Emergency Response Plan of Action for COVID –19 crisis in Bangladesh

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Bangladesh Red Crescent Society (BDRCS)

31 May 2020

About this Emergency Response Plan

The COVID-19 pandemic is unprecedented in recent history. It is both a public health crisis and a humanitarian crisis that is impacting the lives, health and livelihoods of people around the world. On the 31st of December 2019, WHO was alerted to a cluster of pneumonia patients in Wuhan City, Hubei Province of China. One week later, on the 7th of January 2020, Chinese authorities confirmed that they had identified a novel (new) coronavirus as the cause of the pneumonia. On the 30th of January 2020, the Director-General of WHO declared the COVID-19 outbreak a public health emergency of international concern under the International Health Regulations (IHR, 2005). The potential impact of COVID-19 on the world's most vulnerable people already affected by displacement, conflict, natural disasters and climate change makes it the most urgent threat of our times.

The COVID-19 pandemic was confirmed to have spread to Bangladesh in March 2020. The first three known cases were reported on 7 March 2020 by the country's epidemiology institute, IEDCR. Infections remained low until the end of March but saw a steep rise in April 2020.

The operational strategy developed in this document is based on and adapted from the WHO global COVID-19 preparedness plan (published in February 2020), National Preparedness and Response Plan for COVID-19 of the Bangladesh Government, Revised Emergency Appeal on COVID-19 outbreak of IFRC and UN Coordinated appeal.

This document sets out the 'preparedness and response plan' of the Bangladesh Red Crescent Society for COVID-19. The document outlines the planning scenarios, areas of work and priority activities required to scale up capacities to respond to and prevent COVID-19 threats in a coordinated manner.

This emergency response plan also outlines the public health measures that BDRCS stands ready to provide all over country to prepare for and respond to COVID-19. The document takes what BDRCS have learned so far throughout the response and translates that knowledge into strategic action to guide BDRCS and partners' response in different contexts.

Food pack distribution for the vulnerable families. (Photo: BDRCS)

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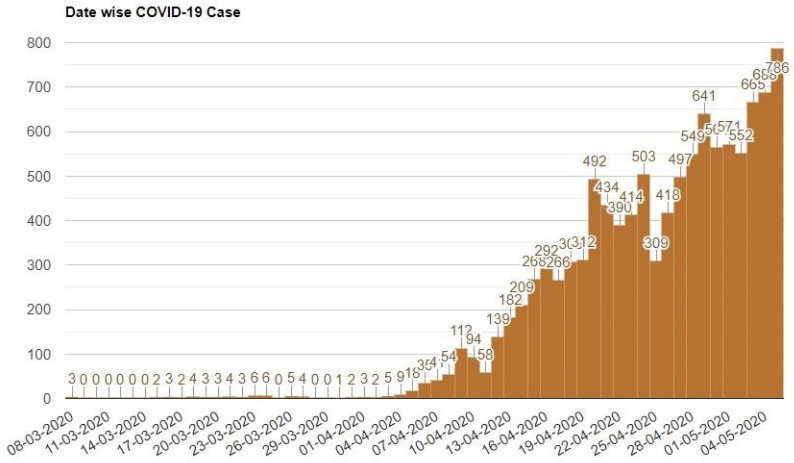
Awareness raising in local communities through miking. (Photo: BDRCS)

Situation Assessment

Epidemiological Overview as of May 2020

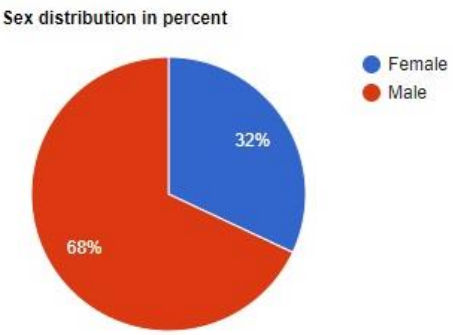
- **31 December 2019:** The Government of China reported a cluster of cases of pneumonia of unknown cause in Wuhan, Hubei Province.
- **9 January 2020:** WHO announces that the outbreak in Wuhan is caused by a previously unknown type of coronavirus. The virus is temporarily called 2019-nCoV.
- **30 January 2020**: The WHO International Health Regulations Emergency Committee declares the 2019-nCoV outbreak a public health emergency of international concern (PHEIC).
- **11 March 2020**: WHO declares COVID-19 is a global pandemic
- **8 March 2020:** The coronavirus pandemic was confirmed to have spread to Bangladesh in March 2020. The first three known cases were reported by the country's Institute of Epidemiology, Disease Control and Research (IEDCR) on 8 March 2020.
- **On 22 March 2020:** Bangladesh declared a 10-day shutdown effective from 26th of March to 10th of April, later extended to 14th April.
- **6 April 2020:** The country had a big spike in confirmed cases and deaths, with 35 new detected and 3 new deaths.
- **13 April 2020:** The total number confirmed cases overpassed the thousand mark. Over two thousand samples were tested daily.
- **25 May 2020:** In the week ending 11 April, new cases in Bangladesh grew by 1,155 percent, the highest in Asia, ahead of Indonesia, with 186 percent. As of 25 May the number of total confirmed cases reached 35585. Bangladesh has reached distant milestone of 500 deaths from COVID 19 in the last 24 hours[1].

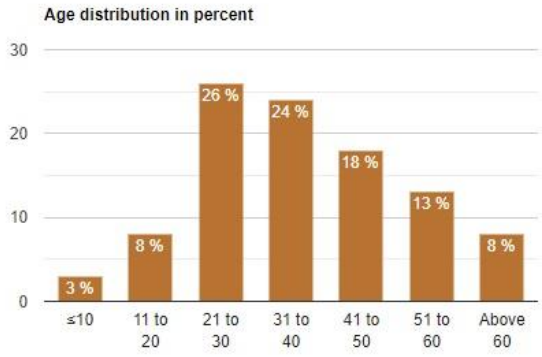


Bangladesh: Date wise COVID-19 cases, as of 5 May 2020. (Source: IEDCR/DGHS)

Risk Analysis

Bangladesh remains especially vulnerable to Covid-19. Pre-existing drivers of humanitarian need such as violence, displacement, poverty, inequality, food insecurity, vulnerability to disasters, poor water and sanitation





Sex and age distribution among the infected patient in Bangladesh, as of 5 May 2020. (Source: IEDCR/DGHS)

[1] https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Bangladesh#18_May

infrastructure and services, low education level, unequal access to information etc. have the capacity to exacerbate the effects of the epidemic in the country. Some of the main risks identified in the Bangladeshi context includes:

Bangladesh is one of the most densely populated countries in the world and, capital city Dhaka is the most densely populated with 47,000 people per square kilometre. According to the national database and Nikkei Asian review, 1.1 million people live in 3,400 slums Dhaka, mostly rickshaw pullers, day laborers, factory workers and transgender people. Also 30% of the population is concentrated in slums where the population faces the poor WASH conditions. It is also a reality in big cities such as Chottogram, Gazipur especially in urban slums, with almost same poor WASH conditions.

According to World Bank data only 15% of Bangladeshi people earn more than $5.9 per day. The U.S. and China have 29 and 42 hospital beds for 10,000 people, whereas in Bangladesh the number is only eight. There are only five doctors for the same number of people in Bangladesh.

In Bangladesh, where 90% of workers are in informal sectors and health insurance is absent, this COVID-19 shutdown places the people in these slums and low to middle income families at serious financial, mental and social risk. The severity of COVID-19 is adversely affecting the lives of the Bangladeshi people, exacerbating their existing crisis, and putting the lives of Rohingya refugees at greater danger.

Within Bangladesh is an especially vulnerable group: in the refugee camps in Cox's Bazar, which hosts around 1.1 million displaced people from Rakhine in Myanmar. In fact, Kutupalong alone is home to over 630,000 people and it is the world's largest refugee camp. Population density, coupled with unsanitary conditions, put displaced populations residing in the camps at greater risk. They suffer from many disadvantages in the camps: highly congested accommodation, lack of social distancing, lack of awareness about the effects of COVID-19, insufficient access to lifesaving medicines, lack of advanced health care facilities and limited access to personal hygiene products.
(Source: Nikkei Asian Review).

COVID-19 can infect all sectors of society, in all contexts and locations, however statistics shows that certain people are most at risk from COVID-19. People with high risk are:

- Poor and Extreme Poor Household
- Vulnerable Livelihood (Rickshaw Puller, Agri and non-agri labor, Garments worker, Tea stall worker, Grocery worker, Domestic help worker)
- People with Disability
- Women and Women Headed Household
- Ethnic Population
- Floating Population
- Sex Worker
- Recurrent Disaster Vulnerable
- Small Business peddler's local grocery shop kipper/worker, rickshaw mechanics, street food/vegetable sellers, beauty salon/parlor, tailoring, small garments, transport worker, sex worker, transgender group.[2]
- People living in crowded condition and with poor access to safe drinking water, sanitation, and hygiene.

From an operational point of view the RCRC staff and volunteers who would be involved in responding to this situation are also vulnerable and as such the precaution measures would be a must to minimize the exposure

Impact Analysis

This section provides an overview of the humanitarian impacts caused by the COVID-19 pandemic Bangladesh where a humanitarian response is already taking place by the Government and other institutions.

Impact on Public Health of the COVID-19 Pandemic:

[2] Multi Sectoral Anticipatory Impact Analysis and Needs Assessment; Needs Assessment Working Group Bangladesh

Bangladesh has been detecting daily more than one thousand confirmed cases of COVID 19. Community transmission is confirmed with cases continuing to increase drastically. The COVID-19 pandemic is straining health systems worldwide as well as in Bangladesh. Government of Bangladesh declared general leave and ban all inter district transports since 26th March 2020 and most of the economic activity are remain close to reduce the transmission of COVID 19. Within the current situation, priority will be ensuring the health system is strengthened to support all people in Bangladesh.

The coming months will be critical in terms of the impact it will have on the economy and other sectors in the longer term both from a global perspective as well as domestically in Bangladesh. The cyclone and monsoon seasons (and resulting flooding and landslides) will further aggravate the health needs of the most vulnerable groups in the coming months.
The crisis will damage the nutritional status of vulnerable groups through multiple mechanisms and will slow down the efforts and outcomes made by the national policies in country which was a priority development last years. It is expected that a dangerous decline in dietary quality stemming from the income losses related to government-mandated shutdowns, as well as from the freezing of food transfer schemes such as school feeding programs and the breakdown of food markets due to both demand shocks and supply constraints (IFPRI-the COVID-19 nutrition crisis: What to expect and how to protect, April 2020).
But malnutrition will also increase due to healthcare failures, as already strained healthcare systems are forced to divert resources from a range of nutritionally important functions – including antenatal care, micronutrient supplementation, and prevention and treatment of childhood diarrhoea, infections, and acute malnutrition—toward combating COVID-19.

However, many uncertainties remain, including the full extent of the current outbreak. Strong community engagements and effective risk communication can reinforce the importance of public health measures to be followed by the population and good infection control practices within the health facilities will reassure communities on promote utilisation of services to meet their essential health needs. Moreover, to remove additional barriers to accessing services during a pandemic consideration should be given to waiver the service fees usually charged by service provider

Socioeconomic Impact:

The COVID-19 pandemic is having, and will have for several months or even years, serious effects on economic growth in the countries, with the global economy expected to contract by 2.5% in 2020[3]. Reduction of industrial and tertiary services production is affecting domestic consumption, supply chains, international trade and the balance of payments, public and private debt and fiscal space. Diminishing fiscal revenues – and the repurposing of already limited government budgets for the COVID-19 response – will negatively impact already overstretched social programmes and services (health, education, etc.), leaving the most vulnerable without essential services. With over 50 million workers in the informal sector in Bangladesh, reduced economic activities will bring about unemployment, declining wages, and, hence, loss of income. According to Labour Force Survey (LFS) 2016-17, this represents 81.5 % of employed labour in country. Females are more involved in informal activities (91.8 per cent) relative to 82.1 per cent for males. In both rural and urban areas, females and youths (aged 15-29) are more likely to be in informal employment. Over the years, the share of informal employment has not declined much; it was estimated to be 87.5 per cent in 2010.

The food and agriculture sector will also be impacted. On the supply side, the sector could get hurt by shortages of labour curbing production especially of labour-intensive crops; transport interruptions and quarantine measures limiting farmers' access to input and output markets; and an increase in food loss and waste resulting from food supply chain disruptions.

However, Needs Assessment Working Group(NAWG) Bangladesh reported that the ongoing lockdown situation is anticipated to have a severe impact on socio economical vulnerable people in Bangladesh COVID19 risk is related to human social behaviour, with high likelihood to impact the congested urban areas with higher population density, people with low immunity or elderly and people who are easily exposed In the urban areas, floating populations, people living in slums and urban focused unsustainable livelihood dependent people will face further issues as they face a higher risk of unemployment and income loss as these population depend on daily income, tend to have no savings, and sometimes are living under the burden of loans, they remain highly vulnerable. To analysing these impacts, several aspects of demographic exposure and urban critical urban livelihood scenarios are described in the lens of vulnerability:

[3] The Economist Intelligence Unit.

Vulnerability Related to density:

- High density population areas are susceptible to higher rate of COVID-19 spread; Bangladesh has a high population density with more than 1100 people living in per square kilometer
- People in higher density areas tends to live in the congested living arrangement which increase the risk of being affected

Vulnerability of Different Age Group:

- Older people in terms of protection, access to services and aid due to the socio physical obstacles to key services
- Age can impact access to humanitarian information and services
- Fatality risks (27-30 percent of affected population) of elderly population is higher than others

Vulnerability Related to floating and Slum Population:

- Floating population has higher risks of exposure to virus
- Most of the floating population and slum dwellers depend on unsustainable Livelihoods
- There are 0.15 million floating population and 2.6 million slum dwellers in Bangladesh

Vulnerability of Urban Unsustainable livelihood dependents:

- Unsustainable livelihood such as rickshaw pullers, small street tea stall workers, street fruits/vegetables sellers etc may lose their income due to lockdown situation
- Majority people from this livelihood group depend on day to day income
- These livelihood group tends to have no savings

Impact on Gender, Protection and Rights:

Like all crises, the COVID outbreak will affect people differently based on their sex, gender and other factors, including age, disability, sexual orientation, health status, legal status, ethnicity, and other aspects of the person. Emergencies exacerbate existing gender inequalities, and the incidence of sexual and gender-based violence (SGBV), violence against children can be expected to increase. Marginalized groups are highly likely to more adversely affected by the outbreak and the consequences of the response. COVID 19 has already changed context in which women and children live Bangladesh The Government of Bangladesh has already taken steps in operationalizing quarantine measures, such as school closures and restrictions on movements, which has disrupted children's routine and social support As a result, Stigma and discrimination related to COVID 19 has immensely affected children more vulnerable to violence and psychosocial distress Due to limited control measures that consider the gender specific needs and vulnerabilities of women and girls has increased their protection risks and lead to negative coping mechanisms In Bangladesh the most susceptible vulnerabilities among women and children, are those in various institutions, children on the streets, women working in tea gardens Consequently, there has been an increase of 40% call to Child Helpline related to COVID 19 increase in child abuse, and exploitation being anticipated while approximately 45 million children in Bangladesh live confined now in homes. The GoB will need enormous support in ensuring that protection authorities take concrete steps to ensure protection of women, children including adolescent girls/boys is integral to all COVID 19 prevention and control measures Vulnerability related to Gender[4]. According to the UN[5] the impacts of COVID 19 are exacerbated for women and girls: Economic impacts will be felt specially by women and girls as they normally hold low paid, insecure jobs and have less savings. In this sector the key vulnerable factors are:

- Women are exposed more to different vulnerabilities and risks. Gender-based violence is increasing. Many women are forced to be in lockdown with their abusers and have less options to seek support and shelter
- Women, especially women headed household faces challenge to get access to services
- Persisting gender inequality and GBV
- Mental health is an issue for women to deal with increased burden of care work as well as uncertainty of income, food security and access to hygiene and health facilities.

[4] *COVID 19: Bangladesh Multi Sectoral Anticipatory Impact and Needs Analysis; Needs Assessment Working Group BANGLADESH, April 2020*

[5] *Policy Brief: The Impact of COVID-19 on Women, 9 April 2020, United Nations.*

- Protection concerns related to exclusion and stigma and Social Practices of ignore people with disability

- Ethnic population are likely to be poor and more vulnerable in terms of physical, social and economic capital. Restrictions on people's movement and freedoms may affect marginalised and vulnerable groups
- Disproportionately in particular those living in camps.
- Heightened risk of loss of income, for workers in the informal sectors, leading to a lack of access to services and basic goods, and loss of dignity
- COVID 19 lockdown is bringing changes in the living environment of children. They are affected by school closures, restrictions on movement and can be at heighted risk due to family separations caused by sickness or lockdowns. Children may be exposed to exploitation and negative coping mechanisms such as early marriage

Gender Based Violence (GBV):

Global evidences that shows pandemic/ disease outbreak increase GBV incidences often leaving girls and women vulnerable to violence and rape - a result of the civil unrest and instability that epidemics leave in their wake. Quarantines, isolation, school and office closures public health measures aimed at slowing the spread of disease put girls and women at higher risk of violence. The scenario can potentially be no different in Bangladesh between 15-31 March, 23 cases of GBV between has been reported in media of which 11 were rape cases Where 382 cases on average are registered monthly in one district by the caseworkers this live saving GBV response is now stalled Intimate partner violence among the ever married young women (20- 24 years) is 28.1% highest across age groups The recent data collection informs that 49.2% women and girls feel safety and security is an issue in the current lockdown 51.7% of the women responded insufficient personal health items available to them, which is potentially as a results of movement restriction[6].

Gender based violence is already an under reported social pandemic which will only exacerbate in any circumstances of no prevention measures, adequate support services and potential social instability. Lockdown and quarantine leading to loss of livelihood, unemployment, food insecurity will intensify partner violence, domestic violence and vulnerability of key population.

Effects on Education:

As schools close, students are missing out on opportunities to learn and more vulnerable students may not return to the education system. This translates to reduced learning outcomes and lower long-term earning trajectories for them and their families, as well as reduced overall human capital for the economies of the countries in which they work and live. Access to learning during the national lockdown varies depending on the socioeconomic status of the children's families which will exacerbate inequalities in the long run. The key vulnerabilities are:

- Lower enrolment appears as vulnerable human capital
- Due to the school closure, a higher number of children are staying at home Poor children especially don't have access to TV/ online based learning
- Anticipated high dropout rate due to this crisis

Recurrent Disaster Risks and Vulnerability:

Disaster Incident and their severity of impact from 2014 to 2019 has been analysed by Need Assessment Working Group (NAWG). It has been analysed that there are total 14 major disaster during this period which impacted in different areas of Bangladesh. On the basis the previous disaster impact scenario, there are 10 districts which experiences severe impact of monsoon flood and other 20 districts also impacted by regular monsoon flood. In terms of cyclone there are four districts which impacted severely cyclone and landslide more than one time in last six years. On the other hand coastal 15 districts has experiences cyclonic wind and had to moved to shelter due to high danger signal of cyclone. The flash flood also had potentially sever impact in 07 districts of Haor region. As forecasted by BMD, it is anticipated that these highly impacted districts could be impacted this year.

[6] *COVID 19: Bangladesh Multi Sectoral Anticipatory Impact and Needs Analysis; Needs Assessment Working Group BANGLADESH, April 2020*

Need Identification

Health

The health sector of Bangladesh is generally good however it remains highly centralised. The public sector is largely used for out-patient, in-patient and preventive care, while the private sector is used largely for outpatient and in-patient curative care. The Ministry of Health and Family Welfare (MoHFW) is responsible for planning and management of curative, preventive as well as promoting health services to the population of the country. However, the COVID-19 pandemic is impacting the overall capacity of the health system of the country.
WHO compiled a country readiness checklist in late January 2020 to assess the capacity of the health system in Bangladesh to address the threat of COVID-19. This document sets out the 'preparedness and response plan' of Bangladesh for COVID-19 and outlines the capacity deficits, needs, areas of work and priority activities required for the Bangladesh health sector to scale up its core capacities to prevent, quickly detect, characterize the response and efficiently control, in a coordinated manner. Some of the key needs are –

- Based on aggravation of the situation, high dependence service along with ICU facilities need to be strengthened. Emphasis need to be given to infection prevention control measures for prevention of hospital acquired infection and protection of both patient and the care givers at the health care facility, home, and the community. In the country there are shortages of essential PPE for staff and volunteers working during COVID-19 outbreak. Front-line health service providers urgently require IPC training and PPE that meet the minimum standards for working in a clinical setting providing direct care.
- Emphasis needs to be given for prevention of catastrophic health expenditure with the principle of 'No One is Left Behind' and social and gender inclusion.
- Strong intensive efforts are needed for risk communication nationally and locally using all media and IEC/BCC materials.
- In case of quarantine, especially during community quarantine, measures will be needed to ensure basic needs of the people and security of property of people in general and the care givers through active involvement of the law enforcing agency.

Psychosocial Support

People are overwhelmed and distressed by different myths and rumours regarding COVID-19 as well as the market situation, lockdown period, price hike etc. General fear, anxiety and panic in the public is arising from lack of proper information, rumours and misconceptions may exacerbate the risk of transmission as people may not practice proper preventive measures. A grievous case has reported on March 25 (2020), after returning from Dhaka, a 36-year-old Bangladeshi man (Zahidul Islam) committed suicide because he and the people in his village thought he was infected with COVID-19 based on his fever and cold symptoms and his weight loss (Somoy News, 2020). Due to the social avoidance and attitudes by others around him, he committed suicide by hanging himself from a tree in the village near his house. Unfortunately, the autopsy showed that the victim did not have COVID-19 (Somoy News, 2020). The main factor that drove the man to suicide was prejudice by the others in the village who thought he had COVID-19 even though there was no diagnosis. Arguably, the villagers were xenophobic towards Mr. Islam. Although xenophobia is usually defined as a more specific fear or hatred of foreigners or strangers, xenophobia is the general fear of something foreign or strange (in this case COVID-19 rather than the victim's ethnicity).
In addition, front line workers in the various hospitals, BDRCS staff and volunteers responding to COVID-19 may experience heightened fear, anxiety, and stigma due to the nature of their work, possible quarantine and isolation from families and loved ones.

Infection Prevention and Control (IPC)

Among the five pillars of the National Preparedness and Response Plan for COVID-19, Infection Prevention and Control is one. The spread of COVID-19 infections, however, can be prevented and controlled. Several simple and cost-effective strategies can help to prevent infections which is starting from hand hygiene to the disinfected approach. BDRCS has already identifies different priority actions such as establishment of hand washing units, nationwide surface disinfectant for hospitals, health facilities, emergency service facilities and public places are also critical interventions to prevent and control infection for preparedness, containment, and mitigation phases. Public places and community places are potential areas where virus can spread and cause community transmission.
This is vital in terms of prevention measures that people working and seeking care in these facilities have the information and equipment (including handwashing and Infection Prevention and Control). They need to know

how safely carry out their activities and guidance on how correctly disinfect regularly surfaces and preparation of correct disinfection solution. Thus, it is important to assess the knowledge and skills of the people on infection prevention and control. Carrying out training and capacity building initiatives are also crucial to address knowledge and skill deficiency on the infection prevention and control. Facilitate and conduct trainings to address any identified skills and performance deficits on the infection prevention and control

Bangladesh has successful examples of community-based interventions to manage disaster risk and to maintain public health services. Based on previous experiences, relevant knowledge and information on the IPC can be delivered to the household and community care providers. Furthermore, engagement of public authorities and community organizations is vital to implement the coordinated IPC activities in public places such as schools, markets, public transport as well as community, households, and family practices**.**

Water Sanitation and Hygiene (WASH)

Limited access to safe and improved water and sanitation facilities in Bangladesh is an issue which can exacerbate the transmission of COVID-19:

- Areas where water scarcity is high and areas where people use polluted surface water and ponds to bathe, wash and cook may be a source of COVID-19 transmission.
- Hand pumps: Currently there are 1.7 million hand pumps in rural areas, used by millions of people, these hand pumps handles need to be disinfected otherwise they may become points of transmission.

UNICEF Bangladesh is developing a Guideline to Ensure Community Water Point Functional and Safe to Use. The WASH cluster is planning to work to reduce faecal contamination in rural areas.

Infection prevention and control support to hospitals and clinics are also a critical area that should be continuously focused on. The GoB, public and private agencies as well as BDRCS has been working together to providing hand washing units for different public places and district administrative offices. This is the simplest but effective approach to preventing the spread of infections. There are needs to support through handwashing and sanitizing in key locations such as transport hubs and markets. At the same time, the delivery of water and setting up hand washing spots in areas lacking regular water service such as informal settlements particular in correspondence public spaces like markets, bus stands, communal and public sanitation facilities and other areas where people gather. High density slum areas are also important.

Most poor people don't have access to proper hygiene kits (masks and gloves), hand sanitizer or any disinfect materials. Even in the market there are scarcity of personal hygiene materials. On the other hand, the test kits are not sufficient which is very essential now. The following table shows the division wise vulnerable population in Bangladesh. It is clear through the table that around 9 million people living with extreme poverty i.e. few or no means of income and about 1.4 million people found as floating or even shelter less.

Division	Number of Extreme Poor (HH)	Number of Floating Population
Barisal	508,007	9,707
Chattogram	1,223,574	32,284
Dhaka	1,470,687	68,559
Khulna	1,086,880	9,218
Mymensingh	933,825	4,348
Rajshahi	1,433,144	8,728
Rangpur	2,039,095	5,814
Sylhet	347,055	8,102
Total	**9,042,267**	**146,760**

Livelihood and Food Security

The Bangladesh Government declared general holidays and restriction on movements (some sorts of country lockdown) from the 26th of March to the 11th of April for preventing the spread of COVID-19. This decision prevails as highly effective to reduce the spread of COVID-19 at community level. However, the decision impacted the economy of the country and brought severe impacts to the most vulnerable households. Day labourers, maids, construction workers, small informal business, people working in the transportation sector,

hawkers or salespersons are anticipated to face a severe economic crisis as well as food insecurity[7]. The Government and some private and public actors have supported some vulnerable groups with food and cash. The Government also introduced a dedicated hotline (333) for humanitarian needs especially food insecurity and for updating the social protection database to target food distribution to the most vulnerable. However, the needs are much higher than the current supply and the food supply may go further down if the situation continues for a longer period of time.

Shelter

While the physical structures in which people live or are being sheltered may not be immediately affected by the COVID-19 crisis, the physical and social conditions under which people live can have an effect on the spread or containment of the disease and how effectively people can protect themselves and their families. This will have a particular impact in densely packed urban areas, refugee camps and for floating people where populations living in poverty have few options and little support and risk the virus spreading quickly and widely.

The needs in this regard are significant when we consider the housing and neighbourhood conditions in urban areas, particularly in densely populated slums where marginalized groups reside and where health, water and sanitation services are poor.

There might be a need to pre-position and distribute shelter materials and basic household items as necessary, particularly for slums and floating peoples especially who are migrants. While the physical structures in which people live or are being sheltered may not be immediately affected by the COVID 19 crisis, the physical and social conditions under which people live can have an effect on the spread or containment of the disease and how effectively people can protect themselves and their families. This will have an impact in densely packed urban areas, where populations living in poverty have few options and little support and risk the virus
spreading quickly and widely. There is also needed to contribute to the development and dissemination of guidance across the sector, including through the Shelter cluster and other inter-agency initiatives and coordinate at country level. It has been reported by the Need Assessment Working Group Bangladesh that many people particularly the different vulnerable groups like marginalized people living on the street and slum don't have enough capacity and space to ensure safe home quarantine during this COVID 19 crisis. Around 54 % of the vulnerable people highlighted the need for essential NFI like bed, mosquito net and others.

Information vs Misinformation and Social Stigma

The COVID pandemic has been accompanied by an overabundance of information, some accurate and some not, which has made it difficult for people to differentiate between reliable and fake information. Misinformation is a potential source of stigma in the community. It also can lead to more harm and risk-taking behaviours. Though, currently all the information shared in the mainstream media has come from Govt. press releases and briefings, nevertheless there are several rumours of underreporting of actual situation in the country.

On the other hand, according to UNICEF, everyone is talking about coronavirus disease (COVID-19), and everywhere there's some information on the virus and how to protect from it. Knowing the facts is key to being properly prepared and protecting yourself and your loved ones. Sadly, there's a lot of information out there that is incorrect. Misinformation during a health crisis leaves people unprotected and vulnerable to the disease and spreads fear and stigmatization. Since, a hotline centre has established to provide psychosocial support and accurate messaging has been publishing through the BDRCS social media (Facebook, twitter and others) on COVID-19.

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7 *https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/assessments/20200325_covid_19_nawg_sitrep_and_anticipatory_impact_updates.pdf*

BDRCS Actions as of Now

BDRCS has been actively engaged from the beginning of the COVID-19 emergency in the country. The followings highlight some of the key BDRCS achievements as of the 28th of April 2020:

13,531
Number of staff and Red Crescent Youth/ Cyclone Preparedness Program/ Camp/ Community volunteers being mobilized throughout the country.

256,017
Hygiene and Protecting gears distributed i.e. soap, hand sanitizer, masks, hand loves, eye protectors and hygiene kits.

127,153
Number of Total People Reached (average/day)

1,264,142
People reached through Information, Education and Communication (IEC) materials across the country.

1,200,000+
People received life-saving awareness messages on COVID-19 through social media. (as of 26 April 2020)

10,240
Hand-washing stations established throughout the country including in camp settlements in Cox's Bazar.

90,918
Pre-monsoon Kit Distribution at Cox's Bazar camp settlements.

2,285
262 Hospitals being sprayed disinfectants for 2285 times throughout the country.

12,804
Set of Personal Protective Equipment (PPE) provided to individuals working on COVID-19 response.

29,083
Women reached through Dignity Kit Distribution at Cox's Bazar.

In addition, BDRCS has also undertaken the following activities in the country:

- Emergency Coordination meetings of BDRCS governance and senior management taking place on regular basis. While the Red Cross Red Crescent Movement Coordination meetings (teleconference) on COVID-19 response also taking place on weekly basis.
- Chairman of BDRCS sent a letter to all unit offices appreciating the invaluable contributions they are making to serve humanity despite health and life risks under COVID-19 pandemic.
- The psychosocial support call centre at BDRCS National Headquarters receiving several calls. This centre is operated 5 days during week and managed by two RCY volunteers and a medical doctor. As of 30 April 2020, total 1897 individual

Food parcels are being distributed in all 64 districts. (Photo:

reached through Mental Health and Psycho-social Support (MHPSS) Services. Meanwhile a stress management session was organized for 26 staff at National Headquarters. 194 staff and volunteers received Psychosocial First Aid (PFA) training. 1,613 individuals (568 male, 264 female and 781 children) are reached through PSS services – through the hotline as well as face to face in the Cox's Bazar camp contexts. 90 volunteers are reached through care for volunteer activities.

- 88,734 food parcels are being distributed throughout the country.

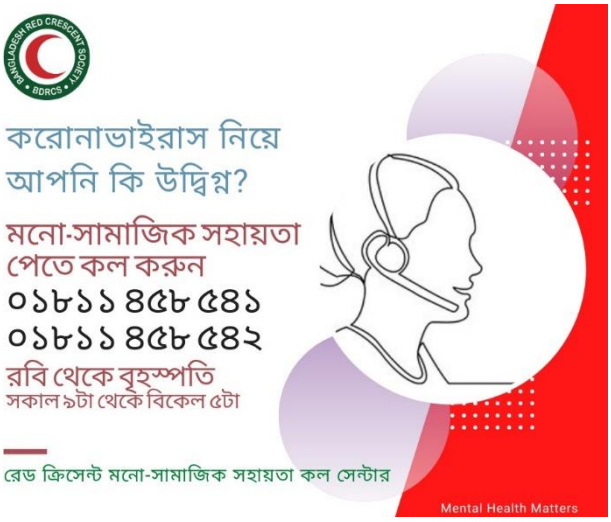
- BDRCS is also strongly taking the ongoing cyclone season into consideration and making necessary arrangements of their tools and resource mobilization if a crisis arises while the COVID-19 pandemic is not yet under control. BDRCS is working with the Government of Bangladesh (GoB) through their joint Cyclone Preparedness Programme (CPP) and working together to customize the existing cyclone preparedness protocols considering the current COVID-19 situation in order to protect their volunteers and minimize spreading of COVID-19 as much as possible.

- Unilever and Water Resource Group of World Bank is supporting BDRCS to set up handwashing stations at all 64 districts in the country and BDRCS with their support providing 64 Deputy Commissioner (DC) offices with the disinfection activities. In addition, with the support of Unilever BDRCS is providing drinking water purifier machines, soap items and hygiene kits to DC offices.

- With the support of Coca-Cola, 114,600 pcs bottles containing 500 ml water have already been distributed to the 11 COVID-19 dedicated hospitals and three COVID-19 research/response authorities including major operational points of Dhaka Metropolitan and among Dhaka District Police.

- Different video messages on awareness including addressing stigma are prepared by BDRCS and shared widely.

- BDRCS continues social media messaging on COVID-19 awareness through its Facebook, Twitter and Instagram pages. BDRCS organized a Facebook live event with the support of health professionals of its Holy Family Red Crescent Medical College Hospital regarding mass awareness and maternity heath related to COVID-19 crisis. BDRCS also opened a communication channel in partnership with Viber to share the key awareness messages on COVID-19 to mass people.



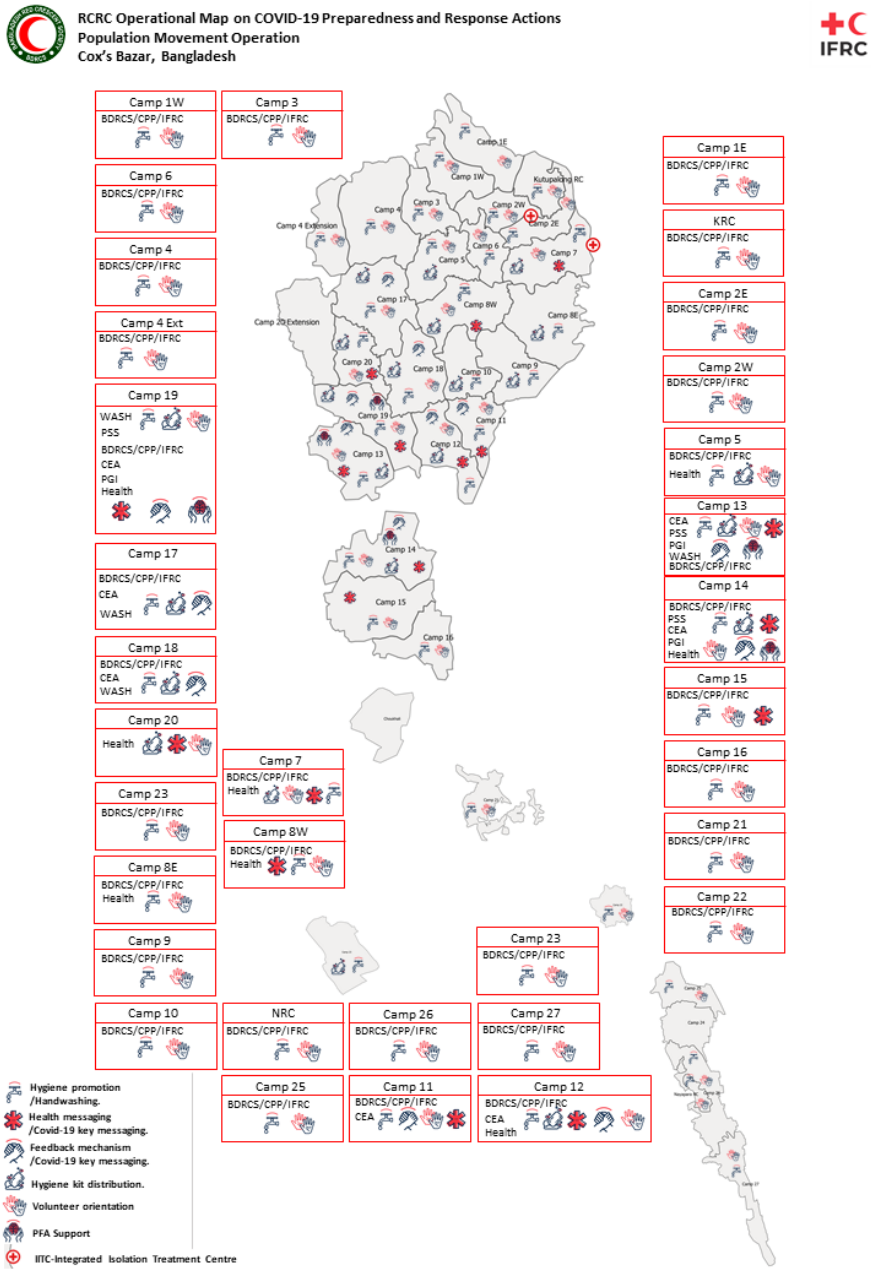
BDRCS PSS hotline number.

- Community Engagement and Accountability (CEA) teams both in Dhaka and Cox's Bazar are coordinating with Risk Communication and Community Engagement (RCCE) and Communications with Communities (CwC) working group respectively and collaborating in sharing information and awareness materials with other actors.

- Apart from the technical and logistic support being provided by BDRCS NHQ, several branches/units have been providing many other types of supports to the most vulnerable and most marginalized people based on local need. This includes but not limited to (a) dry and cooked food packages, (b) drinking water, (c) awareness messages distribution, (d) hygiene materials, (e) establishing thermal check points intending to restrict unsafe mobility of people, (f) supporting food distribution and other activities of district administration.

- Two BDRCS volunteers from each unit office are engaged in monitoring and coordination of different activities at 61 prisons in 2 shifts every day. These activities include temperature checking & chlorine spraying, awareness raising on social/physical distancing and mandatory footbath & hand wash.

Population Movement Operation (PMO) in Cox's Bazar



BDRCS with support from Red Cross Red Crescent (RCRC) partners and CPP has reached 462,675 people and mobilized a total of 6,238 staff and volunteers through implementation of preparedness and response activities on COVID 19. Major activities continued such as the supply of Personal Protective Equipment (PPE), preparing 80 integrated isolation beds at two locations, distribution of hand washing or personal hygiene items, COVID 19 orientation for staff and volunteers and dissemination of key message to households in camps and host communities. BDRCS started the process of recruiting necessary personnel for the isolation facilities being established in order to make them fully functional by June.

As part of supporting and complementing the efforts of Government of Bangladesh in terms of its National Preparedness and Response Plan to the coronavirus pandemic in country with the support of IFRC, BDRCS has recently handed over 50 isolation beds, medical supplies and basic equipment for screening the patients plus PPE materials to two Upazilla (sub-district) health complexes in Cox's Bazar - 20 to Ramu Health Complex and 30 to Chakaria Health Complex. Further supports to these two health complexes to ensure uninterrupted services to the people in need in the surrounding communities will be provided soon. Moreover, BDRCS has also extended its logistics support in collecting the blood sample from Cox's Bazar district.

COVID-19 prevention strategies instructed by Health/WaSH sectors and Refugee Relief & Repatriation Commission (RRRC) office maintained firmly.

Hygiene promotion messages being disseminated at all 34 camps and adjacent host community areas through CPP/ Host/ Camp/ Community volunteers with proper maintenance of personal protection and social distancing.

Myanmar Refugee Relief Operation (MRRO) at Cox's Bazar

Besides other ongoing activities, with UNHCR, BDRCS its under MRRO is actively involved in Cox's Bazar camp area. 105,000+ pre-monsoon kits consisting of wire, rope, iron peg and white kit bag distributed at camp area distributed. 385,710 soaps distributed among 14,235 families in the camp settlements. Liquified Petroleum Gas (LPG) – new set, refill, distribution being continued for both host and guest communities.

Strengths, Capacities and Expertise

The major strength of BDRCS in delivering its services includes, the image and auxiliary status to public authority, country wide reach through its 68 Branch (Unit) offices in all 64 Districts and 04 Branches (Unit) in each of the metropolitan cities of Dhaka, Chittagong, Rajshahi and Khulna. It has a network of skilled and dedicated volunteers throughout the country who act as a first responder to reach out the people who are most vulnerable and needing humanitarian assistance most. Despite of different challenges in different context, the BDRCS remains in a strong position with an adequate number of volunteers to meet the programming needs.

The major program focuses on emergency response owing to disasters and emergencies including movement/ displacement of population, disaster risk management, community development, cyclone preparedness programme (CPP), health services, organizational development, branch development and youth development. All these programs and services are designed in line with the country humanitarian context and toward achieving vision and mission of the Society.

BDRCS has been operating one of the largest humanitarian response operations, the Population Movement Operation (PMO), in recent times supporting about 260,000 people displaced from Rakhine living in the camps in Cox's Bazar.

BDRCS exercises strong autonomy to elect its leadership at National to Branch level and selection programs and interventions helps upholding principles and minimum standard of humanitarian services.

Representation of BDRCS in external forums. Representation of the Society on or at committees or bodies constituted by (International Red Cross and Red Crescent Movement) for furthering the objects similar to those of the Society.

BDRCS is a recognized organization in humanitarian field and it has axillary status. The Legal Base (PO-26, 1973) provides for the roles and responsibilities of BDRCS as auxiliary to the public authorities in Bangladesh.

Provision of relief for the mitigation of suffering and distress caused by cyclones, earthquake, floods, epidemics, civil disturbances and other disasters, whether in Bangladesh or outside.

The organization has long experience to serve in disaster and crisis through their country wide Branches and volunteer network.

Few photos of BDRCS actions regarding its nationwide COVID-19 response. (Photos: BDRCS)

Sector wide Summary Plan

Sector	Activities	Key Target
Health 10,236,998 Swiss Francs (CHF[8])	• Mass Awareness (Risk communication, Health promotion)	2,000,000 people
	• PPE for BDRCS frontline volunteers and staffs	20,000 People
	• Psychosocial support to general public, affected individuals and responders, including RCRC volunteers and staffs.	10,000 People
	• Isolation facilities in the Holy Family Red Crescent Medical College Hospital (HFRCMCH) for COVID-19 patients	300 Beds

[8] CHF 1 = USD 1.03140

	• Increase ICU capacity in HFRCMCH for critical cases of COVID-19 patients.	20 ICU Unit
	• PPE for health workers	2,000 People
	• Enhance laboratory facilities of HFRCMCH and procurement of testing kit for COVID-19	5,000 testing kit
	• Provide ambulance service for COVID-19 related patient to transport to government identified isolation and treatment centres for severe and critical case management	4 ambulance unit
	• Population Movement Operation (PMO) in Cox's Bazar: Existing PMO health facilities to be equipped with necessary PPE, medical supplies and equipment to ensure continuity and sustainability of delivering basic health care services.	
	• Population Movement Operation (PMO) in Cox's Bazar: Establishing an integrated isolation centre on BDRCS Field Hospital (50 beds) and BDRCS-Swiss Red Cross facility in camp 2E (30 beds) with the capacities to contain and screen cases and refer them to temporary treatment facilities if a suspected case is confirmed	80 bed
Infection Prevention and Control (IPC) 676,200 CHF	• Disinfection of offices, hospitals, public transportation etc	200 Hospital, 500 Public places
	• Coordination with DGHS, WHO and other stakeholders	
Livelihood and basic needs 4,403,189 CHF	• Distribution of food parcels	200,000 HHs
	• Distribution of cooked food	100,000 HHs
	• Provide multipurpose cash grant assistance	50,000 HHs
WASH 1,043,319 CHF	• Mass awareness on hygiene practice	1,000,000 People
	• Provide Hygiene parcels	25,000 HHs
	• Installation of hand washing station	10,000 station
Shelter 101,430 CHF	• Provide appropriate shelter assistance where required *(e.g. temporary makeshift shelter or camp settlement using tent).*	5,000 HHs
Protection, Gender & Inclusion (PGI) 190,228 CHF	• Sex, age, and disability disaggregated data collection • Training on minimum PGI standards. • PGI messaging on against stigma and xenophobia: • **Knock Knock**! Red Crescent Youth at doorstep to assist elderly people living without family. • **Hello RC Kids!** Provide useful information about COVID19 through social media	
Migration 50,000 CHF	• Humanitarian Diplomacy • Coordination with authorities and at the inter-agency level • Dialogue, sharing and peer support with sister NSs	
Strengthen National Society 2,517,190 CHF	• Insurance and Risk incentive for BDRCS volunteers and staffs.	
	• Ensure operational support BDRCS staffs and volunteers	
	• Media Communication and Video documentary	
	• Development of emergency PMER framework	
	• Business continuity plan: Identifying the potential impact/ threat of operation on overall operational capacities for business continuity plans.	
	• Communication strategy for preparedness and response	
	• Evaluation: Real-time evaluation, mid- and end term evaluations are carried out along with lessons learned workshop.	
	• Capacity building of BDRCS *(Health, Logistic, Unit etc)* according to BOCA and OCAC recommendations	

Operational strategy

Overall Operational objectives

The overall operational objective is to contribute to reducing morbidity, mortality and social impacts of the COVID-19 outbreak by preventing or slowing transmission and helping to ensure communities affected by the outbreak maintain access to food, protecting livelihoods and other basic social services and can support themselves in dignity.

The overall operational objective has been developed in line with the National Preparedness and Response Plan of Bangladesh Government for COVID-19 crisis.

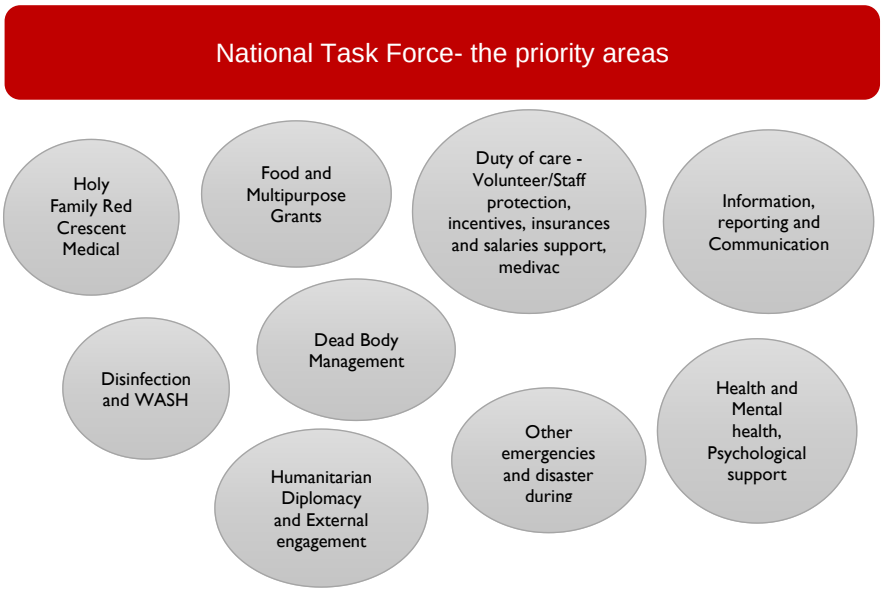
Red Cross Red Crescent Movement Task force

A Red Cross Red Crescent Movement Task Force has been formed to provide strategic leadership support and guidance to the BDRCS COVID-19 operation. The task force will review situation, funding positions, commitments from domestic and international donors, priorities on the ground and will guide the operational priorities. The task force will maintain a close coordination with Bangladesh Government's plan and directives. The task force will also ensure transparency and accountability at all level.

Task Groups

Nine task group has been formed based on the priorities of the operational area. The task groups will have broad responsibilities on the following areas:

- Technical advice and support
- Prioritization, budget and cash flow
- Opportunities, challenges and solution focus for the latter
- Mobilize surge as required
- Risk management
- Progress monitoring
- The task group will act as a serving group to the leadership
- Reporting back to the task force by the team leader



BDRCS nation-wide approach based on its strategic positioning

BDRCS nation-wide approach for prevention, mitigation and treatment efforts include mobilization of its collective strength across the country.

- **Engage in its auxiliary status to Government of Bangladesh:** BDRCS will closely coordinate with Ministry of Health/Director General of Health Services to provide strategic support to government of Bangladesh through targeted interventions in health sector and prevention work throughout the country. Similarly, it will engage with government and local authorities in Cox's Bazar to provide services to both host and guest communities.

- **Provide strategic health service support:** BDRCS will provide targeted support in close coordination with government authorities and other key stakeholders utilizing available heath facilities and resources as needs arise.
- **Mobilize strength of 64 branches in each district and 4 branches in city corporation**: BDRCS will use its volunteers and community volunteers to conduct prevention awareness activities at each district on hygiene promotion, social distancing and tracking COVID-19 related rumours which is an important component of responding to a pandemic. BDRCS is supporting local health authorities in COVID-19 preparedness and response. BDRCS will also use this network to assist vulnerable persons or groups needing special assistance with food and cash assistance as per needs assessments.
- **Mobilize network of nation-wide youth volunteers**: Youth volunteer network of 800,000+ will be mobilized for community support activities, prevention activities, public awareness messaging, amplifying social media reach and engaging their own households and neighbourhood through positive messaging
- **Mobilize network of CPP volunteers in 13 coastal districts**: BDRCS will mobilize the strength of 55,000+ volunteer network spread around 13 coastal districts to reach local communities with public awareness messaging and preparing for emergency situations in times of a pandemic.
- **Mobilize nation-wide social media reach**: BDRCS will use its social media reach to share public awareness messaging, promoting positive messaging and actively tacking rumours, a key component of managing pandemic response
- **Mobilize strength of staff and volunteer networks in covering all 34 camps in Cox's Bazar:** BDRCS will mobilize the strength of its staff, volunteers and over 3,500+ community health and WASH volunteers, PGI, CEA, PSS, and CPP camp volunteers spread across all 34 camps in Cox's Bazar to conduct household level awareness sessions together with multitude of partners and support response activities.
- **Engage in Water, Sanitation and Hygiene Promotion:** BDRCS will engage its staff and volunteers in increasing hand washing points, access to hygiene promotion material, hygiene promotion activities through its program activities and mobilization of volunteers.
- **Mobilize collective power of its movement partners**: BDRCS will utilize the staff, technical, logistical and fund-raising strength of the movement partners for collective action including ICRC, IFRC and partner national societies.
- **Coordinate closely with WHO, other UN agencies and partners**: BDRCS will coordinate with WHO, other UN agencies and partners across Bangladesh and specifically in Cox's Bazar setting to provide targeted and strategic support to ensure collective impact.

Targeting

Target group	Rationale
General Population	To raise awareness among general population about the potential risk of Covid19 and its precaution/containment measures
Elderly people	The elderly people are highly vulnerable considering the death rate of above age of 50 years.
Refugees in camps	Considering the highly congested and crammed settlements of displaced people from Rakhine in Cox's Bazar, adequate prevention, preparedness and containment measures are needed.
Most vulnerable families (marginal income farmers/ daily workers/day labours, trans gender, physically challenged people, widowed/women headed family etc)	Due to the lockdown situation, economically marginalized people and other most vulnerable people have lost employment/livelihood and are struggling to access food and essential items.
Public Authorities	BDRCS has already received a letter from the DGHS to support ongoing COVID19 response in Bangladesh. Public authorities have primary mandate, and scale of the crisis requires better and meaningful cooperation to address the emerging needs and fill the gaps. Taking comparative advantage of ongoing collaboration with the public authorities at all levels BDRCS can develop a robust mechanism for coordination with the public authorities which will also help BDRCS to deliver planned services.

Guiding Response Principles and Key Considerations

The BDRCS response plan aims at maximizing coherence and delivering an effective and efficient response by building on the comparative advantages of BDRCS as humanitarian organizations. The response approach is guided by the following principles, which will be integrated in all the interventions:

- Respect for humanitarian principles.
- People-centered approach and inclusivity, notably of the most vulnerable people, stigmatized, hard to reach, displaced and mobile populations that may also be left out or inadequately included
- Cultural sensitivity, and attention to the needs of different age groups (children, older people), as well as to gender equality, particularly to account for women's and girls' specific needs, risks and roles in the response as care providers
- Two-way communication, engagement with, and support to capacities and response of local actors and community-based groups in the design and implementation of the response, using appropriate technology and means to account for mobility restrictions and social distancing.
- Complementarity and synergies between agency plan and responses.
- Preparedness, early action and flexibility to adjust the responses and targets to the fast-evolving situation and needs.

Crisis phase Categorization and Scenario Planning

BDRCS and IFRC secretariat have taken into consideration of this GoB planning scenario while declaring the COVID-19 crisis categorization for the BDRCS and IFRC in Bangladesh. According to the contextualized crisis categorization in **Bangladesh IFRC BD and BDRCS is now under 'ORANGE phase'** where the 'cluster of cases- country level 3' falls under ORANGE phase.

BDRCS and IFRC Bangladesh Country Office will continuously monitor the situation through the CMT (crisis management team) and will notify if there is any trigger to either scale up or scale down of the crisis phase.

The scenario planning for the COVID-19 situation in Bangladesh has been developed through a two-prong approach. One is for the entire country as an overall scenario planning and the other one is for the Cox's Bazar PMO considering its' fragile context.

1. **For the Whole country- Scenario Planning:** DGH of GoB, in its 'planning scenarios and response level' classification, has considered three level of response for identified 4 level of scenarios. The three levels are 'Preparedness', 'Containment' and 'Mitigation'. For each of the response level DGH of GoB have identified seven priority areas for planning and actions- Coordination and planning; Surveillance, laboratory and Points of Entry (PoEs); Case finding, contact tracing and quarantine; Clinical case management; Infection prevention and control; Risk communication and public awareness and Operational Research. At the same time Ministry of Disaster Management and Relief (MODMR) has initiated general awareness through disaster management committees and has started general relief programs to support the socio-economic impact. Considering the government plans and BDRCS mandate the following scenario planning has been worked out to within the defined crisis phase classification. However, all the priority areas identified by DGH of GoB might not be part of the IFRC-BDRCS response strategy. Continuing the essential service delivery of ongoing operations like flood early recovery operation, population movement operation at Cox's Bazar are huge concern in case particular areas are lock down. In addition to that. the upcoming pre monsoon cyclone seasons (April-May 2020) is one of the major concerns.

Scenarios	Phase classification	Scenario definition	Humanitarian impact	Focus actions
Scenario 1	**Yellow**	Imported cases and limited Human-Human Transmission. The government has indicated that it is considering introducing measures such as movement controls	Low	Enhance preparedness measures to stop transmission, prevent spread

Scenario 2	**Orange**	Cluster of cases identified. Government closes schools, and non-essential public services Majority of shops, markets, workplaces closed	Medium	Containment measures. Socio economic support to reduce impact due to home-lock
Scenario 3	**Orange**	**Localized transmission has been established and is rapidly increasing** **Government has imposed movement restrictions or other measures that impact on business continuity**	**High**	**Increase containment measures and entry to mitigation.** **Socio economic support to reduce impact due to home-lock**
Scenario 4	**Red**	Community transmission Virus spreads rapidly and is reported to be overwhelming containment measures. Civil power unable to enforce containment measures - Government to deploy military forces in an internal security role	Very high	Enhance the mitigation measures. Scale up Socio economic support to reduce impact due to home-lock and scarcity of health services for other health crises

2. **Cox's Bazar- PMO-Scenario Planning:** Considering the WHO scenarios and applicability to the Cox's Bazar setting based on the background information shared above, BDRCS/IFRC PMO Business continuity plan is based on the following scenarios:

Transmission scenario	**Definition**		**Aim**
1	No Cases	No Reported Cases	Scale up preparedness and mitigation measures
2	Sporadic Cases	One of more cases, imported or locally acquired	Stop transmission and prevent spread
3	Community Transmission	Experiencing larger outbreaks of local transmission like - Large numbers of cases not linkable to transmission chains, Large numbers of cases from sentinel lab surveillance and Multiple unrelated clusters in several areas of the country	Slow transmission, reduce case numbers, end community outbreaks
4	Worst Case	Outbreaks plus cyclone. Complex emergencies.	Provide the mitigation measures to limit the primary and secondary impacts brought by multiple hazards.

In preparation for managing this crisis within all the above scenarios, BDRCS/IFRC PMO has developed a scenario based contingency plan and related business continuity plan in close coordination with BDRCS and partners national societies in the Cox's Bazar. These both documents will be updated as per the ground realities on a periodical basis.

Stakeholders

Red Cross and Red Crescent partners in Bangladesh actively involved in the operation: International Federation of Red Cross and Red Crescent Societies (IFRC), American Red Cross, British Red Cross, Canadian Red Cross, Danish Red Cross, German Red Cross, Italian Red Cross, Japanese Red Cross Society,

Qatar Red Crescent, Swedish Red Cross, Swiss Red Cross, Turkish Red Crescent and the International Committee of the Red Cross (ICRC).

Other partner organizations actively involved in the operation: Institute of Epidemiology, Disease Control and Research (IEDCR), Bangladesh; Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh; WHO, UNICEF, other UN agencies, Start Fund Network, INGOs and NGOs.

Corporate and business organizations supporting this operation: Coca Cola Bangladesh and Uniliver Bangladesh. Other corporate and business organizations are requested and encouraged to support this operation.

District branches: all 68 branches of BDRCS are engaged in this operation and playing the implementing role as front line responders.

Summary Budget and Funding Strategy

Sector	Nationwide *(in CHF)*	PMO in Cox's Bazar *(in CHF)*	Grand Total *(in CHF)*
Health	5,427,069	4,809,929	10,236,998
Livelihood: Food & multipurpose cash grant	4,403,189		4,403,189
Water, sanitation & hygiene Promotion (WASH)	389,942	653,377	1,043,319
Infection & Prevention Control (IPC)	676,200		676,200
Protection, Gender & Inclusion (PGI)	87,455	102,773	190,228
Shelter and settlement	101,430		101,430
Migration	50,000		50,000
Strengthen National Societies	2,010,040	979,900	2,989,940
Grand Total	**13,145,324**	**6,545,979**	**19,691,303**

To cover the funding requirement BDRCS will have the below funding strategy:

- BDRCS will launch an appeal by its own to attract domestic and international funds.
- BDRCS will continue its regular donation channels to receive funding for this operation
- BDRCS will request IFRC to launch an international appeal to raise funds internationally. This process is standard RCRC response mechanism followed in every disasters and crisis.
- BDRCS district branches will also be engaged in local fundraising to support the activities
- BDRCS will collaborate with government to receive funding
- Activities will be implemented based on available funding and the topmost priorities at that point in time.

Detailed Plan of Action

Health

People targeted: 1,500,000
Male: 50%
Female: 50%
Requirements (CHF): 10,236,998

Needs analysis and risk analysis: Refer to Section A: Needs analysis, targeting, scenario planning and risk assessment and COVID-19 Country Plan of Action.

Population to be assisted:

- Preparedness activities will focus on the most at-risk communities, while building the capacity and relationships needed for NS and volunteers to effectively respond.
- Containment activities will focus on the communities at risk of transmission, and individuals experiencing COVID-19 infection.
- Support BDRCS to prepare and to provide health service to COVID-19 patients through Improving the existing capacity of Holy Family Red Crescent Hospital and its' other health facilities. (e.g. equipping with necessary medical supplies and equipment to provide 300 bed isolation and 20 bed ICU service).
- Activities that focus on reducing anxiety, stigma and develop coping strategies among individuals through providing Psycho-Social Support (PSS) and psychological first aid (PFA) including concerns staff and volunteers of BDRCS and movement partners.
- Training on the appropriate, safe and effective use of PPE for health workers, staff and volunteers of BDRCS.
- **I**nfection & prevention Control**:** Coordination with government and support nationwide disinfection activities in hospital, health facilities, emergency service facilities etc. with the support of BDRCS volunteers
- **Population Movement Operation (PMO) in Cox's Bazar:** Existing PMO health facilities to be equipped with necessary PPE, medical supplies and equipment to ensure continuity and sustainability of delivering basic health care services based on its WHO and health sector defined functions. Further, this entails incorporating social distancing and adequate hygiene measures in the centres, raising awareness of staff, opening triage and short-term isolation areas (i.e. holding areas) until suspected COVID-19 cases are transferred to temporary isolation and treatment centres. Activities that will improve community- level prevention, detection of serious cases, and referral through conduct of community-based health and surveillance activities in camp areas identified most at risk.
- **Population Movement Operation (PMO) in Cox's Bazar:** Establishing an integrated isolation centre on BDRCS Field Hospital (50 beds) and BDRCS-Swiss Red Cross facility in camp 2E (30 beds) with the capacities to contain and screen cases and refer them to temporary treatment facilities if a suspected case is confirmed

Programme standards/benchmarks: SPHERE standards, WHO guidelines and National Guideline for COVID-19 Management.

PHASE 1: PREPAREDNESS

Health Outcome 1: Communities and National Societies can quickly and effectively respond to an outbreak of COVID-19	*NS together with MoH completed capacity and risk mapping and response planning. (Target: Yes)*											
Health Output 1.1: Increase understanding of risk and safe activities, including risk communication and health promotion based on community feedback	*# of people reached through risk communication and community engagement activities. (Target: 1,000,000)*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Context analysis: Rapid assessment to identify most at risk, barriers to healthy behaviours and gather insights on cultural and contextual factors that could help or hinder an effective response	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Health promotion: Mobilize NS volunteers' networks and key influencers (i.e. religious and community leaders) to encourage promotion of general health behaviours and address mistrust, misinformation and rumours with actionable and verified information	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Risk communication: Carry out risk communication activities	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

based on community information needs, concerns and perceptions, share timely and trustworthy information, address misinformation and build knowledge, acceptance and intention about signs and symptoms, transmission modes, preventive actions (handwashing, social distancing) and care-seeking behaviours by people experiencing respiratory symptoms. .												
Community Radio, TV Programs: Community radio, TV shows for all over country, including Cox's Bazar to share the key awareness message dissemination, dos and don'ts, where people can get the right treatment.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
CEA materials: Preposition of IFRC, UNOCHA, WHO prescribed community engagement and communication materials in local language for rapid use by volunteers in at risk/affected areas (i.e. FAQ documents)	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Feedback mechanisms: Set up a community feedback system (including rumours tracking) to monitor, address and answer information gaps, believes and misconceptions, questions and rumours and inform health approaches	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Health Output 1.2: National Societies are prepared to maintain life-saving humanitarian and development activities during an outbreak of COVID-19 and can adapt their approaches to the evolving outbreak.	*# of people reached with community-based epidemic prevention and control activities. (Target: 50,000 people)*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Plan response: Develop and review pandemic preparedness & response plan.	*x*	*x*	*x*				*x*	*x*	*x*			
ECV training: Conduct training on Epidemic Control for Volunteers – focused on COVID-19	*x*	*x*	*x*	*x*								
PPE training: Training and sensitization of the appropriate, safe and effective use of PPE to staff and volunteers	*x*	*x*	*x*	*x*								
Develop materials: Localise, contextualise and/or translate COVID-19 materials and tools for community-level use including IEC materials on MHPSS.	*x*	*x*	*x*	*x*	*x*	*x*						
Preposition PPE for health workers, volunteers and staff working in high-risk conditions	*x*	*x*	*x*	*x*								
Readiness checks: Conduct national- and branch-level readiness checks to prepare to activate CBHFA, ECV and other community-based volunteers to respond in the event of an outbreak	*x*	*x*	*x*	*x*								

PHASE 2: CONTAINMENT

Health Outcome 2: National Societies support rapid containment of localised outbreaks when they occur in new communities	*NS supported outbreak response at the request of the respective government. (Target: Yes)*											
Health Output 2.1: Support public confidence in the health system and outbreak response measures, and promote effective community engagement, risk communication, behaviour change and hygiene promotion approach to motivate action and promote participation. Reduce stigma and violence	*NS working in clinical setting following IPC guidance. (Target: Yes)*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Map resources and positive practices: at the community level to support locally driven actions for preparedness, containment and response are helpful and empowering preparedness activities.	*x*	*x*	*x*	*x*	*x*							
Information and referral: Communicate about relevant available services (e.g. psychosocial support, designated COVID-19 health facilities etc.), based on community questions and concerns.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Public Education and Mass Awareness: Carryout public education activities based on the knowledge and skill deficiency and need, develop user friendly educational materials and	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

disseminate key messages on the infection prevention and control.												
Influence strategy: Influence government and partner approaches to quarantine, isolation, treatment and other response approaches based on community feedback such as hygiene promotion.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Health Output 2.2: Reduce risk of secondary transmission of the virus to prevent an outbreak or once local transmission has begun, reduce risk of more generalised transmission of the virus to contain the outbreak.	*# of people reached by psychosocial support. (Target: 10% of population)* *# of government hospital regularly disinfected through BDRCS supported infection prevention and control initiatives. (Target: at least 200 hospitals)* *# of public places regularly disinfected through BDRCS supported infection prevention and control initiatives. (Target: at least 500 public places)* *# of people reached by psychosocial support.*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Psychosocial support: to general public, affected individuals and responders, including RCRC volunteers and staffs	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Conduct Psychological First (PFA) training for staff and volunteers - focused on COVID-19	*x*	*x*	*x*	*x*								
Infection prevention and control: Coordination with government and support nationwide disinfection activities in hospital, health facilities, emergency service facilities etc. with the support of BDRCS volunteers Develop the IPC guidelines; facilitate and conduct trainings to address any identified skills and performance deficits on the infection prevention and control.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Infection prevention and control: Disinfectant activities in all 64 districts for government hospital in district HQ, medical college hospitals in respective districts and public places.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

PHASE 3: MITIGATION

Health Outcome 7: National Society has increased capacity to manage and respond to health risks	*NS requested by MoH to provide health service related to COVID-19 (Target: Yes)*											
Health Output 7.1: BDRCS along with its health workers, volunteers and staffs are able to provide better, more appropriate, and higher quality emergency health services	*# of people received health service related to COVID-19 from BDRCS health facilities.* *# of patients transported through ambulance service.* *# of government hospitals provided with medical equipment by BDRCS.* *# of people reached by psychosocial support.*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Coordination with health ministry, DGHS, WHO and other stakeholders.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Health services: Support health systems to mitigate secondary impacts of outbreak on access to health care through scaling up the capacity of BDRCS existing HFRCMCH and other health facilities.			*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Health services: Enhance laboratory facilities in HFRCMCH for COVID-19 testing			*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Health services: Enhance and maintain Isolation facilities in HFRCMCH and other health facilities of BDRCS for COVID-19 patients			*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Health services: Increase ICU capacity in HFRCMCH for critical cases of COVID-19 requiring life support.			*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Provide ambulance service for COVID-19 related patient to transport to government identified isolation and treatment centres for severe and critical case management.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Setup triage, screening, IPC, isolation standards and processes/SOPs at integrated isolation facility												
Establish and scale existing non-medical processes/SOPs, such as HR management, operational management, waste management, laundry service, cooking, O&M etc.) at integrated isolation facility.												

Population Movement Operation (PMO) in Cox's Bazar: Existing PMO health facilities to be equipped with necessary PPE, medical supplies and equipment to ensure continuity and sustainability of delivering basic health care services.				x	x	x	x	x	x	x	x	x
Population Movement Operation (PMO) in Cox's Bazar: Establishing an integrated isolation centre on BDRCS Field Hospital (50 beds) and BDRCS-Swiss Red Cross facility in camp 2E (30 beds) with the capacities to contain and screen cases and refer them to temporary treatment facilities if a suspected case is confirmed				x	x	x	x	x	x	x	x	x
Psychosocial support: to general public, affected individuals and responders, including RCRC volunteers and staffs			x	x	x	x	x	x	x	x	x	x

Water, Sanitation and Hygiene Promotion (WASH)

People targeted: 500,000
Male: 50%
Female: 50%
Requirements (CHF): 1,043,319

Needs analysis and risk analysis: Refer to Section A: Needs analysis, targeting, scenario planning and risk assessment and COVID-19 Country Plan of Action.

Population to be assisted:

- Mass awareness on handwashing and hygiene practice (including MHM) through demonstration and disseminating key messages.
- 50,000 personal hygiene kits will be provided among the health workers, BDRCS volunteers and staffs
- 5,000 hygiene parcels will be provided to most vulnerable households are in need.
- Installing 10,000 handwashing stations

Programme standards/benchmarks: SPHERE standards, WHO guidelines, ISCG WASH Sector Working Group Guidelines

WASH Outcome 1: Reduce risk of secondary transmission of the virus to prevent an outbreak or once local transmission of the virus to contain the outbreak	*# of Households reached on COVID-19 Hygiene Promotion and Handwashing sessions.* *# of Hygiene Kits distributed. (Target: TBC)* *# of handwashing stations installed. (Target: 150)*											
WASH Output 1.1: Prevent and /or reduce transmission through tailored risk and behaviour change communication focusing on hygiene promotion key messages												
Activities Planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Mass awareness on handwashing and hygiene practice (including MHM)	x	x	x	x	x	x	x	x	x	x	x	x
Provide safe drinking water in isolation centres, hospitals etc.	x	x	x	x	x	x	x	x	x	x	x	x
Installation of hand washing stations	x	x	x	x								
Procurement and distribution of personal hygiene kits	x	x	x	x	x	x						
Develop and disseminate IEC materials on best hygiene practice related to COVID-19	x	x	x	x								
Installation of additional handwashing stations in Child Friendly Spaces (CFS) Community Safe Spaces (CSS), community centres and distribution centres of BDRCS PMO	x	x	x	x								

Livelihoods and basic needs

People targeted: 1,000,000
Male: 50%
Female: 50%
Requirements (CHF): 4,403,189

Needs analysis: Refer to Section A: Needs analysis, targeting, scenario planning and risk assessment and COVID-19 Country Plan of Action.

Population to be assisted:

- 200,000 most vulnerable households will be supported with food parcels.
- 400,000 most vulnerable people will be supported with cooked food
- 50,000 most affected households will be provided multipurpose cash grants (MPCG) through financial service providers to cover the emergency need of one month.

Programme standards/benchmarks: BDRCS and Food security cluster recommendation. Multipurpose cash grant package is based on national cash working group recommendation.

Outcome 1: Communities, especially in disaster and crisis affected areas, restore and strengthen their livelihoods	*# of households that have enough food, cash to meet their needs.*											
Output 1.1: Basic needs assistance for livelihoods security including food is provided to the most affected communities	*# of households reached with food parcel.* *# of people reached with cooked food.*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Procurement and distribution of food parcel among most vulnerable households	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Provide cooked food among most vulnerable people	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Output 1.2: Households are provided with unconditional/multipurpose cash grants to address their basic needs	*# of families reached with multipurpose cash for basic needs*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Provide MPCG among the most vulnerable families	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Market assessment	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

Shelter

People targeted: 20,000
Male: 50 %
Female: 50 %
Requirements (CHF): 101,430

Needs analysis: During COVID-19 crisis, the physical and social conditions under which people live can have an effect on the spread or containment of the disease and how effectively people can protect themselves and their families. The needs in this regard are significant when we consider the housing and neighbourhood conditions in the urban areas, particularly in densely populated slums where marginalized groups reside and where health, water and sanitation services are poor. According to NAWG initial findings marginalized people living on the street and slum; don't have enough capacity and space to ensure safe home quarantine during this COVID-19 crisis. To ensure safe living environment and considering of the people vulnerabilities; temporary makeshift shelter or camp like settlement is being anticipated.

Population to be assisted:
Support 5,000 people who are in specific vulnerable living condition considering COVID-19 with appropriate shelter assistance like temporary makeshift or camp settlement using tent in consultation with government.

Programme standards/benchmarks: Bangladesh shelter cluster standards and recommendations.

Outcome 1: Communities strengthen their safety and well-being through shelter and settlement solutions	*# of people targeted/reached with safe and adequate shelter and settlement. (Target: 5,000)*											
Output 1.1: Short, medium and long-term shelter and settlement assistance is provided to households in need	*# of people provided with appropriate safe shelter assistance. (Target: 5,000).*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Pre-position and distribute shelter materials and basic HHIs as necessary, particularly for collective shelters, camp settlements and urban hotspots, or to respond sudden new population movement.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Advocate with authorities for safe shelters in specific vulnerable environments and assist to identify solutions for specific temporary isolation measures.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Output 1.2: Technical support, guidance and awareness raising in safe shelter design and settlement planning and improved building techniques are provided to households are in need.	*# of people provided with technical support and guidance, appropriate to the type of support they receive (Target: 5,000)*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Adapt and disseminate technical guidance relating to COVID-19 and how it relates to informal settlements, camps, collective accommodation, and in particular, densely populated urban contexts and slums etc.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

Protection, Gender and Inclusion

People targeted: 1,500,000
Male: 50%
Female: 50%
Requirements (CHF): 190,228

Population to be assisted: All the people involved/assisted in either relief phase and through any sectoral interventions, must include PGI lenses, especially in beneficiary selection, delivery of interventions, monitoring and reporting.

Program standards/benchmarks: IFRC minimum standards for protection, gender and inclusion in emergencies, SGBV guidelines, Child Protection Policy of IFRC, Code of Conduct, etc.

Protection, Gender & Inclusion Outcome 1: Communities become more peaceful, safe and inclusive through meeting the needs and rights of the most vulnerable.	*Targeted people's needs and rights are met and PGI are included in all stages. (Target: Yes)*											
Protection, Gender & Inclusion Output 1.1: Programmes and operations ensure safe and equitable provision of basic services, considering different needs based on gender and other diversity factors.	*Initial assessments include key PGI areas. (Target: Yes)* *Sex, age and disability disaggregated data is collected. (Target: Yes)* *# of staff and volunteers trained on minimum standards. (Target: 100)*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Assessment of needs to include PGI: Conduct an assessment of specific needs of the affected population based on criteria selected from the minimum standards for PGI in emergencies.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Gender and diversity in planning: Support sectoral teams to include measures to address vulnerabilities specific to gender and diversity factors (including people with disabilities) in their planning	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Orientation session for staff and volunteers on gender and diversity sensitivity, and protection and exclusion risks from the consequences of COVID-19 and referral pathway to get health support and SGBV support	*x*	*x*	*x*				*x*	*x*	*x*			
PGI messaging on against stigma and xenophobia: Incorporate key PGI messaging together with RCEC for integrated delivery to National	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*

Society and communities to promote acceptance and trust against stigma and xenophobia												
SADDD data: Support sectoral teams to ensure collection and analysis of sex-age and disability-disaggregated data (see guidance in Minimum Standards)	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Knock Knock! Red Crescent Youth at your doorstep to assist elderly people living without family.	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Hello RC Kids! Provide useful information about COVID19 through social media	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Protection, Gender & Inclusion Output 1.2: Programmes and operations prevent and respond to sexual- and gender-based violence and other forms of violence especially against children	*% of staff and volunteers signed the Code of Conduct. (Target: 100%)*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Integrate child protection: Use Minimum Standards as a guide to support sectoral teams to include child protection and measures to mitigate the risk of SGBV	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Code of Conduct: Establish a system to ensure IFRC and NS staff and volunteers have signed the Code of Conduct and have received a briefing in this regard	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Child protection policy: Volunteers, staff and contractors sign, are screened for, and are briefed on child protection policy/guidelines	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
CEA Outcome 1: Develop mechanisms that will promote effective community engagement, risk communication, behaviour change and tailor hygiene promotion approach to motivate actions and promote participation	*# of hubs/ desks/feedback box setup in camps.* *# of CEA project staff (officers and community mobilizers) trained on COVID-19. Preparedness and Response as Disseminators.* *# of community volunteers trained on COVID-19 Awareness Sessions.* *# if individuals reached on COVID-19 awareness in CEA info hubs/desks.* *# of individuals provided information/ Feedbacks in CEA hubs.* *# of feedbacks/information referred to other sectors/ offices/ external agencies.* *(Targets: TBC)*											
CEA Output 1.1: Establish risk communication and community engagement strategies that will guide sectors in effectively communicating key messages to people												
Activities Planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Coordination meeting with (RCCE, Shongjog, PNS) and Co-host digital learning sharing events with multi-stakeholders	*x*											
Community perception survey online/offline on COVID-19 (Design social campaign at the community level)	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Capture best practices, stories, learnings and case study on COVID 19	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*	*x*
Provide guidance to sectors in developing/ adapting and producing IEC materials in close coordination with Communicating with Communities (CWC) Sector in Cox's Bazar.	*x*	*x*										
Community feedback/suggestions/complaint handling on Covid-19 (through information hub, hotline, mobile, feedback email messenger, web, FGD) across the country including PMO Cox's bazar, MRRO												
Connecting community through Live TV, Radio shows and voice massage through mobile												

Migration

People targeted: 100,000
Male: 50%
Female:50%
Requirements (CHF): 50,000

Population to be assisted: This operation will support BDRCS to assist vulnerable migrants and displaced populations – irrespective of their legal status – their family members, and others affected, e.g. host communities. This will include along migratory routes, e.g. Bangladeshi migrants abroad, Bangladeshi migrants returning, and migrants in Bangladesh, as well as displaced populations in Bangladesh.
Risk analysis: The operation will closely monitor and analyse evolving and possible risks in the context of migration and displacement, including: increasing stigma and discrimination; onward large-scale movement away from areas of infection, or following quarantine or closure of specific locations (either within Bangladesh, returning to Bangladesh or from Bangladesh); also informal and formal barriers to accessing services to migrants and displaced communities.
Program standards/benchmarks: This operation will be undertaken in accordance with relevant policies and guidelines, including the IFRC Asia Pacific Guidance Note on COVID-19: Including migrants and displaced people in preparedness and response activities - Guidance for Asia Pacific National Societies (2020); the Policy on Migration (2009), the IFRC Asia Pacific Framework on Migration and Displacement (2017) and the Guidelines to Protect Migrants in Countries Experiencing Conflict or Natural Disaster (MICIC) (2017).

Migration Outcome 1: Communities support the needs of migrants and their families and those assisting migrants at all stages of migration (origin, transit and destination)	*# of displaced people reached with information and services provided from welfare desks. (Target: 100,000)*											
Migration Output 1.1: Assistance and protection services to migrants and their families are provided and promoted through engagement with local and national authorities as well as in partnership with other relevant organizations	*# of affected people have access to basic services. (Target: 50,000)*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Humanitarian diplomacy in favour of vulnerable migrants, including undocumented migrants.												
Assess possible risk of COVID-19 on migrant communities, and identify vulnerable migrants												
Provide relevant and accessible information on COVID-19 to migrant in a language that they understand												
Support sectoral teams to address the vulnerabilities specific to migrants across their activities												
Migration Output 1.2: Awareness raising and advocacy address xenophobia, discrimination and negative perceptions towards migrants are implemented.	*# of staff and volunteers are trained on RCRC migration approaches. (Target: 50)*											
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12
Migration and Displacement Analysis and Assessment												
Sharing good practice and knowledge in reaching vulnerable migrants with concerned stakeholders												

Strengthen National Society

Requirements (CHF): 2,989,940

Outcome: National Society capacity building and organizational development objectives are facilitated to ensure that National Societies have the necessary legal, ethical and financial foundations, systems and structures, competences and capacities to plan and perform	• *# of volunteers and staffs insured. (Target: XXXX)* • *% of staff and volunteers are provided with necessary PPE. (Target: 100%)* • *NS developed Business Continuity Plans finalized. (Target: Yes)* • *# of communications materials produced/published. (Target: XX)* • *BDRCS participate local and national dialogues/meetings. (Target: Yes)* • *Lessons learned workshop is conducted. (Target: 1)*											
Output: BDRCS has necessary corporate structure and system in place												
Activities planned Month	1	2	3	4	5	6	7	8	9	10	11	12

Insurance and risk incentive coverage: Ensure that BDRCS volunteers and staffs have insurance and risk incentive coverage						x	x	x	x	x	x	x
PPE prepositioning: Preposition stock of Personal Protection Equipment for BDRCS staffs and volunteers												
Video documentary on BDRCS activities and broadcast on television media						x	x	x	x	x	x	x
Media Communication in district and Dhaka level						x	x	x	x	x	x	x
Emergency PMER framework												
Unit development based on BOCA and OCAC recommendation						x	x	x	x	x	x	x
Capacity building BDRCS health facilities considering COVID-19 and future similar pandemic crisis.						x	x		x	x	x	x
Ensure continuous operational support for COVID-19 response (salary, transportation etc)						x	x	x	x	x	x	x
Capacity building of BDRCS support service						x	x	x	x	x	x	x
Business continuity plan: Identifying the potential impact/ threat of operation on overall operational capacities for business continuity plans.												
Emergency response framework: Develop a framework to ensure an effective emergency response with reduced resources, including a mapping of the minimum structures needed to keep core business going as part of the business continuity plan.						x						
Communication strategy for preparedness and response						x	x	x	x	x	x	x
Evaluation: Real-time evaluation, mid- and end term evaluations are carried out along with lessons learned workshop.						x				x	x	x

Contact for further information

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