COVID-19 Outbreak Multi-Sectoral Response Plan

UNITED NATIONS IN TIMOR-LESTE

2020

UN Timor-Leste: COVID-19 Outbreak Multi-Sectoral Response Plan

April to September 2020

Working Document (version 13 May 2020)

Table of Contents

Introduction

The Government of Timor-Leste declared a State of Emergency (SoE) on 28 March 2020, following the first confirmed case of COVID-19 pandemic in Timor-Leste. The declaration originally lasted until 26 April 2020 and was subsequently extended until 27 May 2020. The SoE was declared in an effort to contain the spread of COVID-19 and prevent high levels of morbidity and mortality. A country with a weak health system and high level of multi-dimensional poverty, the potential health and socio-economic impact of COVID-19 outbreak in Timor-Leste is huge, with a disproportionate negative impact on the poor, the excluded and the most vulnerable.

To date (13 May), Timor-Leste has had 24 confirmed positive cases, 17 of whom have since recovered, and no death. The last positive case was recorded on 24 April. There has been no known local transmission.

International support to the national health sector preparedness and response to COVID-19 has been ongoing since the early stages of the global outbreak, under the technical coordination and leadership of WHO. In recognition of COVID-19 as a "human crisis" impacting human security, it is imperative that the COVID-19 outbreak response in Timor-Leste is multi-sectoral, with a firm focus and prioritization on addressing the multi-dimensional needs of the people most affected and/or at-risk.

Purpose and Scope

The UN in Timor-Leste, under the leadership of WHO, has been supporting the Government of Timor-Leste with national preparedness and response through the Country Preparedness and Response Plan (CPRP), focusing on addressing the direct health impact. The COVID-19 Outbreak Multi-Sectoral Response Plan is an inter-agency response plan in support of the Government response to COVID-19 outbreak in Timor-Leste, focusing on addressing the indirect socio-economic impact. As such, it should be read in conjunction with the CPRP (see Annex 1).

The COVID-19 Outbreak Multi-Sectoral Response Plan focuses on preparedness and response to the initial immediate and urgent multi-sectoral needs and response to the pandemic for the next six months (April to September 2020). The Plan is a working document, which will continue to be reviewed and updated, informed by the findings and recommendations of the joint UN Socio-Economic Impact Assessment (SEIA) and other data/evidence. The Plan does not attempt to address secondary or tertiary issues related to macroeconomic effects or more longer-term requirements in various sectors. The longer-term impact of COVID-19 outbreak will be addressed through readjusting and reprioritizing as appropriate the UN Sustainable Development Cooperation Framework (UNSDCF) (2021-2025). This will be guided by the recently launched "A UN Framework for the Immediate Socio-Economic Response to COVID-19." Areas of readjustment and reprioritization may include scaled-up support to the Government's investments towards universal health coverage, strengthened social protection, closing gender and related inequalities, digital connectivity and recovery of small to medium-sized enterprises (SMEs).

The COVID-19 Outbreak Multi-Sectoral Response Plan prioritizes the needs of the people most affected and/or at-risk of health and non-health impact of COVID-19 outbreak. It focuses on areas that the UN has

the comparative advantages to provide the necessary support, with existing delivery capacities of the UN and partners.

Needs Analysis

Timor-Leste's health system is weak, poverty levels remain high in all their dimensions, and inequality in accessing quality services and opportunities continues to be a challenge. 430,000 people[1], or over one-third of the total population, are chronically food insecure. Rural communities, women, early adolescent girls and boys, children under 5, and people with disabilities are the most vulnerable to exclusion and marginalization in Timor-Leste. Such vulnerabilities are exacerbated in times of crisis, making them most at-risk to both the health and non-health impact of COVID-19 outbreak. In addition, globally, older persons have been disproportionately affected by the virus.

Should there be local transmission in Timor-Leste, the health system would be severely constrained in its ability to prevent the spread and provide health care to infected people, as well as sustain essential health services to the general population, including sexual and reproductive health services, mental health and psychosocial support (including in the context of health responses to gender-based violence), and overall management of non-communicable diseases.

The effects of the pandemic on people and institutions are compounded by pre-existing drivers of needs, including multi-dimensional poverty, inequalities (including on the basis of gender and geographic location), food insecurity, malnutrition, poor health, water and sanitation infrastructure and services, low education levels, limited social safety nets or social assistance, unequal access to information and high level of gender-based violence and violence against children. Amongst the laborers, those in the informal sectors and those employed in the SMEs[2] are particularly vulnerable to economic shocks and will be disproportionately affected by the ongoing crisis. With the return of migrant workers from countries such as Australia, Indonesia and Republic of Korea, the livelihoods of vulnerable households that had been dependent on remittances are being negatively affected.

Misinformation, panic and fear related to COVID-19 can weaken social cohesion, lead to xenophobia and create violence (including violence against women and children), exacerbating existing gender discrimination, including within the households. Those who are unable to meet their basic needs due to the negative consequences of COVID-19 outbreak, such as women, adolescent mothers and children living in poverty, may be driven to engage in high-risk behaviors, ignoring prevention measures or bypassing imposed mobility restrictions, and are at risk of sexual exploitation and abuse.

The restrictions to supply chain and travel pose additional challenges to service delivery in general and delivery of the COVID-19 outbreak response in particular. Timor-Leste is highly dependent on import of both food and non-food items. Over 50 percent of total cereal consumption needs are met through import of rice and maize. Rice import requirements in the 2019/20 marketing year (April/March) is

[1] Integrated Food Security Phase Classification (IPC) Analysis Report, January 2019.
[2] According to the Government's Development Financing Assessment Report (June 2018), the SMEs constitute 66% of Timor-Leste's private sector.

estimated to be 100,000 MT, accounting for 70 percent of total rice consumption needs. In March 2020, the Government indicated that there was a total of 30,000 MT of rice in stock in-country, which would be able to meet the rice demands up to June 2020. The Government is looking to procure 30,000 MT of rice through Government-to-Government agreement with Vietnam. Shortage of rice would pose a risk to the peace and stability in the country.

The global and regional supply shortages and the expected increase in global and regional prices – however temporary – of basic commodities and medical supplies, would negatively impact Timor-Leste. Increase of local food prices is likely to cause food insecurity affecting vulnerable urban households.

Strategic Priorities

In line with the Global Humanitarian Response Plan for COVID-19, the following are the three Strategic Priorities to be addressed through the Country Preparedness and Response Plan (CPRP) and the Multi-Sectoral Response Plan:

1. Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality. [Addressed through CPRP]

2. Decrease the deterioration of human assets and rights, social cohesion and livelihoods.
    i. Preserve the ability of the most vulnerable and affected people to meet the additional food consumption and other basic needs caused by the pandemic, through their productive activities and access to social safety nets and humanitarian assistance.
    ii. Ensure the continuity and safety from risks of infection of essential services including health (immunization, HIV and tuberculosis care, reproductive health, psychosocial and mental health, gender-based violence services), water and sanitation, food supply, nutrition, protection, and education for the population groups most exposed and vulnerable to the pandemic.
    iii. Secure the continuity of the supply chain for essential commodities and services such as food, time-critical productive and agricultural inputs, sexual and reproductive health, and non-food items.

3. Protect, assist and advocate for those particularly vulnerable to the pandemic.
    i. Advocate and ensure that the fundamental rights of those who are particularly vulnerable to the pandemic are safeguarded, and that they have access to testing and health-care services in line with existing standards, are included in national surveillance and response planning for COVID-19, and are receiving information and assistance.
    ii. Prevent, anticipate and address risks of violence (including violence against women and children), discrimination, marginalization and xenophobia by enhancing awareness and understanding of the COVID-19 pandemic at community level and ensuring functioning monitoring and accountability mechanisms are in place and operational for reporting and taking actions on violations of fundamental human rights.

These Strategic Priorities will be reviewed, informed by the findings and recommendations of the joint UN Socio-Economic Impact Assessment, which is planned for late May 2020.

Summary of People in Need, People Targeted & Financial Requirements

Sector	People in Need	People Targeted	Financial Requirements (USD)
Food Security		660,000	21,300,000
Nutrition		680,946	4,600,000
Logistics			800,000
Education	392,178		1,460,000
WASH	766,426	349,208	2,200,000
Protection			500,000
Economic Recovery			6,250,000
Social Protection	598,604		1,000,000
Essential Health Services		1,300,000	11,154,300
Total			**49,264,300**

Food Security

Sector Lead: FAO and WFP

Sector Members: National Logistics Center under MCTI, Civil Protection, SAMES, Ministry of Agriculture and Fisheries (DRM Task Force), Ministry of Transportation and Communication, MOEYS, CVTL, UN AFPs

1. Sectoral Impact of COVID-19 on People and Systems

The COVID-19 outbreak is rapidly exacerbating food insecurity in Timor-Leste, where over one-third of the population are chronically food insecure. The medium-term food security is also at risk as a result of the pandemic's negative impact on agricultural production, which is a source of livelihoods for 70 percent of the households.[3]

Timor-Leste is a food deficit country, where up to 70 percent of the rice consumption needs are met through import. With the global rise in demand for rice, there are concerns over the stability of regional food supplies that would negatively impact the physical availability of the main staple food – rice – in-country. Major exporters - including Vietnam, which supplies most of the rice consumed in Timor-Leste - have temporarily halted rice export while reviewing their national demand. Prices of rice in rice producing countries (China, Vietnam, Thailand, and Myanmar) have seen a sharp increase over the past months (USD 500/MT for 5% broken rice). Shortage of rice in Timor-Leste is a risk to peace and stability in-country.

Access to food – both economic and physical – has been disrupted due to COVID-19 containment measures and loss of livelihoods. Physical access to local fresh produce is disrupted as a result of movement restrictions on both people and goods. Local market structures[4] are not compliant to physical distancing requirement, further reducing access to local fresh produce. The prices of imported foods commodities have increased and may further see physical shortages due to border restrictions and regional and international price increases.

Food utilization has also been negatively impacted. Demand for higher value food products (such as fresh food, fish, meat) have in general fallen due to higher levels of uncertainty, containment measures and reduction in consumer purchasing power. On the other hand, the demand for lower value, imported, dry/long shelf-life high energy staple food (rice and oil) has risen, not least as a result of consumer stockpiling. A negative impact on the nutritional status, particularly of the urban poor, is anticipated.

Furthermore, there are concerns over medium-term food security as a result of COVID-19 outbreak's negative impact on agricultural production. Constrained access to local markets will work as a strong disincentive to farmers to cultivate their land, while existing production might be wasted both for fresh and dry food. Farmers traditionally do not have storage facilities even for dry food. With the main rice harvesting period from April to June, shortages of labour, combined with quasi unavailability of a farm harvest and post-harvest mechanization will disrupt the production and processing of all locally grown food.

Hence, the shortage of vegetable seeds and other farming inputs would need to be urgently addressed ahead of the next cropping season, as this has a medium-term impact on livelihoods, agricultural

[3] 2015 Census.

[4] It should be noted that the majority of market vendors are women, whose livelihoods have been lost and who are at-risk if they continue to operate in the local markets.

productivity, and dependency on imported food. In particular, the main limiting factor for crop cultivation is the availability of labor in a context where mechanization is extremely low.

Furthermore, the second cropping season is traditionally more labour intensive. In addition, the national production is facing the serious threat of Fall Army Worm (FAW), first detected in Timor-Leste in February 2020 and already present in all municipalities surveyed. A rapid FAW prevalence assessment showed that the pest infested 33% of maize plants in fields randomly survey. The prevalence is high and varies by municipalities between 22% in Liquica and 71% in Ainaro. If not addressed, the pest will create significant damages to maize for the next main cropping season.

Furthermore, a rapid *Chefe de Suco* opinion assessment on the impact of Covid-19 on food and agriculture conducted by MAF in April 2020 has also shown that food security continued to deteriorate, with some communities reportedly being in food distress in Mape, Covalima Municipality. Other communities might be in a similar situation. Local market disruption is the main immediate cause of food insecurity. Most *Sucos* reported that agriculture products were spoiled (fruits, vegetables and some maize) due to a lack of access to markets. Strategies adopted by households to cope with the deteriorating food security situation can aggravate the already very high prevalence of malnutrition. This is a serious concern as it may worsen an already high child mortality rate due to malnutrition.

The aggregated national food supply situation is, however, improving, owing to commercial rice imports by the private sector and the Government of Timor-Leste. In the immediate future, the risk of a supply break is averted but monitoring of the situation is required.

These factors, if not addressed, will lead to agricultural land not being cultivated, resulting in a further dependency on imported food and a greater burden on the national financial reserves.

The Government is attempting to import 30,000 MT of rice as strategic reserve and buffer stocks, but any deficit will need to be covered by food assistance and additional efforts to promote local production.

The Government has not yet appealed for international food assistance. However, the ongoing political impasse may slow down the Government's response capacities. Therefore, the Food Security Sector is preparing for a worst-case scenario to undertake general food distribution to 660,000 people in case the Government's plan to procure rice is delayed and the private sector experiences difficulties in importing rice.

2. Sectoral Response Priorities

a. Sectoral Objective

To meet the food security needs of the vulnerable population and maintain agriculture production with a special focus on supporting subsistence farmers negatively impacted by COVID-19 outbreak, through supporting national responses and optimizing inter-cluster collaboration and partnerships for a more holistic response.

b. Ongoing response

FAO, WFP and UNDP are currently working with the Ministry of Agriculture and Fisheries (MAF), the National Logistics Center (NLC), importers and others to strengthen Food Security and Market Monitoring.

This includes a thorough review of national food balance sheet with regard to rice production, consumption and import. Data accuracy remains a challenge.

FAO and WFP are supporting MAF to assess the prevalence of the FAW outbreak on maize and rice production.

FAO is supporting MAF Disaster Risk Management Task Force to put together a Government response plan to COVID-19 outbreak.

MAF is evaluating the status of the irrigation schemes and the opportunity of rapid maintenance work that could increase the area under cultivation. The provision of small hand-tractors at a subsidized price to farmers could significantly boost staple food production (particularly rice).

c. Priority response for the next 6 months

FAO will work with MAF to encourage farmers to reduce market barriers and expand cultivated area as of the second cropping season to increase the national grain output and promote production and supply. Key elements of the Government response should include:

- Regular data collection from *Chefe de Suco* and from both female and male farmers (by mobile phone) to monitor the impact of COVID-19 outbreak on food security and agriculture;
- Provision of incentives to ensure transport is available to enable itinerant merchants/farmers to bring local produce to consumer markets;
- Development of guidelines on how traditional markets (e.g. Taibessi, road-side markets, etc.) can continue to operate, considering the health safety measures such as physical distancing and accessible handwashing and sanitation facilities (UN Women can support);
- Import facilitation of all farming and veterinary inputs (including removing tariffs);
- Operation, including a communication campaign, to address FAW, targeting the next cropping season[5]; and,
- Large operation to repair MAF tractors and import two-wheel tractors to prepare farmers' land for the next cropping season and, in parallel, accelerate the establishment of public-private partnership for mechanization, import of fertilizers and other farming inputs (bio-pesticides against FAW, veterinary equipment and inputs, etc.).

As part of its "Pro-Resilience" project funded by the EU, FAO is organizing farmers groups in Covalima, Ainaro, Manufahi and Viqueque to sustainably increase maize production as of the next main cropping season.

With technical support from WFP, the Government is purchasing a three-month emergency supply (30,000 MT) of rice from Vietnam to offset potential shortages during the pandemic. WFP will continue to provide technical assistance on food storage, delivery, distribution, and monitoring of the Government's food assistance programme. WFP is discussing the option of providing emergency food assistance as a last resort of response. It will cover two months of rice consumption needs for 660,000

[5] The main cropping season of maize starts at end of November to January and ends in March/April; the second cropping season of maize is April/May and physiological maturity is reached in July/August while the farmers may sometimes wait until September/October before harvesting.

vulnerable people, including 430,000 food-insecure people (IPC Levels 3/4) and 230,000 urban/rural poor impacted by COVID-19.

WFP is working with UNDP, the Ministry of Agriculture and Fisheries, and the General Directorate of Statistics on food price monitoring, remotely or face to face, in the market outlets covered by the monthly Consumer Pice Index (CPI) excercise .

WFP is monitoring the global food supply and its impact on port operation and the supplies of cargos , in particular the rice import business.

WFP is collaborating with the Ministry of Education aiming to deliver a nutrious take-home food basket to students and their families during the school closure imposed by the state of emergency.

People Targeted

660,000 vulnerable people, including 430,000 food-insecure people (IPC Levels 3/4) and 230,000 urban/rural poor impacted by the COVID-19 outbreak.

d. Indicative financial requirements

Activity	Details	Cost (USD)
FAO support to MAF response	See section c.	5,000,000
WFP emergency food assistance	2-month rice consumption needs to 660,000 vulnerable people	16,000,000
WFP School Feeding Programme	Take-home ration (rice, beans, eggs and vegetable oil)	300,000
Total		**21,300,000**

Nutrition

Sector Lead: Ministry of Health
Sector Co-Lead: UNICEF
Sector Members: WHO, WFP, FAO, European Union, World Bank, DFAT, USAID, JICA, KOICA, World Vision International East Timor, Alola Foundation, CARE International East Timor, CRS (Catholic Relief Services), Haim Health, Child Fund, Mercy Corp, CVTL, Oxfam, PHD, TOMAK, AVANSA, Catalpa, MalukTimor

1. Sectoral Impact of COVID-19 on People and Systems

Limited access to health services for the fear of contracting the COVID-19 disease and poor dietary intake as a result of limited movement and impact on markets, may result in increased case of wasting. Fear of cross-contamination may result in reduced breastfeeding practices. Fear of being infected by health workers, limited information, lack of protective gears and low motivation amongst the health workers may disrupt health services.

Estimated number of people most affected and/or at-risk

	Total	Male	Female
Under-5 children			
Adolescent girls			
Pregnant and lactating women			

2. Sectoral Response Priorities

a. Sectoral Objectives

1) To provide quality care for treatment and management of acute malnutrition.
2) To strengthen community capacity and linkages to enhance early identification of malnutrition and referral to facilities and participate in the promotion and support of optimal infant and young child feeding practices.
3) To prevent and protect vulnerable groups against the deterioration of nutrition status and mainstream gender and protection in programme delivery.
4) To strengthen nutrition surveillance and reporting systems to monitor the nutrition situation.
5) To strengthen Nutrition Sector coordination and partners engagement with and across other sectors such as Food Security, Health, WASH, Education and Protection when possible.

b. Ongoing response

To cope with severe underlying nutrition challenges, WFP is working with MoH and UNICEF to address severe underlying nutrition challenges, reactivating and scaling up Targeting Supplementary Feeding Programme (TSFP) to improve nutrient intake for children under 5, and pregnant & lactating women, as planned under the Country Strategy Plan (CSP) 2018-2020.

c. Priority response for the next 6 months

- Continued preventive nutrition services where and when movement restrictions allow them, with treatment of severe wasting.
- Integration of nutrition messaging to support Risk Communication & Community Engagement on (CPRP Pillar 2):
  - Breastfeeding for all mothers, including infected mothers, including establishing safe breastfeeding policy and protocol with MOH; ensure a policy that avoids widespread distribution and donations of breast milk substitutes (BMS) while ensuring that children with no possibility to be breastfed are adequately supported with formula;
  - Complementary feeding, including feeding during illness, hygiene and responsive feeding; and,
  - Continued utilization of primary health care services at community and facility level – where they are functioning.
- Discussion and agreement with MOH and other partners on which life-saving nutrition services are to be continued if the situation moves to acute phase and mechanisms to continue service provision if and when delivery platforms become disrupted or non-functional. This would be coordinated with the Health Cluster/Sector.
- Continuity of Infant and Young Children Feeding (IYCF) services, particularly on responsive feeding and addressing any breast milk substitutes (BMS) violation.
- Reinforcement of protocols for inpatient management of SAM in the context of COVID-19.

People Targeted

Interventions	Total	Male	Female
SAM without medical complication	8,471		
SAM with medical complication	941		
MAM (under-5 children)	45,080		
Vitamin-A supplementation (under-5 children)	167,093	85,217	81,876
Iron supplementation (Pregnant women)	51,997		51,997
Deworming	147,537	75,244	72,293
Micro-Nutrient Powders (6-23 months)	69,296	35,341	33,955

Infant and Young Children Feeding – Pregnant and Lactating Women	190,531		190,531

d. Indicative financial requirements

USD 3,000,000 (UNICEF)
USD 1,600,000 (WFP, for Targeted Supplementary Feeding Programme)
Total – USD 4,600,000

Logistics

Sector Lead: WFP

Sector Members: National Logistics Center under MCTI, Civil Protection, SAMES, Ministry of Agriculture and Fisheries, Ministry of Transportation and Communication, CVTL, IOM, WHO

1. Sectoral Impact of COVID-19 on People and Systems

Movement restriction and trade protection have caused disruptions of global supply chain. Shipping markets, a major player of global trade, continue to operate but the situation is very unpredictable and volatile. Port delays, equipment/container imbalances and higher operating cost have started resulting in cash flow problems for even some of the larger global carriers, including those that the humanitarian organizations are dependent upon for their ocean transportation needs. There is a genuine risk of collapse of some of the shipping lines in the coming period if this situation continues. Measures that could be seen in response to the squeeze from COVID-19 restrictions could include reduced frequency of sailings to reduce cost and to maintain freight rates at minimum operating levels. This has a huge negative impact on food security of low-income import-dependent countries like Timor-Leste, where 65 to 70% of its rice consumption depends on import. It also poses a great risk on the COVID-19 health and non-health response, as transportation of much-needed medical and other essential supplies for the humanitarian response is delayed and made more costly.

Migrants are already being impacted by movement restrictions and border controls applied by various governments to contain the pandemic, resulting in both health and wider socio-economic impacts. Return of migrants from countries with local transmission to Timor-Leste could lead to the seeding of new clusters in areas of return, transmission among returnees and border crossings, as well as those held in collective settings for quarantine. There is a need to track cross border flows in order to understand population mobility trends within and between certain areas, which in turns helps to inform the COVID-19 outbreak public health response.

2. Sectoral Response Priorities

a. Sectoral Objectives

1. To provide common service to the humanitarian community in Timor-Leste to ensure free movement of critical humanitarian workers - including frontline medical workers - and timely supply of humanitarian relief items.
2. To increase national capacity to monitor and map mobility utilizing the Displacement Tracking Matrix (DTM) at Points of Entry (POEs) to support COVID-19 outbreak public health response.

b. Ongoing response

- WFP is providing procurement service including food availability and shipping options to the National Logistics Center (NLC), the national body for food procurement.

- WFP conducted a joint visit with NLC to Batugate immigrations and customs office on 21 March 2020 to ascertain what impact COVID-19 has had on border trade. Most officials interviewed indicated possible delays and business closure due to unforeseen changes in operation plans amid COVID-19.
- As per the request from MoH, WFP has refurbished an isolation room at Dili International Airport.
- As per the request from MoH and Secretariat of the State Civil Protection (SSCP), WFP has ordered 3 prefabricated offices (Prefabs) and 4 Mobile Storage Units (MSUs). ETA of the consignment is 22 April 2020.
- IOM is providing transportation and logistics support to the Ministry of Health COVID-19 Task Force.

c. Priority response for the next 6 months

WFP:

- Support the development of food distribution SOPs on centralized food dispatch, distribution and monitoring for 30,000 MT of rice to be purchased by the Government.
- Support National Logistics center (NLC) for the supply chain management by providing transportation service, rehabilitation of warehouses etc.
- Support the Medical and Pharmaceutical Supply Agency (SAMES) for the supply management of medical supplies, facilitating transportation services, strengthening storage capacity etc. At present SAMES uses mSupply application for the stock management limited to the center in Dili and the National Hospital, and this needs to extend to all 13 municipalities.
- Support MAF to ensure supply of vegetables and fruits to the markets.
- Provide humanitarian common service to facilitate the movement of humanitarian passenger and cargos (global.serviceprovision@wfp.org).
- Identify major food importers and suppliers in the country and engage regularly with them to obtain stock/pipeline data.
- Identify potential warehouses and transportation service providers in the country; maintain the list of service providers and vendors and make them available for inter-agency use during service demand.

IOM:

- Support to national level surveillance systems at points of entry (POEs) by linking mobility information collected by Migration Services to disease surveillance data. IOM can utilize its DTM to support partners vis-à-vis targeting of COVID-19 interventions and preparedness plans through the deployment of the DTM flow monitoring methodology; participatory mapping exercises that can be used to inform regional and national preparedness and response plans; translation of materials into local languages; provision of information management support to new and expanded rounds of data collection; training the national government on surveillance techniques; developing tools for contact tracing and purchasing additional supplies.
- Support to relevant authorities on conducting data collection at POEs and in isolation/quarantine facilities as baseline of migration flow monitoring to support the key partners to map out the distribution of the migrants, disaggregated by sex, age and disability foe better tailoring responses.
- Establishment of an information management system (DTM) showing the updated situation for monitoring the migrant flow from origin location abroad Timor-Leste to every municipality within Timor-Leste; as well as the updated situation of isolation, quarantine and treatment centers that include information related to the COVID-19 suspected and confirmed cases.

d. Indicative financial requirements

Activity	Details	Cost (USD)
WFP		
Supply chain management capacity strengthening to NLC	Renting warehouses, hiring staff, transportation service, etc.	300,000
Development and updating of a database for real-time information on available stock for medicines and medical supplies	Hiring consultant for the development, update, integration and training of the software mSupply	150,000
Support to SAMES on supply management of medical supplies	Providing transportation services, warehouse management	150,000
Support to MAF to ensure supply of vegetables and fruits to the markets	Supporting transportation, coordination and linkages	100,000
IOM		
Establishment of surveillance system at POEs (link with CPRP Pillar 4; link with WASH)	DTM IMS; monitoring; training; support to IPC and WASH interventions at POE sites	100,000
Total		**800,000**

Education

Sector Lead: UNICEF
Sector Members: WHO, UNDP, UNFPA, UNESCO, UN Women (all TBC)

1. Sectoral Impact of COVID-19 on People and Systems

According to the Decree Law approved by the Council of Ministers on 28 March 2020, which outlines the various measures to be taken during the State of Emergency, all schools and educational establishments will remain closed and students as well as teachers are prohibited from staying on school premises.

The closure of schools and disruption to learning will affect all school-going children in the country. As a result, the gains made in access to education and learning are at risk. The poorest and most marginalized children face even broader risks due to limited access to essential services, information on disease prevention as well as water sanitation and hygiene. Being out of school for long periods puts children, especially girls, at increased risk of carrying higher burdens of household care work, sexual exploitation, abuse and other dangers. Children with disabilities are equally at risk of neglect and marginalization from remote learning opportunities, which might not be accessible to them. In the event of escalation of COVID-19 outbreak and school closure continuing for a longer period of time, there is also a risk that some of the most vulnerable may not return to school due to economic pressures on families requiring these children to be engaged in supporting families in different ways, particularly girls and children with disabilities.

During this critical time of school closure, it is essential to ensure the continuity of learning and well-being for children, especially for the most vulnerable, affected by this crisis and to ensure better preparedness of the education system in the face of future emergencies.

Estimated number of people most affected and/or at-risk

The closure of schools affects all school going children in Timor-Leste. The table below provides the number of children that are affected by school closure, disaggregated by gender, urban/rural, level of schooling and disabilities (source: EMIS 2019).

	Urban	Rural	Male	Female	Children with disabilities (EMIS 2016 data)
Preschool	9,490	14,516	11,995	12,011	147
Primary	91,636	204,988	150,445	146,179	825
Secondary	46,818	24,730	34,011	37,537	409
Total (in school)	**147,944**	**244,234**	**196,451**	**195,727**	**1,381**

Out of School Children	*n/a*	*n/a*	*33,590*	*14,575*	

2. Sectoral Response Priorities

a. Sectoral Objectives

1) To ensure continuity of learning for all children, particularly the most vulnerable and marginalized children as well as children with disabilities.
2) To ensure adequate preparedness measures are in place for the eventual reopening of schools, building trust and reassurance to parents and students that it is safe to go back to school.

b. Ongoing response

The Education Sector is supporting the following Government response:

Campaign on COVID-19, targeting 520 preschools, supported by the Government of New Zealand
On 11 March, the Ministry of Education launched a school-based campaign targeting 520 preschools (public, private and community) to raise awareness among parents, communities and students about COVID-19 and prevention measures. Under this campaign, an orientation to 520 preschool coordinators was conducted; cleaning materials and hygiene kits were distributed to all 520 preschools; and, guidelines on how to use the cleaning materials/hygiene kits were developed and utilized as a part of the orientation.

Eskola ba Uma (education programme for online/distance learning)
Under the leadership of the Ministry of Education and supported by UNICEF, 20 programmes of 30-minute online lessons for all levels of schooling (from preschools to secondary) have been developed, to allow for continuity of learning through TV, radio and digital media. A digital library platform is being developed, as well as a preschool song kit for homeschooling.

Reaching children in rural/remote areas for continuity of learning
With an aim to reach children in remote/rural areas, UNICEF is supporting the Ministry of Education with student work books for cycle 2 students (grades 1 to 4).

c. Priority response for the next 6 months

To ensure continuity of learning for all children, particularly the most vulnerable and marginalized children as well as children with disabilities, through distance learning modalities, the following response will be prioritized over the next 6 months:

- Development, printing and distribution of age-appropriate learning/play resource pack to promote responsive caregiving and continued learning and to reduce the anxiety/stress levels of caregivers and children (targeting 250,000 children, of whom 125,000 in rural/remote areas) (USD 100,000)
- Development, printing and distribution of IEC materials for parents on healthy parenting, talking to children about COVID-19 and helping young children cope with stress (USD 110,000)

- Development of age-appropriate content for radio, TV and online media to promote responsive caregiving and learning activities (USD 100,000)
- Technical assistance to the Ministry of Education to design and deliver distance learning programmes (USD 150,000)
- Development of a digital library platform (USD 100,000)
- Mapping of existing innovative online resources available globally to identify appropriate learning content for Timor-Leste curriculum (USD 25,000)
- Development, printing and distribution of student workbooks for cycle 1 students in rural/remote areas, as well as accompanying guidebooks for parents/siblings to facilitate learning at home (USD 500,000)
- Monitoring of the effectiveness of distance learning initiatives, including on children's learning (USD 150,000)

Distance learning can be delivering through low/no tech and offline modalities or high-tech online modalities; they can be self-learning/one-way or teacher interaction/two-way. In planning for distance learning modalities in Timor-Leste, the penetration rates of internet (39%), mobile phones (111%) and social media (31%) in Timor-Leste will be considered.[6]

To ensure adequate preparedness measures are in place for the eventual reopening of schools, the following response will be prioritized over the next 6 months:

- Development and implementation of back-to-school campaign to meet children's socio-emotional needs and provide reassurance to parents (USD 50,000)
- Adaptation, translation and implementation of the WHO-UNICEF/IFRC Guidance for Prevention and Control of COVID-19 (USD 15,000)
- Training/orientation to teachers to: identify children's mental health and psychosocial needs; provide basic psychosocial, social and emotional learning support; and, refer children in need of specialized services through cross-sectoral cooperation (USD 40,000)
- Orientation for parents and students on COVID-19 protection measures to prevent resurgence of COVID-19 and disseminate hygiene promotion messages; procurement of disinfectant materials for all schools (public and private schools across all levels of education) (USD 90,000)
- Provision of support to the Ministry of Education to strengthen education system preparedness to respond to public health and other emergencies in the future (USD 30,000)

d. Indicative financial requirements

Sectoral Objective 1	USD 1,235,000
Sectoral Objective 2	USD 225,000
Total Education Sector	**USD 1,460,000**

[6] https://www.slideshare.net/DataReportal/digital-2020-timorleste-january-2020-v01?from_action=save

WASH

Sector Lead: General Directorate of Water & Sanitation (DGAS)

Sector Members: MoH, UNICEF, WHO, UNDP, PLAN, PHD, Mercy Corps, Water Aid, CARE, CVTL

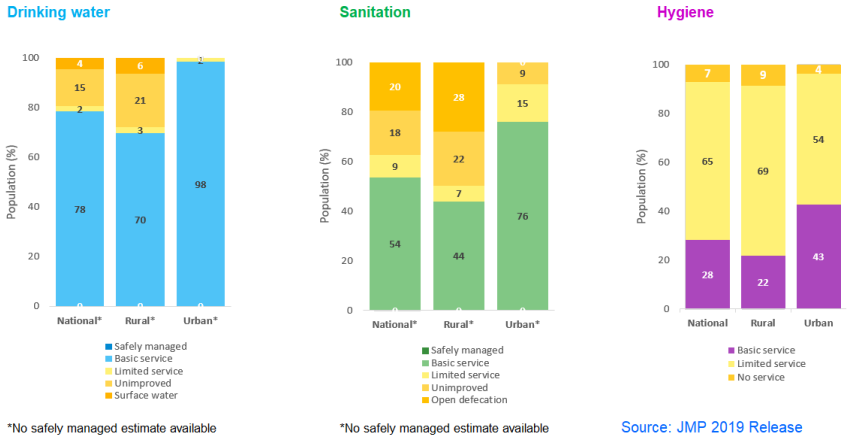
1. Sectoral Impact of COVID-19 on People and Systems

Hand hygiene and clean environment are two essential factors in combating with the rapid spread of COVID-19. As a result, demand for water, sanitation and hygiene (WASH) will increase significantly during both "preventive" and "clinical" management of the outbreak. This will push the service providers as well as community to ensure accessibility, availability and quality of WASH services to be adequate enough to cater for the needs of the situation.

On the preventive front, WASH in public spaces, communities as well as institutions (schools and health facilities) need to undergo extensive review of their capacity, followed by necessary improvements. This needs to be complemented with consistent behavior change communication programs with clear messages. It will require strengthened coordination between the health sector and the WASH service providers, as well as between the MoH and the Ministry of Public Works.

When it comes to clinical aspects, both health and quarantine facilities need safe WASH facilities above basic level that Timor-Leste has already targeted. WASH services in health facilities and quarantine facilities require urgent and significant infrastructure renovation or new construction, as well as service management.

WASH sector may need to review its current SDG 6 targets and elevate them from basic to safely manage levels and from limited to basic levels, at least for communities and institutions at increased risk. The figure below shows how accessibility and qualitative service levels exist in both rural and urban domains of Timor-Leste with quite visible deprivations.



Accelerating and elevating WASH targets in response to COVID-19 will be both infrastructure and labor intense exercise. It would lead to the challenge of raising new financial resources as well as developing human resources in terms of numbers, skills and competencies. Moreover, the institutional capacity too

has to increase to accommodate the demand, and governance issues related to asset management and decision-making would need to be addressed.

Estimated number of people most affected and/or at-risk

Considering the fact that the virus mainly spreads from human to human with close contacts, it is assumed that all urban population and 50% of rural population of Timor-Leste will be vulnerable. Thus, the estimated people in need to WASH support is **766,436**, of whom 349,208 are urban, 417,218 are rural, breakdown of which are as per below table:

Municipality	100% of Urban Population			50% of Rurual Population			TOTAL TARGET POPULATION		
	Total	Male	Female	Total	Male	Female	TOTAL	MALE	FEMALE
TIMOR-LESTE	**349,208**	**179,565**	**169,643**	**417,218**	**210,774**	**206,444**	**766,426**	**390,339**	**376,087**
AILEU	2,592	1,344	1,248	23,123	11,920	11,203	25,715	13,264	12,451
AINARO	6,250	3,197	3,053	28,443	14,492	13,951	34,693	17,689	17,004
BAUCAU	17,357	8,660	8,697	52,923	26,585	26,338	70,280	35,245	35,035
BOBONARO	12,787	6,443	6,344	42,488	21,216	21,272	55,275	27,659	27,616
COVALIMA	9,130	4,611	4,519	28,086	14,179	13,907	37,216	18,790	18,426
DILI	244,584	126,823	117,761	16,348	8,427	7,921	260,932	135,250	125,682
ERMERA	8,850	4,414	4,436	58,426	29,572	28,855	67,276	33,986	33,291
LAUTÉM	12,471	6,074	6,397	26,385	12,995	13,390	38,856	19,069	19,787
LIQUIÇA	5,201	2,585	2,616	33,363	16,926	16,438	38,564	19,511	19,054
MANATUTO	3,703	1,921	1,782	21,458	10,916	10,543	25,161	12,837	12,325
MANUFAHI	7,332	3,749	3,583	23,180	12,001	11,179	30,512	15,750	14,762
SAR1 OF OECUS	12,421	6,459	5,962	28,246	14,125	14,121	40,667	20,584	20,083
VIQUEQUE	6,530	3,285	3,245	34,752	17,423	17,329	41,282	20,708	20,574

2. Sectoral Response Priorities

a. Sectoral Objectives

1) To provide at least basic level water supply to target households and schools
2) To provide at least basic level sanitation facilities to target households and schools
3) To provide at least basic level hygiene (hand washing) facilities to target households, as well as to schools and health facilities in the target areas
4) To provide safely managed water supply to health care facilities and isolation/quarantine facilities (if needed)
5) To provide safely managed sanitation to health care facilities and isolation/quarantine facilities (if needed)

b. Ongoing response

- Provision of public handwashing facilities
- Improvement of existing public water and sanitation facilities
- Provision of portable handwashing devices (bucket + tap) to preschools, quarantine facilities and key institutions such as the airport
- Social mobilization on best hygiene practices

c. Priority response for the next 6 months

- Improvement of WASH services in urban communities of all municipalities due to their relatively high vulnerability to COVID-19 caused by higher population density and increased person-to-person contacts. These urban areas would be entry points of COVID-19 risk to the rural areas of the respective municipalities.
- Improvement of quarantine or isolation facilities standards by identifying additional land, shelter and on scaling up WASH and health services in the sites, especially for migrants and high-risk populations.

People Targeted

349,208 people (179,565 male; 169,643 female) across the country, as per below:

Municipality	100% of Urban Population		
	Total	Male	Female
TIMOR-LESTE	**349,208**	**179,565**	**169,643**
AILEU	2,592	1,344	1,248
AINARO	6,250	3,197	3,053
BAUCAU	17,357	8,660	8,697
BOBONARO	12,787	6,443	6,344
COVALIMA	9,130	4,611	4,519
DILI	244,584	126,823	117,761
ERMERA	8,850	4,414	4,436
LAUTÉM	12,471	6,074	6,397
LIQUIÇA	5,201	2,585	2,616
MANATUTO	3,703	1,921	1,782
MANUFAHI	7,332	3,749	3,583
SAR1 OF OECUS	12,421	6,459	5,962
VIQUEQUE	6,530	3,285	3,245

d. Indicative financial requirements

Activity	Details	Cost (USD)
Establishment of public handwashing facilities in key locations with high community access (including necessary water supply improvements)		300,000
Rehabilitation of public sanitation facilities including renovation and/or adding water supply hand washing facilities		300,000

Provision of hand washing facilities to preschools and schools		200,000
Provision and / or improvement of WASH in health care facilities (including water, sanitation, hygiene and waste management)		400,000
Provision and / or improvement of WASH in quarantine facilities (including water, sanitation, hygiene and waste management)		200,000
Running and maintenance of WASH services in public places, schools, health facilities and quarantine facilities		300,000
Social mobilization and behavior change on improved hygiene and use of WASH facilities		200,000
Support government and implementation partners' field monitoring including safety equipment		100,000
Total		**2,200,000**

Protection

Sector Lead: UN Women
Sector Members: UNICEF, UNFPA, UNDP, IOM, UNCDF, HRAU/OHCHR, SEII, MSSI, PDHJ, civil society

1. Sectoral Impact of COVID-19 on People and Systems[7]

The COVID-19 pandemic has generated a variety of protection issues affecting diverse women, men, girls, and boys in Timor-Leste in distinct ways. These experiences can further exacerbate pre-existing inequalities within the society and push those individuals and sub-groups within communities at risk of vulnerability into further exclusion. Such exclusion may be due to their lack of protection within their families or discriminatory practices that prevent them from accessing their basic human rights. Addressing these risks requires strong attention to identifying and empowering groups who have historically been excluded or marginalized (on the basis of their gender identity, sexual orientation, abilities, societal status or geographic location, among other factors). Key considerations in the Protection Sector include:

- The increasing vulnerability of marginalized groups[8] due to disruptions in the operation of basic health, security, justice and social support services following movement restrictions for community members and related service providers (e.g. public transport, reduced hours of operation, lack of information, perception that some services are not essential, etc.).
- The risk of particular individuals and groups being excluded from social protection or COVID-19 responses due to neglect and discrimination by their families, caretakers, service providers or local authorities. This might affect individuals who do not have essential national identity documents – identity cards or household registration cards; women and children providing domestic work who are residing with their employers; LGBTI persons, survivors of past violence and their children who might not be supported by their families or be able to seek services due to stigma and abuse; and individuals who reside in institutional facilities.
- The increased risk of gender-based violence (particularly domestic violence against women and sexual harassment), violence against children and sexual exploitation and abuse as a result of containment measures, restrictions in movement of individuals outside their homes, and loss of livelihood and educational opportunities.
- Violence and neglect against older persons and persons with disabilities, who are at higher risk of contracting COVID-19 and who might depend on others within their family or community to facilitate their daily caretaking needs, mobility or access to information, communication and services.
- Front-line health, facility support and home-based caretakers' (who are often informally employed) increased exposure to COVID-19 without having adequate information and access to protective equipment, information and support.
- Possible discrimination and stigmatization of people exposed to COVID-19 (e.g. those in Quarantine and the front-line service providers supporting them) as well as those affected by COVID-19.
- State of emergency and emergency legislation, which lead to the derogation of certain human rights and enhances the power of law enforcement actors without adequate oversight and monitoring.

[7] Issues and actions identified adapted from IASC: Gender Alert for COVID-19 Outbreak (March 2020)
[8] Marginalized groups in the Timor-Leste context include: women and children, especially those with disabilities, living in rural areas, LGBTI persons, survivors of past violence, adolescent mothers young people, informal workers, migrants and individuals in institutional settings (prisons, shelters, juvenile homes, etc.).

Estimated number of people most affected and/or at-risk

Using the 2015 Population Census and 2016 DHS, the following groups among the population of 1.3 million are most at-risk, recognizing that persons from the groups below affected by COVID-19 outbreak (including in quarantine and isolation facilities) will be particularly vulnerable due to existing marginalization:

Children, Adolescents and Young People, noting half of all children under 14 years are living below the national poverty line[9]. Particular sub-groups at-risk include:

- Children, especially girls, with disabilities;
- Children living in rural areas;
- Children, adolescents and young people in institutions (*asramas*), living with relatives or in domestic work; and,
- Adolescent mothers and youth-headed households.

Women, in their diversity, with particular attention to:

- Those living in rural areas, noting rural women are most at risk with 87% working in vulnerable jobs, contrasted against the lowest rate amongst men employed in urban areas at 37%[14] and disparity in urban-rural poverty;
- Women in informal labor, noting that only 40% of working age women are economically active in the formal labour sector (2016 data), and according to 2015 population census, women hold less than one third of government positions (31% women vs 69% men), 37% of jobs in state-owned enterprises, and only a quarter of private sector jobs (24% women vs 76% men). This aligns with the results of the 2016 Enterprise and Skills Survey, which indicate women comprise 24% of private sector workers.
- Pregnant and lactating mothers; and,
- Survivors of domestic violence (both those in shelter facilities and living in abusive situations), noting over a third of married women had experienced violence in the 12 months preceding the 2016 DHS.

Older people (60 and above), totaling an estimate 50,325 women (8.6% of female population) and 46,617 men (7.8% of the male population) based on 2015 census.

People with disabilities, totaling an estimate 17,978 women with disability (3.1% of all females) and 20,140 men (3.4% of all males), noting these figures are likely under-reported, considering that on average, persons with disabilities represent 15% of people across countries.

Persons with diverse gender identities and sexual orientations, noting the stigma, discrimination and violence faced by the LGBTI community and barriers to accessing key health and security services and access to information.

Mobile and border populations totaling an estimate 163,058 people (81,838 men and 81,220 women) (Census 2015). Mobile populations such as truck drivers, taxi drivers, microlet (bus) drivers (who are overwhelmingly male), and travelers may have higher exposure to COVID-19 transmission, as their work entails coming into contact with passengers, other drivers and transport staff. In addition, many do not have access to supplies to employ appropriate cleaning practices, as part of good hygiene. Border populations may also be disproportionally vulnerable to COVID-19 transmission due to closure of official

[9] UNICEF (2018). Sustainable Development Goals – Child Data Book 2018, Timor-Leste

border crossings with Indonesia, increasing the possibility of subsequent crossings at unofficial border points.

Migrants (regular and irregular) in Timor-Leste, totaling an estimate 8,400 people (5,074 men and 3,326 women) (UNDESA International Migrant Stock: Country Profile 2019). Migrants are already being impacted by movement restrictions and, increasingly, socio-economic impacts as a result of the pandemic due to their living and working conditions and barriers to access the health system, public education and outreach.

People deprived of their liberty, including in prisons, are at a heightened risk of infection/contamination in case of an outbreak, particularly as physical distancing is difficult to achieve and access to adequate sanitary conditions might be limited. Overcrowding of prisons[10] and other detention facilities makes effective public health control measures extremely difficult. Particular attention should be paid to the situation of women, children, persons with disabilities or medical conditions, such as people living with HIV or tuberculosis, elderly people, those requiring drug or other rehabilitation services. In addition, the risk is extended to the staff working at such institutions.

2. Sectoral Response Priorities

a. Sectoral Objective

To reduce the identified risks against specific individuals and groups within the population and mitigate immediate and longer-term risks through targeted initiatives and measures, including ensuring advocating for any restriction of rights guaranteed to be legal, necessary, proportional and temporary. This ensures that COVID-19 prevention and response measures uphold a gender-responsive, human rights-based and Do No Harm approach, focused on reaching individuals and groups furthest behind. It advances safe, accessible and needs-based interventions that recognize the agency, empower and build on capacities of affected individuals, communities and promote collaboration and coordination across diverse stakeholders.

b. Ongoing response

To achieve the protection sector objectives, key population groups need to be visible and their issues represented in response plans. This requires consulting and including them into decision-making and participation in COVID-19 prevention and responses. It is equally critical to invest in gender-responsive and inclusive monitoring of the impact of the pandemic as well as of all responses to address the pandemic.

Coordination of Gender and Protection Working Group and Response (UN Women with UNICEF) to identify issues, map actors, exchange knowledge and reference materials, join efforts and actions (guidance, advocacy, etc.), and streamline resources and opportunities to respond.

[10] According to official information obtained, the total prison population in Timor-Leste at present is 810 detainees with an official prison capacity of 380. In addition, pre-trial detainees constitute 17 per cent of the total prison population.

Technical and policy analysis and inputs to emerging COVID-19 Responses. This includes development of background analyses, advocacy and guidance on gender and protection issues in the context of the State of Emergency, in regards to quarantine and isolation facilities, multi-sectoral plans, etc.

Promote continued operation and awareness of VAWC services (across health, social, security and justice sectors); strengthening monitoring of administrative data on VAWG service usage; supporting services to be accessible for persons with disabilities, adapting design of prevention interventions to the COVID-19 context and supporting civil society to adapt organizational practices and programming on EVAWG in the context of COVID-19. This is supported via the EU-UN Spotlight Initiative and identification of additional needs beyond funds through the Spotlight Initiative.

Ensure that gender, abilities, mobility and other factors of vulnerability is taken into account in public health and risk communication messaging, and that information is communicated to marginalized groups (including migrants/ mobile populations, persons with disabilities, LGBTI persons, persons with low literacy, as well as persons deprived of their liberty).

Support participation of affected groups, civil society and the National Human Rights Institution (NHRI) in COVID-19 response efforts, as well as in monitoring by civil society and the NHRI of implementation of restrictions to rights during State of Emergency and other types of measures that impact the access to and exercise of human rights.

Distribution of dignity and hygiene kits in quarantine facilities in Dili. This includes UNFPA and IOM (50 kits to migrants), working with the Ministry of Health, to improve quarantine centre standards through provision of necessary equipment and supplies for self and environmental hygiene.

c. Priority response for the next 6 months

In addition to the ongoing responses above, the following are additional priority response for the Protection Sector:

1. Risk, Needs and Impact Assessment of COVID-19 Response

- Identification of gender and protection issues across sectors and guidance for response. The Gender and Protection Working Group will be the initial mechanism to do this, including as part of the joint UN Socio-economic Impact Assessment.
- Identification of other venues where protection issues are being discussed.
- Facilitation of engagement of marginalized groups to actively contribute to planning, design and risk assessments, decision-making, implementation, monitoring or evaluation of response plans, in all phases.
- Support to civil society and NHRI to monitor impact of and response to COVID-19, including in regards to restriction of human rights and related advocacy initiatives, including public reports and messaging, as well as participate in decision-making bodies related to COVID-19 response.

2. Interventions to mitigate increased risk of domestic violence, sexual violence, harassment, exploitation, and abuse

- Ensuring continued VAWG and VAC services - including for persons with disabilities - and enabling access to these services reaches individuals affected by restricted movement or those in facilities.
- Continued provision of essential social protection and services for women and child survivors of violence without disruption, including through remote means of support.
- Service adaptation to reach survivors of violence affected by COVID-19 outbreak and reduction of stigma against them.
- Service delivery adjustments to reduce risk of COVID-19 exposure for individuals seeking essential VAWG services.
- Information and support for women and child survivors of violence in their homes, including potential safety planning.
- Support related to psychological and mental health impacts of COVID-19 outbreak.
- Development of accessible and gender-responsive risk communications and outreach with marginalized groups.

3. Measures to reduce impact of disruption to health, education and livelihoods

- Grants to associations (vendors, domestic workers) or community groups to monitor conditions of informal workers and ensure safety and access to protection and services.
- Community mobilization and grants to support monitoring of education interventions and ensuring that the Education Sector supports mitigates risk of GBV, including early marriages and sexual exploitation and abuse of girls when educational activities/schools are suspended.
- Support for sexual and reproductive health services and outreach to ensure communities can still access and are encouraged to seek key services - through additional funding or surge capacity – and distribution of dignity/hygiene kits where relevant.
- Development of communications and advocacy developed with most-affected groups to inform COVID-19 response programmes.

4. Improve gender and protection measures and management of quarantine and isolation facilities and management of places where people are deprived of their liberty, particularly prisons

- Gender-inclusive assessment of isolation/quarantine facilities, with attention to gender and protection issues[11]. The assessment will determine the demographics of the population against the high-risk groups as identified per WHO guidance.
- Support development and roll-out of Guidance and Codes of Conduct for quarantine and isolation facility personnel
- Support development and roll-out of mechanisms for reporting and monitoring sexual exploitation, harassment and abuse at quarantine and isolation facilities
- Based on the assessment, prioritization of planned activities in consultation with facility managers and the Integrated Crisis Response Committee, and other service providers
- Development of clear communication to all stakeholders residing or working in quarantine and isolation facility, including development of information management mechanisms for migrants to reach the authority and vice versa.
- Mapping of available services and referral pathway to the closest health center that is dedicated to COVID-19 for symptomatic migrant women and other at-risk groups, ensuring all site staff have access to relevant contacts and information.
- Ensuring the Health Sector Response Plan addresses the gender and protection issues related to selection of land, shelter, WASH and health services; supporting service providers and local authorities

[11] This could draw on IOM's Camp Coordination and Camp Management (CCCM) programming as relevant.

with technical assistance on contingency planning, identification of additional sites, especially for high risk populations including migrant women.

- Provision of transportation support for vulnerable individuals to safely return to their homes and destination areas after the quarantine periods (including for persons with disabilities, migrants, etc.).
- Advocate and support civil society and NHRI efforts with relevant entities that all persons deprived of their liberty have access to adequate and appropriate health care at the same standards available to the wider society, without discrimination; as well as that COVID-19 protection measures, as recommended by WHO, are ensured for all staff of prisons and places of detention.
- Advocate with the Government for a significant reduction of the number of detainees, prioritizing alternatives to detention, particularly for those who are assessed as not posing a risk to public safety and security but are most vulnerable to COVID-19 or are in pre-trial detention and present a minimal flight risk.

5. Ensure that mobility and other vulnerabilities are taken into account in public health messaging, and that information is communicated to migrants, mobile populations and other at-risk groups.

- Provision of IEC material package for individuals leaving the quarantine center to be distributed and shared in their final destination areas (which can be tailored to specific groups i.e. migrants).
- Develop campaign materials in different languages (including for migrants) as well as different formats (including for persons with communication or visual disabilities) for public awareness on COVID-19 prevention and mitigation.
- Provision of IEC material on prevention towards COVID-19 at POEs for migrants and mobile populations.
- Conduct cross-border health awareness activity for border communities that advance health behaviors post-COVID-19.

d. Indicative financial requirements

Activity	Details	Cost (USD)
Risk, Needs and Impact Assessment (UN Women)	Technical assistance, Translation ICT	25,000
Grants to CSOs	GBV services (50,000 for x 2 border communities (Covalima and Bobonaro) + 100,000 for Dili and Baucau) + 100,000 to CSOs for monitoring, outreach, economic recovery, processing costs, etc.	300,000
Risk Communications and Outreach – integrate with CPRP Pillar 2	Technical assistance Print, audio-visual, processing costs IEC material package for quarantine center to be distributed and shared in their final destination areas; campaign materials in different languages (especially in language of country of origin of migrants); IEC materials at POEs for migrants; IEC materials on COVID-19 prevention at quarantine	105,000

	centers and treatment centers (including technical assistance, and print, audio-visual, processing costs, etc.)	
Personal Protective Equipment for essential services as relevant[12] - link with CPRP Pillar 8	TBD based on Assessment	
Assessment of existing and planned quarantine and isolation facilities and development of a contingency plan that identifies additional shelter and scaling up health facilities in border communities (IOM)	Technical assistance, translation, printing, ICT Information management mechanism in the quarantine centres Transportation support for safe return to destination Contingency plan development (technical assistance, translation, printing, ICT)	70,000
Total		**500,000**

[12] Based on WHO Guidance: https://apps.who.int/iris/bitstream/handle/10665/331498/WHO-2019-nCoV-IPCPPE_use-2020.2-eng.pdf

Economic recovery

Sector Leads: UNDP

Sector Members: WBG, ILO, UNICEF, UN Women, others TBC

1. Sectoral Impact of COVID-19 on People and Systems

According to the most recent analysis conducted by OECD, the economic impact of COVID-19 may far outweigh anything experienced during the global financial crisis in 2007-2008. Many economies stand to lose 1/5 to ¼ of their outputs, with consumer expenditures potentially dropping by 1/3. The scale of the estimated decline in the level of output is such that it's equivalent to a decline in annual GDP growth of up to 2% points for each month (of strict containment measures)[13]. If the shutdown continued for three months, with no offsetting factors, annual GDP growth could be between 4-6% points lower. The economic impact on small, resource-dependent economies such as Timor-Leste will be staggering. If the oil prices continue declining, the Petroleum Fund (at USD 17.69 billion in December 2019) stands to lose at least USD 2-3 billion from reduced return on investments. In April 2020, the Governor of the Central Bank confirmed to the parliament a loss amounting of USD 1.8 billion, as result of the equity (stock) market crash sparked by the pandemic. This will directly impact the national budget, which almost solely relies on the withdrawals from the Petroleum Fund (public financing accounts for more than 70% of total financing in Timor-Leste).

Globally, the following sectors will most likely bear the worst brunt from the economic recession directly/indirectly caused by COVID-19: transport, manufacturing, services industry, tourism, construction, retail, and professional and real estate services. In the context of Timor-Leste, the fledgling micro-, small- and medium- enterprises, workers unions and others stand to lose the majority of their income due to negative impacts on tourism, services, construction and industries. It is necessary to conduct a socio-economic impact assessment to estimate the overall impact of COVID-19 on the human development, on the economic sector and other areas. A preliminary analysis by the WBG indicate that telecom companies (Timor Telecom, Tellkomcel, Telemor), utility (water, electricity), and airlines (Air Timor, Airnorth, Citilink and others) might be adversely affected.

Estimated number of people most affected and/or at-risk

Based on existing human development indicators, such as monetary poverty (42% of the population), multi-dimensional poverty (affecting at least 46% of the population), high percentage of NEET youth (every third youth, with more young women affected compared to young men), heavy disease burden (TB, dengue), stunting (50% or under-5 children), high prevalence and tolerance of GBV (every third woman is affected, and over half of both women and men justify use of male violence against their spouses), it is safe to estimate that majority of the population will be severely impacted by COVID-19 outbreak. Thus, the following groups would require additional stimulus packages/government support through various measures, including through social protection, with attention to gender disparities:

[13] OECD, Evaluating the initial impact of COVID containment measures on economic activity. 27-03-20

a) Individuals and households living below the poverty threshold; multi-dimensionally poor, especially in rural areas;
b) Marginalized groups/groups experiencing societal stigma, including LGBTQI, people with disabilities of all ages, survivors of violence, people suffering from chronic TB and other chronic diseases, and others;
c) Internal and external labour migrants;
d) Women and girls affected by GBV;
e) Children from low income families;
f) Elderly people living alone/working to subsist;
g) Micro enterprises (street and market vendors and small sellers), SMEs, and subsistence level farmers;
h) NEET youth below age of 35;
i) Unemployed and under-employed workers; and,
j) Self-employed and daily labourers.

2. Sectoral Response Priorities

a. Sectoral Objectives

To support the Government to develop a multi-sectoral approach to reduce the likelihood of the vulnerable households and individuals from falling further into poverty and vulnerability traps due to COVID-10 impact, prioritizing tangible short- and medium-term solutions based on available domestic resources and ODA.

Since the majority of Timorese population will most likely be adversely impacted, the Government may consider 'universal income' solution in a short-to medium-term (eg. USD 150-200 per month per household, less for those who already receive significant levels of targeted social assistance). Other measures could include cash-for-work programmes (short term job creation), access to concessional credits with long-term repayment plans and low interest rates, waivers of taxes/VATs for small businesses, subsidies to transport, tele-communications and airlines sectors, hotel and services industry, tourism industry.

It is worth mentioning that digitalization of the economy becomes more and more important for Timor-Leste's resilience and sustainable economic development. Early lessons of COVID-19 experience from other countries show that countries with digitized and networked economies suffered less impacts by enabling online payments by households, businesses, etc. (eg. Estonia, Mongolia, etc). As digitalization is considered, it is important to address the emerging digital divide within the population to ensure those most excluded are not further isolated in the process.

b. Ongoing response

Many UN agencies are already working on various issues pertaining to economic diversification and local economic development. UNDP has been supporting local economic development and youth employment through its Decentralization, ZEESM (Oe-cusse integrated local development); Knua Juventude, mangroves, and other projects. UN Women has been supporting efforts to raise visibility and concerns of

women in informal and vulnerable employment (domestic workers, market vendors) as the COVID-19 outbreak evolves.

c. Priority response for the next 6 months

- Supporting farmers to grow more food and agricultural produce; organizing government orders directly from farmers, including subsistence farmers in all 12 municipalities and Oe-cusse; possible creation of small value chains. This should consider gender disparities among farmers (literacy, access to labour, agricultural inputs, etc.).;
- Supporting small scale cooperatives, restaurants and food industry to prepare school meals, meals for hospitalized patients, persons under quarantine, with attention to promoting female-owned businesses;
- Supporting youth-led organizations (Knua and others) for skills development, employment and job creation (small scale plastics recycling operations, water production, etc);
- Supporting airlines and shipment companies (Air Timor, cargo, etc) to maintain transport and logistics lifeline to importers;
- Supporting schools, hospitals, clinics and residential areas with uninterrupted electricity (mostly Government responsibility but the UN could support), organizing school meals, free medical services, etc.;
- Support to the Government to reorient the National Employment Strategy in light of current COVID-19 pandemic to map the most vulnerable seeking for employment;
- Support to the Chamber of Commerce in Timor-Leste (CCITL) to provide tools and guidance including business continuity, utilizing existing multiple platform shared by employers organizations globally and promoting good workplace practices for employers to take in COVID-19 response;
- Technical and policy advice to the Government on responses to the outbreak including employment related subsidies and business support measures such as credit lines to SMEs;
- Supporting and incentivizing social dialogue, in particular with respect to workers' retention and cushioning the impact of employment adjustment (including for informal sector workers); and,
- Awareness raising campaign on COVID-19 prevention through workers' and employers' organizations.

d. Indicative financial requirements

It would be important to have the Government co-funding of all activities in this area, so that there's clear ownership, division of labour and responsibilities, and synergies.

UNDP will dedicate about USD 45,000 - 50,000 for conducting a socio-economic impact assessment focused on the most vulnerable households, subsistence level farmers, and micro- and SMEs. UNDP may require additional USD 50,000 - 100,000 to extend this survey to other municipalities and to produce and disseminate the report. UNDP, through its existing Decentralization programme, can coordinate municipal level data collection, evidence verification, interviews, innovative qualitative methods such as micro-narratives, visual story-telling, etc. Potential collaboration with WBG [TBC]. UN Women is contributing to the gender dimensions of an impact assessment (contributing in-kind time plus USD 20,000 for technical assessment-related costs). UNDP could potentially help organize outreach and support to municipalities, small scale farmers, businesses and cooperatives. UNDP, together with other agencies can also help develop cash-for-work type of schemes in a number of areas such as construction

and rehabilitation of community infrastructure, tree plantation, establishing nurseries, and fencing. UNDP can also support farmers to produce rice, vegetables and other food items and link them with markets; and same can be done for communities engaged in fishing and livestock. UN Women could contribute to outreach and connection with women's organizations, organizations representing workers in informal sector and vulnerable work, including within the context of local market places.

Activities	Details	Cost (USD)
Socio-economic impact assessment focused on the most vulnerable households, subsistence level farmers, and micro- and SMEs	Consultants to design the survey, tools, guidelines, analyze the data and prepare the report Costs for enumerators, translators, logistics manager Training of the enumerators: venue, lunch Pre-testing of tools: transportation, printing, etc. Transportation for data collection in municipalities' households and interviews with key informants, focus group discussions, etc. Printing costs	150,000
Support to small scale farmers, businesses and cooperatives to produce rice and vegetables and link them with markets	Outreach to small farmers, businesses and cooperatives Technical inputs through seeds, fertilizers, training to increase production, equipment Innovative solutions to link them with market information (Apps, SMS) and local or regional and urban markets or restaurants, school feeding programmes, hospitals, cafeterias, etc.	800,000
Support to fishery groups for livelihoods	Support for aquaculture activities to fishery groups or most vulnerable fishing households along coastal villages with inputs to ensure their livelihood Support in linking to markets, including support to cooperatives for marketing Support for refrigerator storage facilities to conserve fish harvested and water tank facilities for hygiene purposes	800,000
Support households who are engaged in livestock (poultry, piggery, cattle, etc.)	Support to increase production by providing inputs (feed, training, equipment, etc.), and link them with market	500,000

Plantation (also through cash for work)	Setting up nurseries and planting and taking care of the plants (e.g. mangroves, coconut, fruit, multiple use plants) Setting up fences in the plantation areas	1,000,000
Community infrastructure construction and rehabilitation through cash for work schemes	Construction or rehabilitation of market spaces, irrigation canals, water systems, nurseries, community health centers, community buildings, fish ponds, etc.	2,000,000
Supporting NGOs, CBOs, cooperatives and SMEs	Inputs to support food production, PPE production, organic fertilizer production, seed production, recycling, waste management, etc.	800,000
Digitalization (for payment, market information, marketing, etc.)	Digital payment pilot and testing	200,000
Total		**6,250,000**

Social Protection

Sector Lead: ILO

Sector Members: UNCDF, UN Women, UNICEF, UNDP, WHO

1. Sectoral Impact of COVID-19 on People and Systems

Social Protection is essential to provide the most vulnerable groups with support to ensure a minimum standard of living. In periods of economic turmoil, Social Protection also can become a powerful tool to stabilize aggregate demand, and hence the economy. However, currently in Timor-Leste, the existing delivery mechanisms for the largest Social Protection Programmes (SAII and Bolsa da Mãe) are associated with significant public health risks, as they involve larges gatherings of people and do not have the full reach to those most at-risk of exclusion. Furthermore, this also implies that new programmes designed to support families and individuals during the expected economic downturn will not be able in the short/medium run to use these existing mechanisms, thus handicapping the effectiveness of Social Protection policies and programmes.

The Government, cognizant of the negative socio-economic impact of the COVID-19 outbreak that is affecting the population, approved a COVID-19 economic response package on 17 April. This consists of 19 specific measures to reduce financial and economic hardship and address the threat of increasing poverty among people most affected and/or at-risk during the State of Emergency. One of the specific measures financed through this package is a social cash transfer scheme, which was approved on 24 April.

Estimated number of people most affected and/or at-risk

The groups most affected by the issues highlighted will be part of the groups benefiting from the largest existing social protection programmes below (all data for 2017). In case the Government decides to expand these programmes or introduce new ones, the number of affected people can increase further.

- Child beneficiaries of the Bolsa da Mãe Programme (183,265, ages 0-17)
- Children benefiting from the School Feeding Programme, currently suspended due to school closure (320,040, ages 6-15)
- Elderly and Persons with Disabilities (SAII programme beneficiaries) (87,001 persons aged 60+, 8,298 persons with disabilities)
- Survivors of gender-based violence

2. Sectoral Response Priorities

a. Sectoral Objectives

The main priority is that current and new emergency related Social Protection programmes can, at the same time, realize the vision of universal right to social security and social assistance enshrined in the constitution of Timor-Leste (Article 56), while the ensuring that these programmes minimize the public

health risks associated with the COVID-19 pandemic as well as minimizing the negative impact on social cohesion, in particular with respect to their implementation and delivery.

Hence, the Social Protection sector can be structured around three vectors:

1) Assessing the new needs for social protection and assistance associated with the COVID-19 pandemic, and its health, social and economic impacts.
2) Identifying which programmes (existing or new) can be used to address those needs, noting those already excluded from existing programmes who need to be included.
3) Analyzing how these programmes can be developed and implemented in a way that minimizes the public health risks and social impacts associated with their delivery.

b. Ongoing response

ILO, under its ACTION2 programme, continues to provide technical assistance to MSSI, INSS and other partners in all areas related to Social Protection and Social Security. Through the programme, ILO also tries to act as a coordinating focal point on the matter both amongst UN agencies as well as other development partners. In parallel, ILO keeps a constant dialogue both with its specialists in other countries, in the region and at HQ, as well as other partners, in order to update the Government regarding social protection developments in other countries, and how some best practice examples can potentially be adapted to the reality in Timor-Leste in order to help its people withstand the negative effects of the pandemic, with a particular focus on the most vulnerable groups such as children, the elderly, women and persons with disabilities.

In support of the Government's COVID-19 social cash transfer scheme, which aims to provide immediate relief to low-income households, the UN – under the leadership of the UN Resident Coordinator - has successfully mobilized funding from the global UN COVID-19 Response and Recovery Fund amounting to close to USD 1 million. This will allow the UN – led by ILO and UN Women – together with other development partners to provide necessary technical and financial support to urgently operationalize the Government's programme.

c. Priority response for the next 6 months

Technical support from the UN will be provided to the Government in designing the most effective, efficient and safe implementation plan for the scheme, in line with the principle of Do No Harm and protection of human rights. The design will ensure that specific needs of the vulnerable households – including female- and child-headed households and households with persons with disabilities - are taken into consideration before, during and after the implementation of the scheme. Specific areas of technical support will include:

- Designing mechanisms that ensure that the scheme reaches those most vulnerable and excluded in the society, including female- and child-headed households, households with persons with disabilities and families living in the most remote and border areas of the country.
- Providing support to create a beneficiary accountability mechanism – including for redress - to systematically capture feedback and grievances from the recipients of the cash transfers and avoid abuse and mismanagement. Special attention will be paid to women and individuals representing marginalized groups. This could be done through engaging telecommunication service providers.

- Supporting the development of health and safety guidelines for the teams in charge of delivering the payments to families, following guidance from the Ministry of Health (MoH) and WHO.
- Supporting the Government's information campaign on the scheme.
- Designing of the data collection and analysis process during and after the cash transfers are delivered.
- Providing support in the monitoring and evaluation of the delivery of the cash-transfer scheme, to ensure transparent, equitable and efficient delivery, and enable an ex-post assessment of the impact of the scheme, as well as lessons learned for the future. This can be complemented through the joint UN socio-economic impact assessment, which is being led by United Nations Development Programme (UNDP), which would include a question on the use of the fund and its benefits.
- Compiling lessons-learned from the implementation of the scheme, in order to inform future discussions on strengthening the social protection mechanisms in Timor-Leste in the medium- to longer-terms, with attention to principles of gender equality and leaving no one behind.

Financial support to the Government will contribute towards filling the financing gap in operationalization of the scheme. It is also hoped that the UN support would leverage additional international support from other development partners. The UN's financial support will be vital for a swift roll-out of the scheme, which in turn would contribute towards alleviation of socio-economic hardships currently experienced by vulnerable households and help to revitalize the local economy, contributing towards ensuring a decent living standard during the first months of the COVID-19 pandemic in Timor-Leste and minimizing the longer term negative socio-economic ramifications.

The UN technical team will work in direct cooperation with the MSSI task force. The UN will advocate to have an observer in the meetings of the taskforce, to ensure smooth and swift exchange of information between the two teams. This will allow the UN team to adjust to the priorities and the necessities identified by the Government at any point during the process.

d. Indicative financial requirements

USD 999,380 (mobilized from the UN COVID-19 Response and Recovery Fund for joint UN support to the Government COVID-19 Social Cash Transfer Programme)

Maintaining Essential Health Services

Sector Lead: WHO

Sector Members: MOH, HNGV, SAMES, NHL, UNICEF, UNFPA, UNDP

1. Sectoral Impact of COVID-19 on People and Systems

Health systems are being confronted with rapidly increasing demand generated by the COVID-19 outbreak. When health systems are overwhelmed, both direct mortality from an outbreak and indirect mortality from vaccine-preventable and treatable conditions increase dramatically. Prior disease outbreaks and humanitarian emergencies have underscored the importance of maintaining essential health services such as maternal, newborn, child, sexual and reproductive health and immunization services, and effectively engaging communities in planning and service delivery.

Timor-Leste is not alone is having to make difficult decisions to balance the demands of responding directly to the COVID-19 outbreak, while simultaneously engaging in strategic planning and coordinated action to maintain essential health service delivery, mitigating the risk of system collapse. Disruption of essential services such as immunization services will result in increased numbers of sus ceptible individuals and raise the likelihood of outbreak-prone diseases such as measles and others.

The COVID-19 pandemic is expected to exacerbate health systems and delivery challenges in Timor-Leste. With a relatively limited COVID-19 caseload, health systems may have the capacity to maintain routine service delivery in addition to managing COVID-19 cases. When caseloads become high, and/or the health workforce is reduced due to infection of health workers, strategic shifts will be required to ensure that increasingly limited resources provide maximum benefit for a population.

Demand for non-COVID-19 health services may decline during the COVID-19 outbreak period, due to fear or in compliance with measures restricting movement. Pregnant women, mothers' and caregivers may also be afraid and will need additional reassurances to ensure that they continue to seek antenatal, postnatal and well-baby checkups, as well as family planning services and heath sector responses to gender-based violence. It is also fundamental that STI and HIV screening and testing continue during this period.

Health workers on the frontline will also need to be reassured that the state is taking all necessary preventive and protective measures to minimize occupational safety and health risks, provide information, instruction and training on occupational safety and health, including appropriate use of PPE, infection prevention and control and clear guidelines for continuation of routine essential health services.

2. Sectoral Response Priorities

a. Sectoral Objective

To establish a set of targeted immediate actions that Timor-Leste will consider at national and municipal levels to reorganize and maintain access to essential quality health services for all.

b. Ongoing response

WHO, UNICEF and UNFPA are working with the MOH on several health systems components which includes forecasting and procurement of essential medicines, medical devices and consumables; continued support for the essential public health programs like immunization, prevention, care and support for priority public health issues such as tuberculosis, vector-borne diseases, non-communicable diseases and others; supporting MOH is reorganizing care delivery for non-COVID-19 at the national hospital; strengthening the national laboratory; capacity building of health workers, and others. UNFPA is developing guidelines for Maternal-Covid19 and training the health professionals (midwives and Doctors) on ANC, Intrapartum and Post Natal Care; supporting the MOH to ensure continued provision of essential sexual and reproductive health services such as family planning, HIV/STIs and Emergency Obstetric Care services and continue to support the MoH on forecast, procurement and distribution of FP commodities and lifesaving maternal health drugs Additionally, UNFPA is providing dignity kits and GBV information to people in quarantine facilities, as well as training health personnel in quarantine facilities to identify and refer survivors of GBV. UNICEF is engaged in ensuring the essential maternal, newborn, child health, nutrition and WASH services are continued during this period including immunization services.

c. Priority response for the next 6 months

1. Establish simplified purpose-designed governance and coordination mechanisms to complement response protocols

- Establish (or adapt) simplified mechanisms and protocols to govern essential health service delivery in coordination with response protocols.
- Establish triggers/thresholds that activate a phased reallocation of routine comprehensive service capacity towards essential services, through the specific mechanisms identified below.
- Assess and monitor ongoing delivery of essential health services to identify gaps and potential need to dynamically remap referral pathways.
- Establish regular coordination with the General Directorate of Water and Sanitation (DGAS) under the Min of Public Services on WASH Services at public places, health and quarantine facilities.

3. Identify context-relevant essential services

- Generate a country-specific list of essential services (based on context and supported by WHO guidance and tools).
- Identify routine and elective services that can be delayed or relocated to non-affected areas.
- Create a roadmap for progressive phased reduction of services (see also governance above).
- Work with partners to develop implementation guidelines on how to continue to provide essential maternal, newborn and child health services. This should provide "how to" guidance for health posts, CHCs and hospitals in order to maintain routine essential health services. Examples include decision on minimum services packages, task shifting, adopting 'physical distancing' principles in health centers and hospitals, and tracking children who miss out on schedulable services for catch-up later.
- Support case management for children and pregnant women through home-based care for non-severe cases and referral of severe cases, support implementation of case management guidance for pediatric cases and provision of related supplies such as C-PAP, safe oxygen and antibiotics.

- Implement breastfeeding recommendations, replacement feeding for infants unable to be breastfed, and nutritional support for patients with COVID-19.
- Promote handwashing and hygiene (including respiratory hygiene) through multi-sectoral platforms in order to reach households, community and the health workforce.
- Ensure midwives and doctors at maternity clinics have proper skills and knowledge to prevent transmission of COVID-19 during ANC, intrapartum and postpartum care.
- Provide dignity kits to quarantine facilities and maternity clinics.
- Ensure adaptation of health-sector responses to GBV and Safe Spaces are able to operate with access to movement and relevant equipment.

4. Optimize service delivery settings and platforms
   - Conduct a functional mapping of health facilities, including those in public, private, and military systems (this is a shared action with Operational planning guidelines to support country preparedness and response, Pillar 7: Case management).
   - Taking into account re-purposed facilities, concentrate 24-hour acute care services at designated first level hospital emergency units (or similar) and ensure public awareness.
   - Redirect chronic disease management to focus on maintaining supply chains for medications and needed supplies, with a reduction in provider encounters.
   - Establish outreach mechanisms as needed to ensure delivery of essential services.
   - Explore and design alternative service delivery models as appropriate.
   - Strengthen infection prevention and control (IPC) in health facilities through provision of vital supplies (including personal protective equipment, and WASH supplies), adoption of IPC protocols, and related training and monitoring.

5. Establish effective patient flow (screening, triage, and targeted referral) at all levels
   - Disseminate information to prepare the public and guide safe care-seeking behavior
   - Establish screening of all patients on arrival at all sites using the most up-to-date COVID-19 guidance and case definitions.
   - Establish handwashing stations at all health facilities.
   - Establish mechanisms for isolation of patients in all care sites using the most up-to-date COVID-19 guidance.
   - Ensure acuity-based triage at all sites providing acute care
   - Establish clear criteria and protocols for targeted referral (and counter-referral) pathways
   - Ensure ambulance services are available for referral of complicated cases and follow strict infection prevention and control guidelines.

6. Rapidly re-distribute health workforce capacity, including by re-assignment and task sharing
   - Map health worker requirements (including critical tasks and time expenditures) in the four COVID-19 transmission scenarios
   - Maximize occupational health and staff safety measures in all categories listed above, including in relation to gender-based needs (e.g. access to menstrual hygiene for any personnel not able to return home, harassment, abuse of female personnel).
   - Create a roadmap for phased implementation of the strategies above for timely scale-up.

- Allocate finances for timely payment of salaries, overtime, sick leave, and incentives or hazard pay, including for temporary workers.
- Initiate rapid training mechanisms and job aids for key capacities, including diagnosis, triage, clinical management, and essential infection prevention and control

7. Identify mechanisms to maintain availability of essential medications, equipment and supplies
   - Map essential services list to resource requirements.
   - Map public and private pharmacies and suppliers.
   - Create a platform for reporting inventory and stockouts, and for coordination of re-distribution of supplies.
   - Ensure that HMIS data is being monitored closely in order to accurately assess patient volumes, numbers of OPD clients, in-patient admissions, and services provided such as immunizations sessions conducted, ANC visits and institutional births, and GBV responses, or use existing digital health platforms to establish a system to monitor health service delivery and utilization in real time.

d. Indicative financial requirements

Activity	Details	Cost (USD)
Establish simplified purpose-designed governance and coordination mechanisms to complement response protocols	See c.1.	502,200
Identify context-relevant essential services	See c.2.	2,000
Plan and quantification of stockpile of essential goods	See c.3.	8,094,500
Maternal health	See c.3.	35,000
Dignity kits	See c.3.	100,000
Establish effective patient flow (screening, triage and targeted referral) at all levels	See c.4.	1,707,100
Rapidly re-distribute health workforce capacity including by re-assignment and task sharing	See c.5.	513,000

Identify mechanisms to maintain availability of essential medications, equipment and supplies	See c.6.	200,500
Total		**11,154,300**

Annex – Timor-Leste Country Preparedness and Response Plan (CPRP)

COVID-19 COUNTRY PREPAREDNESS AND RESPONSE PLAN

Country name: Timor-Leste

(version 3 March 2020)

Background

On 31 December 2019, the WHO China Country Office was informed about cases of pneumonia of unknown cause, detected in Wuhan City, China. Subsequently, the Chinese authorities identified a new type of coronavirus, called novel coronavirus (2019-nCoV), and the disease is now named as COVID-19. On 30 January 2020, WHO Director-General declared the outbreak of novel coronavirus – a Public Health Emergency of International Concern (PHEIC).

Coronaviruses are zoonotic, meaning they are transmitted between animals and humans. Once in humans, this 2019-nCoV has shown the capacity to transmit from human to human. Most common signs include respiratory symptoms, fever, cough, and breathing difficulties. In more severe patients, an infection can cause pneumonia and even fatal complications.

However, as on 19 February 2020, there are no suspected or confirmed cases of COVID-19 in Timor-Leste.

The Ministry of Health (MoH) in collaboration with the WHO Country Office for Timor-Leste is closely monitoring the situation and strengthening preparedness. WHO is also closely working with key institutions like the National hospital, National Health Laboratory (NHL) and Points of Entry authorities (Airport, Sea ports and Land borders) among others. WHO has worked with the National Laboratory to establish mechanisms to send samples for testing to the Victoria Infectious Diseases Reference Laboratory in Melbourne, Australia.

WHO will be providing the NHL with 10 test kits (1000 tests). Additionally, NHL has placed an order for CDC COVID–19 kit reagents which are available to Timor-Leste via the International Reagent Resource (IRR) system. WHO provided protocols for both test kits (WHO and CDC). Both assay are based on the real time RT-PCR and could be performed by National Health Laboratory. For quality assurance, every laboratory initiating the testing needs to send samples to a Reference Laboratory.

The Ministry of Health with WHO's support is also working proactively to stem any rumours and spread of misinformation by conducting national media workshop, and sensitization sessions for officials of all the Ministries in the government at the central and municipal level.

WHO is also supporting the Ministry of Health in capacity building by conducting multiple workshops and refresher training for not only doctors but all health workers. The purpose of these workshops is to equip health workers and emergency responders with accurate technical

information on 2019-nCoV, strengthen emergency preparedness and response and institute appropriate surveillance systems to detect cases and contacts. An important aspect of these trainings is to provide reliable and accurate information to dispel the many myths also currently circulating.

Based on a current assessment of country risk, vulnerability and readiness to respond to COVID-19, the strategic preparedness and response plan (SPRP) for Timor-Leste estimates the resource requirements to be approximately **$2,052,500** for a period of three months from 1 February to 30 April 2020. This is an estimate for initial planning purposes and will be adjusted as the situation evolves.

Situation and Gap Assessment

Public health in Timor-Leste is built on a foundation of primary health care, limited by insufficient resources and limited capacity, particularly for public health emergency preparedness and responses. The Joint External Evaluation (JEE) for implementing International Health Regulation (IHR 2005) in 2018 highlighted several areas which need to be strengthened in the country, which include:

• Emergency response capacity. needs to enhance its ability to quickly deliver medical resources where they are needed. This includes assessing national emergency communications and mobile resources.

• Laboratory. The integration of laboratory information, improved laboratory capacity, improved quality assurance and better biosafety and biosecurity fit under the common theme of laboratory strengthening.

(Source: WHO, JEE report, 2018)

With the onset of the 2019-nCoV, the WHO Country Office conducted a rapid assessment of the National Capacities on readiness for the 2019-nCoV outbreak among the countries of the Region. For Timor-Leste, there are noteworthy gaps in many areas. For example:

1. Detect:

1.1 National Laboratory Capacity: It is a BSL-2 lab, with functioning and quality subtyping of influenza samples for more than two years, but with no experiences and reagents to conduct test on nCov. The specimen collection, packaging and transport guidelines are available, and sample referring and transportation mechanisms have been established.

1.2 Surveillance and risk assessment: There is an Event Based Surveillance (EBS) system in place which could be scaled-up to include any new case definition. The SARI/ ILI surveillance is in place.

Capacities for rapid risk assessment and analysis of surveillance data are limited. The private sector was not fully involved in the surveillance system.

1.3 Rapid Response Teams: There are Rapid Response Teams (RRT) at national and municipality levels, with agreed mechanisms for deployment, PPE, trained on information collection, contact tracing, donning and doffing PPEs and biological sample collection. However, they should be provided with refresher training and resupply of PPEs.

2. Respond:

2.1 Command and Coordination: the command and coordination mechanism at national level for response is yet to be strengthened. The HEOC is not formally functional, and Incident Management System (IMS) not yet established, and health quarantine law is not available. However, the multidisciplinary emergency response committees, partners for support in the response, political engagement are strong.

2.2 Risk Communication: There are risk communication focal unit/ team, surge capacity, participation of risk communication experts in outbreak response, rumour management capacity, community engagement, and government information management and coordination mechanisms. However, the capacity is still to be strengthened.

2.3 Points of Entry: There are limited space, facilities, equipment and staff for PoEs in Timor-Leste. However, the communication arrangements between the POE and the health facilities and also information dissemination capacity at POE for travelers were functional.

2.4 Case Management: Limited training to medical teams in SARI case management, and ambulance teams need refresher training on SARI patient transportation at the time of the assessment. There is no isolation ward, and reported only having six ICU beds. The PPEs are not enough in healthcare facilities.

2.5 Infection Prevention and Control: There is no triage systems for ARI cases, and observation of droplet/ standard precautions and observation of airborne precautions for needed patients requires improvement. There is not adequate stock of PPE for case management.

2.6 Logistics, procurement and supplies management: There is a procurement mechanism, sufficient storage capacity, a stock management system as well as a transport and distribution system set in place within the countries.

Objectives

Based on the objectives of the global strategic preparedness and response plan, and the country context, the following objectives are proposed:

1. Limit human-to-human transmission, including reducing secondary infections among close contacts and healthcare workers, preventing transmission amplification events.
2. Identify, isolate, and care for patients early, including providing optimized care for infected patients;
3. Strengthen laboratory capacity for specimen collection, in-country testing, and transportation to referral laboratories
4. Communicate critical risk and event information to all communities, and counter misinformation.

Activities

To achieve the objectives, the specific actions are to be taken to prepare for and respond to 2019-nCoV. There are eight pillars of the public health responses:

1. Country-level coordination, planning and monitoring
2. Risk communication and community engagement
3. Surveillance, rapid-response and case investigation
4. Points of entry
5. National laboratories
6. Infection prevention and control
7. Case management
8. Operations support and logistics

The table below describe the detailed activities under each pillar, followed by implementation partners and timelines.

Areas	Activities	Implementation Partners	Timeline
Country coordination	Activate the Multisectoral Policy Level Emergency Commission established under the Prime Minister Office (PMO) and hold regular coordination meetings	PMO, Ministries, UN, NGOs and CSO	Mar–May
	Activate and socialize Pandemic Influenza Preparedness Plan (PIPP)	MOH, MOAF	Mar
	Operationalize the HEOC, and activate the incident management system (IMS)	MOH	Mar-May
	To assess and fill incident management staffing needs (repurpose staff from other departments)	MOH	Mar

	Regular planning and operational meetings between responding agencies	MoH (CDC, HNGV, NHL, SAMES), POE, immigration, police	Mar – May
	Coordination meetings with partners	UN agencies, HCT, development partners, Embassies and community agencies	
Surveillance, RRT and case investigation	Develop system, tools and protocols for contact tracing and monitoring	MOH	Mar
	Train and equip rapid response teams to investigate cases within 24 hours	MOH	Mar– May
	case-based reporting to WHO within 24 hours	MOH	Mar– May
	Regular consultative meetings to review control measures and inform response decisions	MOH	Mar-May
	Produce weekly epidemiological reports for all priority diseases and disseminate to all levels	MOH	Mar-May
	Simulation exercise(s) to test functioning of the surveillance and response system	Airport, Ambulance, HNGV and MoH	Mar
Point(s) of Entry	Prepare rapid health assessment /isolation facilities to manage ill passenger(s) and to safely transport them to designated hospitals	POEs, MOH, Immigration	Mar
	IEC materials for passengers on nCov knowledge	MOH, Airport	Mar -May
	Ensure adequate quantities of Health Declaration Cards, Covid-19 leaflets	MOH, Airport	Mar-May
	Equip and train staff in appropriate actions to manage ill passenger(s)	MOH, POE	Mar-May
Laboratory	Training on specimen collection, management, and referral network and procedures	NHL	Mar-May
	Re-fresher training for Covid-19 testing at NHL	NHL	Mar-May
	Allocate and training on appropriate use of PPE	MOH	Mar-May
Infection Prevention and Control	Engage trained staff and technical expertise to implement IPC activities	MOH	Mar-May
	Support MOH (SAMES) to store and coordinate distribution of PPE to all responding agencies	MOH, UN, DP	Mar-May
	Refresher trainings on correct PPE use and IPC	MOH	Mar-May
	Address shortages of supplies and equipment at HNGV Isolation Ward	MOH, DP, UN	Mar-May

Case Management	Adopt guidelines for case management and conduct trainings	MOH	Mar-May
	Complete refurbishment and provide stocks of supplies and equipment for isolation facility at Formosa CHC	MOH, DP	Mar-May
	Identify additional quarantine facilities for surge capacity for quarantine	Ministries, DP	Mar-May
	Identify and train staff for surge capacity, targeting additional technical resources needed when situation escalates for Case Management and IPC	All partners	Mar-May
Risk communication and community engagement	Organize awareness raising sessions with all ministries, partners, organizations, social and religious networks	All partners	Mar-May
	Provide accurate, credible information for the general public using various means of communication (including social media, mass media, press conference)	All partners	Mar-May
	Weekly press conference to address rumors and misinformation	MOH, media,	Mar-May
Logistics, procurement and supply chain	Procure and supply medicines, equipment and PPE from MOH (SAMES) to relevant facilities and municipalities	MOH, DPs, UN	Mar-May

Resource Need Estimate

Estimated resource requirement to prepare for and respond to cluster of local transmission of up to 50 cases.

Type	Unit Cost	Quantity	Estimated costs (US$)
Meetings/workshops and trainings	800	50	40,000
Staff - international	24,000	20	480,000
Incentive payment - local	800	400	320,000
Service contract (car rental, warehouse	3000	100	300,000
Supplies – medical equipment	300,000	1	600,000
Supplies – consumable kit	4,750	10	47,500
Supplies - medicine	60,000	3	180,000
Supplies - PPE	6,500	10	65,000
Supplies – local	1000	20	20,000
TOTAL			**2,052,500**