was corroborated through interviews with beneficiaries who disclosed that an insufficient quantity of food items was distributed. The consumption shelf life of the groceries provided by MM was sufficient and could last between ten to twelve days.

Clear mechanism and channels of registration established

The National Welfare Department (JKM) was the key resource for food aid who compiled lists of beneficiaries from various non-governmental organizations (NGOs). In turn, MM volunteers responded by distributing the aid. Identification of beneficiaries was done via their level of vulnerability such as single mothers, elderly and families with children. For at- risk communities, focal points were identified who aided with identification of beneficiaries.

Lack of coordination among stakeholders in food distribution

Interviews with volunteers indicated a lack of coordination among stakeholders as they were unable to ascertain whether families had received aid from other organizations. As a result, some families may have received food packets twice while others may not have received any. Volunteers depended on their own discretion to eliminate duplication by referring to the previous history of distribution. Also, several partner organizations had indicated interest in collaborating but were unsure how to contribute.

Distribution of food aid was accessible and convenient for most recipients

MM's food aid distribution considered travel restrictions faced by beneficiaries. Hence, it was delivered to major distribution points to be coordinated by key liaisons or directly to their homes by volunteers. Key liaisons comprised village heads and spiritual leaders. Due to low manpower, the support of the schools was leveraged whereby most schools acted as a distribution center for their students and parents. Owing to social distancing, teachers aided with door-to-door distribution to prevent crowding at the schools.

Distribution was effective and timely although did not prepare for changes in security situation

During interviews with schools, many of them shared that MM's food aid distribution was timely. Additionally, most volunteers cited an average of two days' timeline from request to distribution.

A majority of staff and volunteers however reported an absence of protocols for an emergency during distributions. Despite being executed properly, not having a contingency plan for the escalation of a crisis caused anxiety and fear among the team.

Recipients were not provided with advance details of the distribution plan and schedule

Desk reviews noted an absence of channels for feedback, especially for at-risk communities. Interviews with beneficiaries indicate that despite having some means of raising feedback via volunteers and focal points, a formal point of contact was not provided.

ANNEX 5:
Findings Against Sphere Standards for WASH

Hygiene Promotion

The findings below measured the extent to which MM's Covid-19 Response meet the minimum hygiene promotion standards as stated in the Sphere Standards. The findings consider the key actions and indicators of each minimum standard.

Information, Educational and Communication (IEC) materials positively contributed to hygiene promotion

Drawing from desk reviews, 150 hardcopy posters and flyers were developed to circulate practical information on best hygiene practices to reduce infection threats. This was accompanied by e-posters which were disseminated to identified beneficiaries. During interviews, 80 percent of school teachers indicated that the posters reinforced the adherence to Standard Operation Procedures (SOPs) such as regular handwashing.

Appropriate items to support hygiene, health, dignity and well-being were available and used by the affected people

Desk reviews indicated that many hygiene and cleaning kits were delivered to non-medical frontliners including the Malaysian Civil Department, Fire and Rescue Department of Malaysia and the Royal Malaysian Police. Below is a list of hygiene and cleaning kits that were distributed by MM:

NO	ITEMS	QUANTITY
1	Bleach	1,000
2	Hand sanitizers	5,000
3	Hand soaps	10,000
4	Face masks	50,000

Table 1: List of hygiene and cleaning kits for non-medical kits

In addition, 88 hand washing kiosks were set up at 106 schools in response to the unavailability of those resources, along with hand sanitizers.

All schools reported that the hand wash kits increased the frequency of handwashing among students and that the hand sanitizers significantly contributed to health prevention behavior. The Children Learning Centre (CLC) noted that the quantity of soaps and sanitizers was sufficient which led to an increase in handwashing behavior.

Essential items were made accessible in a timely manner

The increased fear of the pandemic coupled with the lack of resources made it difficult for the schools to implement Standard Operating Procedures (SOPs). Interviews with schools indicated that the majority felt essential items such as the Hand Washing Kiosks (HWK) and hygiene kits arrived at the right time.

Coordinated effort with external stakeholders to distribute items

During the distribution and establishment of hygiene items, relevant organizations were engaged to assist in the implementation. Stakeholders such as the schools and prisons worked closely with the staff and volunteers to ensure smooth distribution. According to interviews, all beneficiaries reported having received the items.

Menstrual hygiene management items lacked beneficiary consultation and management

Based on desk reviews, reusable sanitary pads were provided to some schools. However, the items were not conducive to women and girls. Not only was the current hygiene condition not considered, but no briefing was also conducted on steps to wash the sanitary pads. According to feedback from the girls at Stairway to Hope Children Centre, the lack of soap and water supply made it difficult to wash the sanitary pads.

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