Evaluative Review – Jump Start Programme in Sudan

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Executive Summary

Jump Start Package: The Jump Start program came in response to a 2020 Lancet paper estimating up to 51,459 additional child deaths as an indirect effect of COVID-19 on essential service delivery and potential decline in utilization of child health programs. The UNICEF MENA Regional Office created a multi-faceted, multi-sectoral response around a Theory of Change. Country offices in the region then adapted the components of the Jump Start package to fit specific contexts. The Sudan office implemented all four components of the Jump Start package: maintaining continuity of essential health and nutrition services (H&N), provision of Personal Protective Equipment (PPE), strengthening Infection Prevention and Control (IPC)/water and sanitation services (WASH) and Risk Communication and Community Engagement (RCCE). These activities were incorporated into existing programming, with no separate Jump Start administrative entity created.

Essential Health Services + PPE: Health coverage declined an average of 10-25 percent and immunization campaigns were disrupted in the early stages of the COVID-19 pandemic. The Sudan office responded by developing IPC guidelines to improve safety at facilities, encouraging a return to normal service utilization, implementing new social distancing for community-based programs, providing additional nutrition supplies for families, implementing catch-up vaccine campaigns, and delivering PPE to health workers.

IPC/WASH: Handwashing supplies, soap, chlorine, and WASH infrastructure were provided for facilities. This was coupled with support to quarantine centers and WASH services at points of entry.

RCCE: C4D launched four campaigns that evolved with the pandemic, including staying at home during the lockdowns and returning to health facilities in later stages of the pandemic. An emphasis was placed on building community's trust with health facilities.

Findings: Table 1 summarizes the evaluative review's findings for Jump Start's relevance, effectiveness, and efficiency in Sudan and briefly summarizes recommendations for each sector pilar.

Table 1. Summary of Findings and Related Recommendations

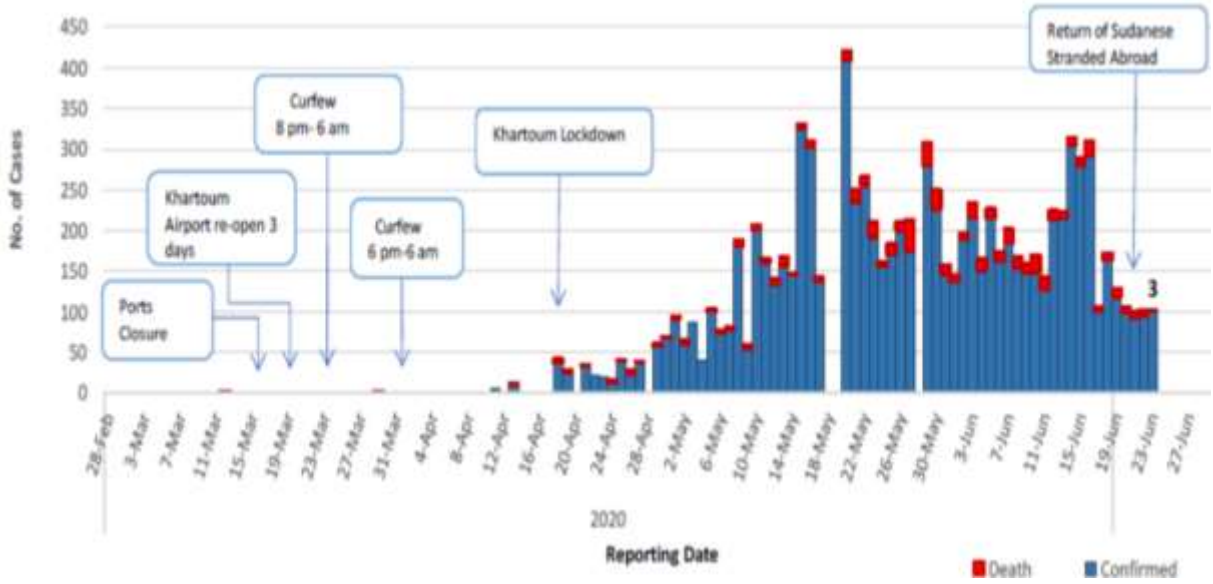
Pillar	Relevance	Effectiveness	Efficiency	Recommendations
H&N	• Relevant to country needs, particularly for specific services and states • Reasonable assumptions, but could have included additional research to assess drivers of the declines in utilization	• TOC represents a feasible hypothesis. • IPC guidelines represent good progress; however, extent of implementation of new protocols is unclear. • Catch-up campaigns achieved good coverage, with indication that coverage is rebounding to pre-COVID-19 levels	• New resources brought in for COVID-19 and were used for Jump Start • Strong partner coordination with MOH and WHO • UNICEF well capacitated	• Improve national and sub-national data collection and quality • Strengthen learning and evaluation approaches where possible • Additional efforts to monitor implementation and effective coverage of new protocols
IPC	• Relevant to country needs • Valid assumptions	• Changes to in-country operations, including increased focus on facility support and work in Khartoum. • Meeting most IPC targets • No outcome data identified for IPC / WASH interventions	• Resources diverted from postponed community-based interventions and new resources brought in for COVID-19 • UNICEF-led partner coordination	• Further prioritization processes for how to select from the 598 facilities requiring support • Strengthen learning and evaluation approaches where possible • Additional efforts to monitor usage of WASH services
PPE		• Initial supplies of PPE were delivered to health workers • Exceeded PPE targets	• Global shortages affected ability to procure PPE in the early stage of the pandemic; improved later on • Global shortages impacted timeliness of PPE delivery	• Consider flexibility in international shipments around country-specific transportation needs
RCCE (C4D)	• Relevant to the identified challenges of trust building and low demand. • Reasonable assumptions; could have improved targeting with baseline data from communities and evidence on underlying drivers for utilization declines	• Improved partner coordination, and improved partner awareness of and support to RCCE due to Jump Start • It is likely that these messages contributed to the improved coverage of health services during Jump Start, due to their relevance to the needs of the population; however, the data needed to confirm this was not available to the review team	• Resources diverted from postponed community-based interventions • UNICEF's internal human resources from other sectors supported RCCE	• Focus more on prevention and good practices in between emergencies, not only during response • Increased two-way communications with communities is needed

Introduction

COVID-19 in Sudan

As of 3 January 2021, Sudan has recorded 26,279 COVID-19 cases (U.S. Embassy in Sudan, 2020); the Johns Hopkins University COVID-19 global dashboard indicates the same number of cases as of 22 January 2021 (Johns Hopkins University, 2020), possibly indicating a lapse in reporting. Most cases have been confirmed in Khartoum, followed by El-Gazira, Gadarif, Sinnar, North Kordufan, Red Sea and River Nile (Altayb et al., 2020). Although Khartoum has seen the highest absolute mortality, other states have experienced a higher case fatality rate (Altayb et al, 2020). It is suspected that cases are considerably higher than reported due to lack of testing, reluctance to report infections, and denial of the pandemic (Altayb et al., 2020).

Figure 1. Trajectory of the pandemic (through June 2020) with mitigation (WHO, 2020)



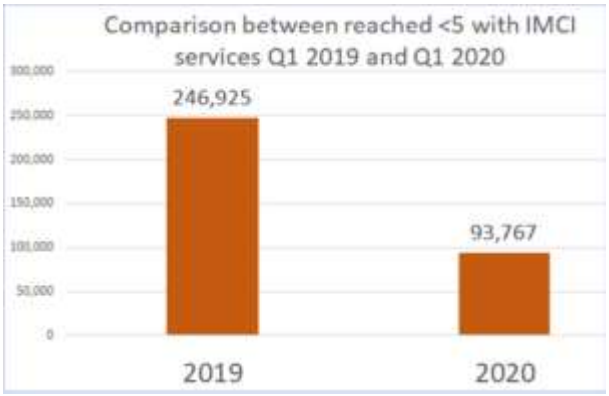
Impacts on the health system

COVID-19 compounded or exacerbated existing challenges in Sudan's health system. When the COVID-19 pandemic began in Sudan, initial service drops of 10 percent were experienced, mainly in primary health care services, and a 10 percent - 25 percent decline in utilization was experienced by refugees and displaced populations (Jump Start Real Time Assessment Report, 2020). Primary health care services moved to a shift schedule to reduce infections and began operating at 50 percent capacity. Large outpatient programs such as therapeutic nutrition were disrupted, community groups were halted, and attendance declined at infant and young child feeding (ICYF) programs from March to May 2020 as movement restrictions impacted the country. UNICEF documents indicated: "significant immunization service interruptions as a result of COVID 19 following mass vaccination campaign suspensions, decreased access due to physical distancing and transportation reductions, supply chain interruptions and high-risk populations at increased risk of immunization inequity" (Jump Start Real Time Assessment Report, 2020). Movement restrictions and stigma were suspected to be driving declines in utilization (Final MENRO Sudan Deep Dive, 2020); however, for some services, declines began as early as January 2020 (WHO, 2020). The World Health Organization's (WHO) Health Cluster report also attributed a lack of funding to drops in services in Q1 2020 (WHO, 2020). Projections for further disruption in services indicated a possible 10 percent reduction in children targeted for treatment of severe acute malnutrition

(SAM) and an 8-15 percent drop in measles immunization (Deep Dive – Brief Note on Impact of COVID-19, 2020).

Figure 2. Decline in maternal health services (Sudan Country Office Jump Start, 2020)

Figure 3. Decline in IMCI services (WHO, 2020)



Many services initially impacted by COVID-19 began to see a recovery in June 2020. IYCF program attendance improved in June as movement restrictions were partially lifted. Similar recovery was seen in measles vaccination campaigns (Final Sudan MENARO Deep Dive, 2020). Despite initial concerns, impact on SAM treatment appeared to be limited, and 90 percent of PHCs remained operational (Final Sudan MENARO Deep Dive, 2020). Immunization and bed net campaigns resumed, and community groups were re-started in July with new infection control protocols in place (Jump Start Real Time Assessment Report, 2020).

Despite initial signs of a recovery, there are concerns that multiple waves of COVID-19 outbreaks could hit the country, increasing disruption of health services (COVID-19 and WASH programme adaptations, 2020). Sudan is experiencing a suspected “uncontrolled epidemic”, and the case fatality ratio stands at 6.4 (COVID-19 and WASH programme adaptations, 2020). There are also concerns that the focus on the pandemic response could divert resources and attention away from routine health concerns and indirectly lead to increases in mortality and morbidity (COVID-19 and WASH programme adaptations, 2020). Finally, while a resumption of pre-COVID-19 coverage levels for routine services is encouraging, pre-pandemic service coverage was poor.

Coupled with impacts on service delivery, the Ministry of Health (MOH) in Sudan was heavily impacted by COVID-19. A lack of telework capacity led to a severe reduction in government operations and delays in approving partner programming and sector workplans. High turnover of MOH management was also experienced (Jump Start Real Time Assessment Report, 2020, interviews). Contextual challenges, including poor infrastructure during rainy season, fuel shortages, high transport costs, and flooding exacerbated challenges in the initial response and continuity of essential health services (Jump Start Real Time Assessment Report, 2020, interviews). Finally, Sudan has also experienced multiple crises during the pandemic, including a polio outbreak, large-scale flooding causing hemorrhagic fever, Malaria and other disease outbreaks, and continued governance instability with the ongoing peacebuilding process.

Sudan's ability to procure necessary personal protection equipment (PPE) has been limited due to international sanctions and a lack of access to hard currency. Procurement therefore fell to partners, with UNICEF leading the efforts. Even when procured, there were reports that ordered PPE did not arrive in time to the country (Sudan COVID-19 Technical - Supplies: Status and Challenges, 2020).

Jump Start Programme – A Regional Framework

The Jump Start Package was introduced in mid-2020 by the Middle East North Africa Regional Office (MENARO) to address concerns with primary health care service (PHC) continuity and coverage of essential Maternal, Newborn, Child Health and Nutrition (MNCHN) services during the COVID-19 pandemic. Designed to be flexible and customizable by country offices, the programme outlined four pillars of activities for implementation: (1) prioritized health and nutrition (H&N) services, (2) infection prevention and control (IPC), (3) personal protective equipment (PPE) and supplies, and (4) risk communications and community engagement (RCCE)[1].

The initiation of Jump Start was spurred by two interrelated occurrences: (1) a 2020 Lancet article which predicted up to 51,459 additional child deaths as an indirect result of COVID-19 and its impact on essential service delivery (Robertson at al., 2020), and (2) health management information system (HMIS) data from MENA countries showing a decrease in service utilization. This was coupled with reports from country offices on stigma and lack of trust during the early days of the COVID-19 pandemic. There was a specific concern that governments in the MENA region had responded with forceful unilateral prevention measures, such as universal lockdowns and facility closures, but were not repositioning their response to focus on management of COVID-19 vis a vis regular health needs and service provision in the country. Thus, UNICEF MENARO – in collaboration with its country offices – determined that a multi-pronged, multi-sectoral response to reestablish coverage of essential services was an important strategy for the region.

The MENARO office, in collaboration with country offices, utilized a multi-sectoral approach to design the Jump Start package, engaging the Health and Nutrition (H&N), Water, Sanitation, and Hygiene (WASH), and Communications/Communication for Development (C4D) sections to work together on an integrated approach. In addition to ensuring continuity of services where UNICEF has a direct role in provision, the H&N section identified the importance of building trust and encouraging a return to regular provision, not only for campaign-based services such as immunization, but also for facility and community-based services including Severe Acute Malnutrition (SAM), Antenatal Care (ANC), and skilled delivery. This approach involved close internal partnership with the C4D section to design behavioral change communication approaches appropriate for the region, and with the WASH section to improve infection prevention and control (IPC) at health facilities. The WASH team hired two consultants in addition to the consultant hired by H&N section to expand UNICEF's capacity on IPC. The consultants designed customized trainings that were rolled out at the country level. All work was informed by reports from the country offices on the situation on ground.

The regional office developed a MENARO Theory of Change (TOC) for the Jump Start programme that was informed by country experiences and customizable to the needs of each country. Country offices were given flexibility to determine which pillars of the package they would focus on.

[1] Note that WASH is sometimes used interchangeably to describe IPC activities, and communication for development (C4D) is often used interchangeably with RCCE in country documents.

Objective of the review and research questions

Objective

The objective of this evaluative review was to identify challenges, how they have been overcome, the reach of success (realized or potential), and actionable learnings for ongoing program improvement. Emphasis was placed on process indicators and qualitative contextualization, given the goal of the review and feasibility of data collection. Early outputs and outcomes from Jump Start were identified and assessed where available. Findings and recommendations aim to generate timely actions to strengthen the ongoing Jump Start Package throughout the MENA region.

Research Questions

The evaluative review prioritized the following questions according to the 2019 OECD DAC's Quality Standards for Development Evaluation. All questions were considered.

Relevance:

- To what extent are the four components of the Jump Start package (essential health and nutrition services, Infection Prevention and Control (IPC), Risk Communication and Community Engagement (RCCE) and personal protective equipment (PPE) and supplies) relevant in terms of its strategy, approach, and design?
- How and to what extent are the assumptions made for the Jump Start approach valid?
- To what extent does the Jump Start Package incorporate human rights, gender & inclusion, CRC, and conflict sensitive programming principals (including working across factions, if applicable)?

Effectiveness:

- What are the early lessons that are emerging from implementation of the Jump Start Package including intended and unintended outcomes?
- What opportunities and bottlenecks are impacting the implementation of Jump Start Package activities, and what strategies have been implemented to mitigate any challenges? What are key lessons learned in each country?
- To what extent has UNICEF put in place effective mechanisms for monitoring the implementation of the Jump Start Package, including the appropriateness of selected output and outcome indicators and the ability to assess program indicators within the programmes theory of change?

Efficiency:

- What is UNICEF's implementation capacity (including implementing partnerships, human resources and financial capacity) and will UNICEF be able to meet the needs required to achieve the objectives of the Jump Start Package?
- Did the Jump Start strategy lead to improvement in the allocation and use of resources, and improved more efficient processes with partners?
- How has UNICEF leveraged existing partnerships to support the Jump Start Package? How efficient is partner coordination?

Methods

Due to timelines, data availability, and the research questions, a qualitative methodology was developed for the evaluative review. A common methodology and initial templates for data collection and analysis were developed across the countries selected for the evaluative review (Iraq, Yemen, and Sudan) and then tailored to Sudan's context. Data sources included primary interview data and secondary documentation pertaining to program implementation and progress.

Document Review

A comprehensive review of programmatic documentation including situation reports, project updates, briefs, data dashboards, and other relevant information served as the foundation of the evaluative review. Documents were provided by the regional office and the Sudan office. A standardized data extraction form was developed based on the research questions and used to support data analysis.

Key Informant Interviews

In-depth qualitative interviews were conducted with key stakeholders and programmatic focal points to contextualize the implementation process and understand how realities on-the-ground influenced the success of the Jump Start Package. The evaluation team worked closely with Evaluation Specialists in each country to identify participants for key informant interviews. Interviews were conducted after completion of the desk review to avoid duplication of effort and minimize the time required of the country team. A semi-structured interview guide was developed based on the initial information gleaned from the document review and the research questions. Interviews were approximately one hour in length and conducted via Zoom. Verbal consent was obtained from all interview participants. Eight stakeholders from UNICEF were included in the interview process for Sudan– four from the regional office and four from the country office (Annex 4).

Analysis

A framework analysis approach was utilized to analyze primary and secondary data. A framework approach to data analysis is appropriate when conducting multidisciplinary qualitative research among teams and can facilitate the rapid analysis of qualitative data (Gale, 2013).

Findings

The Sudan country office is implementing all components of the Jump Start Programme.

Goals, Outputs and Outcomes of Jump Start Sudan

Table 1. Goals of Jump Start Programme, as defined in country office documentation

	Goal	Low-level goal	High-level goal	Citation
H&N	"Ensure continuity PHC services, prevention of any disruption of routine service for children such as immunization, and management of acute malnutrition to reduce mortality & morbidity"	Protect health workers to deliver essential services and promote continuity	Contribute to minimizing the impact of the COVID-19 pandemic on mortality	Jumpstart Package for Continuity of H&N Services-Sudan, 2020
IPC (WASH)	"Support continuity of essential H&N services in	Target health facilities have basic	"WASH fit" model is applied to all	

	targeted PHC facilities by ensuring access to safe water, access to sanitation, ensuring access to hand washing facilities."	WASH services including hand washing	PHCs – "Extending the services to reach more Health facilities and to have comprehensive assessment of wash at HFs & to address the gaps at Health centers through a national plan so every health facilities have access to WASH services as per standards"	
PPE	Not available			
RCCE (C4D)	"Supporting care seeking behaviors at health facility level, including hygiene & family safe practices. While increase the knowledge and inform community about the needed information for H&N, engage the community on the decision to take services, monitoring behaviors at Community level."	Improving community awareness of COVID-19	Increase demand for health services and improve prevention practices	Jumpstart Package for Continuity of H&N Services-Sudan, 2020

Relevance

The initial approach, strategy, and design

All four components of the Jump Start package were considered relevant by the Sudan country office. Country stakeholders emphasized the support of the regional office in developing an integrated approach to the package that was adaptable to Sudan's needs. Decisions were already being taken at the country level to move forward with similar interventions – for example, RCCE programming and support to IPC was already in progress – when Jump Start began. Country office documentation affirmed this:

> "*These are the key sectors that address the determinants of child survival and development, given the multi-sectoral deprivation in Sudan, to achieve maximum impact on child mortality and morbidity and value for money. Furthermore, those sectors are sharing services delivery platforms at health facility and community levels as well as common implementing partners such as Ministry of Health dealing with health emergencies, hygiene and sanitation. We are also sector lead for Nutrition, Wash as well as COVID-19 response IPC Pillar and risk communication and community engagement (RCCE) pillar lead agency*." (Jumpstart Package for Continuity of H&N Services-Sudan, 2020)

One respondent remarked that due to Sudan's size and multiple ongoing crises, the degree of implementation was more limited, but the principles of Jump Start were valid. Similarly, another respondent spoke highly of the roll-out of Jump Start and its relevance to the country office (Box 1).

Box 2. Relationship to regional package

All components of the Jump Start Package were perceived as relevant for Sudan and were implemented by the country office. It appears the Sudan country office followed the regional framework and implemented all four components with relatively equal effort.

In terms of program design, stakeholders at the regional and country level emphasized the integrated nature of the Jump Start from the design phase. Respondents at the country office level frequently referred to collaboration across sector teams and how they supported other sectors' activities under the programme. This provided further evidence that the program's integration during the design phase has continued through implementation. Many emphasized a "one team" approach with the activity design – for example, the WASH team agreed to focus on the same prioritized health facilities as the H&N team, while C4D provided cross-cutting messaging on both hygiene and service continuity.

On the implementation approach, it was noted that while Sudan is implementing all four components of the package, the country office has been forced to prioritize, including geographically by the volume of cases. This was again attributed to the multiple crises faced in Sudan, including the polio outbreak, flooding, and continued stabilization of the new government and Ministry of Health.

Were the assumptions valid?

The origin of Jump Start was spurred both by modeled impacts on women and children and HMIS data[2] from UNICEF country offices (see regional framework). Respondents indicated that Sudan saw a 10-24 percent drop in coverage during the lockdown, with community-based counseling, mother's groups and other "gathering-based" services hit the hardest. With new IPC protocols and guidance in place (led by UNICEF) combined with the lifting of the lockdown, many community-based services appear to have rebounded quickly.

It appears that the assumption of service disruption was well-founded and did occur. For the Sudan office, the impacts of COVID-19 have been more limited than initially feared, with outbreaks generally contained to Khartoum and the neighboring state of El-Gezira (per interview data); however, there have still been nation-wide impacts that required mitigation. What remains uncertain is the true drivers of disruption, whether it was spurred largely by stigma and lack of trust or more because of lockdown policies which were subsequently lifted. The Jump Start package outlined several well-founded hypotheses in the theory of change (TOC), but a baseline survey was not completed to ascertain what was truly driving the disruption. Outside the pandemic, other factors could have also contributed to reduced utilization – for example, WHO documentation indicates a drop in funding for many donor-funded outreach services in January 2020 which led to declines in service provision before the COVID-19 pandemic was widespread (WHO, 2020).

[2] The consultants were not able to receive copies of HMIS data for Sudan and therefore were not able to examine the trendline and recovery of services directly

Therefore, while it is reasonable to attribute the declines to COVID-19, additional insights from communities may have been useful in confirming the hypothesis and targeting response strategies.

Incorporation of human rights, gender & inclusion programming principles

At the country level, principles of human rights, gender and inclusion were referred to in a general way when discussing program design and implementation. Respondents consistently mentioned taking a whole-child approach and the need to remain focused on the rights of children.

The regional office illustrated how it used such principles in designing the original package. For example, many of the impacted services across the region have gender aspects, such as maternal care. Respondents highlighted that not all services were receiving equal attention from government counterparts, with services for women receiving lower priority. For example, many governments in the region have placed an emphasis on restoring immunization campaigns but have not shown the same focus on restoring maternal care coverage with the exception of care for high-risk pregnancies.

The Jump Start approach to C4D centers on rebuilding trust through education and awareness building with communities. This approach was favored due to concerns of government orders superseding individual liberties and generating additional stigma among populations. This review has concluded that although not an explicit focus, a human rights-based approach to C4D was embedded in the country office's campaigns and approach during Jump Start. Documentation from the country office and country strategies similarly emphasize the rights of the child in WASH services– for example, how the Sudan country office works to fulfill Article 24 of the Convention of the Rights of the Child through WASH programming (UNICEF Mid-year progress review, 2020).

Effectiveness

Evolution of country office programming as a result of Jump Start

Although not an original research question, how Jump Start was the same or different than "routine" country operations became a line of valuable inquiry for the review. Documenting process changes that occurred during the program is a useful proxy for understanding consequences of the package, particularly considering data limitations. Shifts in country office operations and programming modalities appears the greatest for the WASH sector and the most limited for H&N.

Table 2. Changes and continuity in UNICEF's approach, by sector

	What changed?	What stayed the same?
H&N	• Integration of IPC into programming • New emphasis on protocol development for IPC	• Working through the national system with the FMOH • Leveraging service agreements with NGOs • Nutrition cluster leadership across partners as well as playing critical role at Health cluster
IPC (WASH)	• UNICEF cluster leadership for IPC across partners	• WASH cluster lead across partners

	• More emphasis on facility-level support for WASH services, compared to community services • Supporting a larger number of facilities than normal, including in Khartoum • Temporarily curtailing some community mobilization activities for WASH	
PPE	• New area of support, according to project documentation	• Leveraging of UNICEF's global procurement capacities
RCCE (C4D)	• Trust building between the community and the health sector was emphasized. Government closures eroded trust and confidence, and UNICEF worked to combat rumors and denial that COVID exists. • The Country Office integrated COVID-19 messages with outreach campaigns and messaging for other services. For example, COVID-19 awareness was included in outreach messages that encouraged communities to return to malaria services.	• Cross-cutting focus on the needs of communities and improving service demand. • Led advocacy efforts.

Challenges with implementation

Jump Start faced many challenges, both programmatically and contextually. Many of these were cross-cutting.

Table 3. Challenges during implementation

	Challenges
H&N	• The existing weakness of the health system capacity for H&N service provision and the occurrence of multiple public health emergencies such as the heavy flooding, disease outbreak, refugee's influx, and tribal conflicts during the COVID-19 pandemic. • Changes in the country's political context and the deterioration of the economy (e.g. fuel shortage, market inflation)
IPC (WASH)	• Underestimated the magnitude of the efforts required in some instances – for example, out of the 598 prioritized facilities, few have received comprehensive support
PPE	• Limited local manufacturing capacities • Long durations needed for internationally procured supplies to arrive in-country • Irrational use of PPEs reported at the beginning of the pandemic in Sudan have led to an acute shortage endangering the lives of healthcare workers. • The limited initial capacity of the national LMIS has made it challenging to collect, organize and process data on inventory, distribution, and consumption of PPEs to allow for proper planning and decision making.
RCCE (C4D)	• Lack of population-level behavioral data – limitations in resources available and political economy/relationships with the government. Government resistance to a two-way information flow with citizenry

	• Lack of government buy-in for recommended prevention measures (e.g., mask wearing) undermines RCCE communications. • High government turnover compounded challenges with approvals and buy-in for C4D – for example, many months of long delays in approval for research across two focal people. • Challenging to sequence campaigns and messaging appropriately with the varied response from the government and readiness of the health facility to accept patients once they are told to go to the facility
Cross-cutting	• Inadequate HMIS – limited visibility into the outbreak or reliable utilization figures • Very weak capacity at the MOH – turnover has made it challenging to build capacity. The country team is constantly having to reinvent the wheel when new staff take up positions. • Flooding, polio outbreak, and continued governance challenges happening concurrently with COVID-19 have spread the country office and resources thin. • Difficult to collect monitoring data during movement restrictions.

The country office provided insights into mitigation strategies. For monitoring data, efforts were made to follow-up with facilities via phone and to capture photos sent via social networking platforms in the absence of verification visits. Effective partner coordination was led by UNICEF across the RCCE/C4D, IPC/WASH, and nutrition sectors, ensuring that actors were speaking with one voice to the government and providing consistent messaging and response strategies. Regional and global guidance was used to inform IPC protocols.

Further prioritization within the 598 prioritized health facilities has been emphasized, due to resource gaps and challenges moving supplies around the country. The review team did not receive documentation on how many facilities have received support, but it was expressed qualitatively that many facilities have not been reached. There was no specified prioritization approach shared with the consultant to determine which facilities to support first, and one respondent indicated there was a somewhat opportunistic response focused on low-hanging fruit and areas where UNICEF could be complementary to other efforts, due to resource constraints.

Other challenges listed in Table 3 represent operational constraints for the Sudan country office that are largely out of their control. For example, a lack of efforts to wear masks by government counterparts has led to a perception of undermining RCCE messages. Efforts by the country team have focused on reframing data and evidence generated to inform RCCE as recommendations rather than evidence to try and seek apolitical buy-in. However, turnover in the MOH has often prevented success.

The impact of the flooding and other multiple, concurrent emergencies has also created major challenges and frustrations for the country office. For example, once the country office had gone through the selection exercise for the 598 facilities, there was significant decline in the magnitude of the COVID-19 outbreak. Therefore, the country office shifted attention to the flood response due to imminent concerns of its life-threatening impact. Many in the country office emphasized that once an activity had started up and a monitoring strategy had been put in place, energies were diverted to another crisis. This constant flow of human and financial resources from one emergency response to another limits the ability of any one program to reach its full intended impact. It has also spread country office staff thin, reducing their ability to prioritize any one response.

This finding is not a negative reflection on the country office team, but rather a contextual one that could warrant further thinking on how to best support country staff when in "multiple crisis" mode.

Monitoring Mechanisms

A key limitation of this review is the lack of monitoring data collected by the review team for Sudan's programming. This could be a limitation of the time frame of the review[3] and/or of the documents made available to the consultant. It could also reflect a broader challenge with monitoring and evaluation data that is readily available at the country and regional office levels. When data was available, it was fragmented across many sectoral specific documents. *It is therefore challenging to assess the effectiveness of monitoring mechanisms. The findings outlined here should be considered hypotheses for consideration based only on the information available to the consultant.*

Monitoring was consistently mentioned as one of the major challenges with Jump Start at the country level. It was noted that some indicators– such as number of people reached with RCCE campaigns – are not disaggregated by disease area or focus (for example, COVID-19 prevention versus continuity of service messaging). HMIS data has proved valuable to track utilization trends but was challenging to secure from the MOH, with late reporting that could impact appropriate conclusions.

Significant barriers to UNICEF's normal monitoring operations were introduced at the start of the COVID-19 pandemic. Curfews, movement restrictions, and lockdowns impacted the country office's ability to travel for supportive supervision and verification exercises. Capacity building for service providers and NGOs on monitoring was disrupted due to the halting of field visits. The country office has responded to these challenges by moving to phone-based and photo documentation for verification, and to continue to encourage the MOH to strengthen their own data collection and reporting systems. Respondents also indicated that Sudan's multiple crises impacted successful monitoring efforts – that as soon as a response is well established with strong M&E in place, resources and attention are diverted to another crisis.

Annex 2 outlines indicators for the Jump Start programme as contained in the assessment report, with data last available as of September 2020. Additionally, indicators are referenced in the document, "*Jumpstart Package for Continuity of H&N Services- Sudan*" (Box 2). Additional indicators were also documented at the regional level for RCCE (see MENA RCCE 2020 Results Pathway COVID + Non); however, data was not received for those indicators. Baseline data was also not identified for any indicators.

Box 2. Indicators for H&N (Continuity of H&N Services-Sudan, 2020)

1. HWs trained on IPC package
2. % of children covered with Penta 3
3. Number of Child with SAM treated
4. % of targeted PHCs have access to WASH services
5. Care givers are aware of key practices and at least practice 2-3 key behaviors of hand washing, physical distance & wearing masks

Much of the output data collected for this review was identified from various reports and documentation at the regional and country level (see Annex 2 and Table 4). At the regional level, reporting from August and September was identified in the regional excel dashboard of institutional indicators (Round 10 HPM Reporting 24September 2020).

[3] For example, the monitoring officer for the country office was not available during the specified time frame,

This data indicates that Sudan has (1) met or exceeded its targets for supplies, PPE, and number of women and children receiving essential health services, (2) nearly reached its RCCE targets for number of people engaged and number of people reached, and (3) has not met its targets for number of people trained in IPC, number of people trained in referral management, and number of children admitted for SAM (Round 10 HPM Reporting 24September 2020). This suggests generally good performance, particularly for activities that are more firmly within the office's control such as supplies, PPE, and reach of messaging.

Indicators selected for Jump Start are deemed to be generally appropriate; however, the utility of the indicators will also depend on the approach to collecting and analyzing monitoring data. Respondents at the country level shared the process for collecting monitoring data, including changes in verification due to COVID-19 restrictions, and shared how they report to the regional office. But it remained unclear how the data is analyzed at the country and regional level and how it is used to inform iteration of the program's design and implementation.

The TOC for Jump Start Sudan (see Annex 3) represents a good working hypothesis on the challenges of essential service continuity. Current Jump Start activities documented in this review do not address all aspects of the TOC (for example, transportation and socioeconomic barriers). It may be possible to strengthen the utility of the TOC by clarifying which aspects of the TOC are addressed directly by Jump Start, which are being addressed by other partners, and which remain unaddressed. This could guide future decisions about resource allocation and partner coordination to fill gaps.

If resources permit, there are opportunities to build on the indicators chosen for the programme moving forward. Current indicators are focused at the output level. Future iterations of the Jump Start monitoring plan can incorporate additional learning and evaluation approaches, including systematic measurement of outcomes (see recommendations). Additional indicators/research would be needed to capture progress on many of the intermediate steps in the TOC – for example, trust in the system or communities' understanding that the system is beneficial. Additional assumptions may also be missing – for example, lack of trust could also be due to poor quality, which pre-dates COVID-19.

Additionally, various analysis approaches can compare progress on indicators with previous years (as the HMIS analysis has done) and across states with different COVID-19 outbreak status and differing levels of Jump Start engagement. This can help compare Jump Start's efforts with relative changes in indicators. Follow-ups could be conducted to translate coverage indicators into an understanding of effective coverage – for example, what is the usage rate of WASH services at facilities? What percentage of trained providers trained on the IPC package are implementing the training at 3- and 6-month intervals? Currently, this information was not available.

Intended and unintended consequences of Jump Start

Table 4. Intended and unintended consequences, by sector

	Intended Consequences / Outputs[4]	Unintended Consequences – Positive	Unintended Consequences – Limitations
H&N	Services delivered to end-users with IPC measures in place: • Catch-up immunization campaigns for measles resulted in near return to 2019 coverage levels by the end of 2020 (Sudan Country Office Jump Start, 2020). • IPV campaign reached 467,398 in 4 states (Sudan Country Office Jump Start, 2020). Guidelines/protocols developed: • IYCF and CMAM interventions during COVID-19 for facilities and community-level • EPI & MNCH service guidance • Package of PHC services during the pandemic • Dissemination and training of nutrition staff on protocols • New IPC approaches and social distancing for facility services, mother's groups, and community counseling • PHC facilities on a 50% shift schedule • RUTF distribution every two weeks and RUSF every four weeks to reduce facility visits	• Facility prioritization exercise helped to identify vulnerable facilities to prioritize in future programming – appropriate way to scale up multi-sector responses	• Unsure of the monitoring strategy for protocol implementation
IPC (WASH)	• Distribution of water tanks, hand sanitizer, chlorine, and soap to point of entry and quarantine/isolation centers • Stand-by supplies were leveraged for immediate response • Support to a sub-set of the prioritized facilities with handwashing supplies, infrastructure needs, etc. Documentation was not available on the status of requests and fulfillment for each prioritized facility • 21,000 IDPs and host community members and 32,000 at-risk populations reached with COVID-19 door to door hygiene		• Not able to reach the full list of facilities; required additional prioritization once the list was developed, but there was potentially a lack of prioritization approaches for which facilities would receive support first

[4] This was collated from available documents and should not be viewed as a definitive aggregation of all Jump Start outputs

	promotion by 11 May 2020 (SCO_COVID-19 RO Update, 2020) • 30 hand water pumps provided expanded access to socially distanced water distribution in N and W Darfur (SCO_COVID-19 RO Update, 2020) • Trained 4,443 health facility staff and community volunteers on IPC using the national protocol and training guidelines.		and/or an inability to reach all facilities • Limited ability for training due to high turnover
PPE	• Met or exceed UNICEF's institutional PPE targets. • AS of 31 December 2020, UNICEF provided PPEs for over 62,163 health facility staff and community volunteers	• Spurred domestic community-based production of cloth face masks to supplement PPE (e.g. for back to school campaigns)	• Limited supply of PPE in the country led to some partner competition for supplies • Irrational use of PPEs reported at the beginning of the pandemic in Sudan have led to an acute shortage endangering the lives of healthcare workers.
RCCE (C4D)	• Four campaigns planed and implemented. • As of 11 May 2020, 1,796,587 people reached via social media, radio, and TV (SCO_COVID-19 RO Update) • UNICEF messaging delivered through radio and TVs in North Darfur, El Fasher, South Darfur, Nyala and El-Dein (SCO_COVID-19 RO Update) • Supported awareness messages that were sent via National TV, Khartoum TV, BN TV, Sudania 24 TV, and state radio channels (SCO_COVID-19 RO Update) • 22,551,000 people reached through SMS messages about COVID-19 prevention; 25.2M reached via radio; 6.8M reached via TV; no date provided for figures (Sudan Country Office Jump Start), n.d)	• Elevation of C4D among country partners, as UNICEF took the lead in coordinating an RCCE response. New coordination mechanisms with UN partners and government were put into place, elevating C4D and improving integration for future responses. • Other sectoral staff supported the C4D unit at the country office to increase capacity	
Cross-cutting		• Development of cross-sector SOPs to respond to future crises • Strengthened coordination and integration across sector teams	

Efficiency

Implementation capacity of UNICEF

The UNICEF country office did an effective job leveraging existing implementation capacity during the Jump Start programme. Sudan's presence nationally and sub-nationally was an asset, as was existing groundwork by C4D for the RCCE campaigns. UNICEF has been one of the largest partners in the UN response alongside the MOH on COVID-19, working closely with the WHO to coordinate and complement efforts. The regional office was helpful to the country office, providing timely support, recommendations, regional experiences, and global evidence and protocols in real-time.

UNICEF did not have existing capacities in IPC explicitly, but it was quick to bring in resources at the regional level to support countries. This included two external consultants and a training program for country offices and other country-level stakeholders. At the country level, UNICEF leveraged its lead partner role in WASH to provide leadership in IPC.

Resource allocation

Financial documentation was not available for this review, which would be needed to assess the cost-effectiveness of the response. Qualitatively, resources were largely diverted from existing in-country activities, particularly in the early days of the response with additional COVID-19 response funding providing extra support.

For RCCE, institutional funds were used. Programmatic funds were also diverted from activities that were postponed due to COVID-19 (for example, community engagement activities). Other sections supported C4D with staff support to speed up the process and maximize resources across the office. Many H&N service continuity activities were already a part of UNICEF's operation in some fashion, with existing resources used. Additional funding was raised as part of the COVID-19 response plan. For WASH/IPC, Jump Start was initially deployed as a part of regular program funding, drawing on preparedness funds and supply stockpiles to support emergencies. As these resources were not sufficient for a national response, additional funds were diverted from other postponed activities (for example, community WASH sensitization), and new funds were also raised through a UN funding window.

Partner coordination

Respondents indicated that partner coordination was generally an achievement of the response thus far. For RCCE and WASH, UNICEF is the lead partner collaborating with the government on response efforts. Partner coordination mechanisms are functioning – for example, RCCE has a two-pillar coordination mechanism: (1) UNICEF-coordinated meetings with the UN and INGOs, and (2) a meeting with government counterparts. Additionally, C4D colleagues worked with the private sector, particularly during the first "Stay at Home" campaign through SMS and radio. However, the polio outbreak and a desire by the government to allocate more airtime to peacebuilding efforts eroded long-term partnership efforts with the private sector.

If partner coordination has worked well, the government coordination has been more challenging. Many respondents indicate that government partners are absent, particularly in C4D coordination. However, others noted that MOH counterparts were committed to the response, particularly in improving service utilization. This indicates varied experiences with different sections of the MOH.

An additional challenge mentioned has been limitation of partners outside the UN response. During the initial lockdown, there were not many NGOs operational on the ground, and staff were challenged by a lack of electricity.

Lessons learned and recommendations

Country and regional respondents indicated there was much to learn from Jump Start and the COVID-19 response more broadly. The programme illustrates the importance of prevention and health systems strengthening/continuity, not just in response to outbreaks but also in the transition and interpandemic phases. COVID-19, being a truly global pandemic, also provides a unique opportunity to emphasis cross-country, cross-regional, and even global learning, research, and evidence generation on pandemic response strategies and how to protect essential health services during times of crises.

Recommendations for Jump Start

- **Additional prioritization processes for how to select from the 598 health facilities requiring IPC and H&N support** is needed. If not already in place, systematic tracking of which facilities received support should be implemented to improve monitoring of this activity and facilitate follow-up on effective use of WASH and infrastructure investments. Further monitoring could determine how the initial facilities that received support were selected (e.g. by level of support required? Differential capacities of the field offices to implement? Differential accessibility of facilities?) and whether the initial prioritization included or left out facilities with the highest vulnerabilities.
- Rapid formative research appears to be largely absent in the early days of Jump Start. A lack of baseline data or behavioral insights from the community were mentioned as challenges. **Strengthening ongoing learning and evaluation processes that move beyond monitoring indicators** could be considered. Examples include: (1) assessments on effective coverage, building on # of people reached, (2) the drivers of utilization changes at the community level, (3) extent of implementation of IPC protocols at facilities following trainings over time, and (4) pre-post analysis of behavior change messaging and COVID-19 education. For C4D, additional behavior monitoring can be considered to track changes in knowledge and attitude and ideally, link these to individual or community practices. Research of this type could shed further light on outcomes and effectiveness of Jump Start in meeting its medium and long-term goals. Additionally, cross-country research and evaluation of the IPC trainings could help standardize aspects of the training and improve effectiveness.
- **Building on lessons learned to prepare for COVAX vaccine allocations and roll-out. Jump Start's integrated, cross-sectoral approach should continue, and all four aspects of the package remain relevant.** RCCE will be critical to building trust in the vaccine and overcoming vaccine hesitancy and misinformation. IPC protocols will be needed to deliver the vaccine safely. High-level advocacy with the MOH will be required to ensure equitable distribution and appropriate prioritization of the vaccine. Additional research like the suggestions outlined above could inform any necessary modifications to the existing protocols, training approaches, and communications campaigns to inform the vaccine roll-out.

Preparedness for the next pandemic

- **Continued investments in the improvement of data systems, HMIS, supply chain and surveillance at the country and sub-national levels**. The government's decision to pursue a nation-wide "lockdown" with movement restrictions may have slowed the spread of COVID-19, but it is also possible that it further disrupted essential services. Improved data does not only inform preparedness and early response strategies, but it can also assist in further targeting limited resources – for example, to areas with the highest COVID-19 case burden.
- Several respondents indicated that COVID-19 highlights the importance of prevention activities. Sudan suffers from recurrent outbreaks of infectious and waterborne diseases. **Prevention through RCCE messaging can be an ongoing activity** and does not need to wait until an outbreak response begins. Community engagement systems should be developed at the grassroots level, so that RCCE platforms can be actively quickly during times of need.
- A current challenge is the lack of two-way communication between RCCE communications and community voices, attributed partially to political sensitivities with collecting such information. **High-level advocacy with the FMOH to improve UNICEF's ability to collect population-level behavioral data and feedback** is needed. Lessons learned from other MENA countries operating with similar political economy constraints could be useful to the Sudan office if not already provided.
- **Mainstream aspects of IPC, including WASH supplies and training at facilities, into regular operations**. The IPC programming was new for the UNICEF Sudan office, despite a history of recurrent outbreaks. Aspects of the existing IPC protocols and trainings may be useful to mainstream into regular operations, improving safety of facilities as one part of an overall prevention strategy.

Strengths and limitations of the review

Strengths

- The short timeline for the review will ensure the relevance and timeliness of findings for the country office.
- The review was forward-looking and focused on areas to build on for continued improvement and refinement of the programme.

Limitations

- Although the country office has continued to report on Jump Start, most documents provided to the review team were developed from April through September 2020. There was a lack of documentation on the program from October 2020 onward specifically available for the consultant's review. Interviews specifically asked about evolution of the program to fill this gap.
- The consultants were only able to speak to four people from the country office in the timeframe provided for the review. Annual leaves, sick leaves, and the holidays created barriers to scheduling. To improve comprehensiveness, three regional interviews were added and documentation was reviewed to triangulate limited interview data.
- In general, there was a lack of quantitative data available to be reviewed. This challenges the ability to analyze the outputs or outcomes of the Jump Start package.
- Primary data collection did not uncover details regarding the PPE component of the Jump Start package. Documentation was relied on for this component.

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Annexes

Annex 1 Interview Guide

INTERVIEW GUIDE – MASTER LIST OF QUESTIONS (SUDAN)

Thank you for speaking with me today. My name is X, and I am a consultant working with the Regional Office's Monitoring and Evaluation team. I've been asked to conduct an evaluative review to learn more about how the UNICEF Sudan office has responded to the COVID-19 outbreak and worked to maintain continuity of essential services.

This interview is expected to take less than one hour. If you are disrupted during our conversation, you can step away and then return to the interview. If I have follow-up questions from her

Participation in this interview is voluntary. The recording and notes from this conversation will be confidential to the team of external consultants supporting this review. Your responses will be synthesized with other responses and will be anonymized in our final report.

Would you like to participate in this interview? Are you OK with me recording this conversation, so I can accurately take down your responses?

ICE BREAKERS

1) How long have you been in the UNICEF Sudan office?

2) Could you tell me about your day-to-day role in X organization, and how its changed due to COVID-19?

INITIAL RESPONSE AND PROGRAM INTRODUCTION

First, I'd like to understand the context of the COVID-19 and how UNICEF Sudan has responded to the pandemic.

3) In your opinion, what were the major challenges introduced by COVID-19 and how have these changed over time?
    a) How did UNICEF respond to those challenges?
        b) What activities are new? Which activities were continued?
        c) How did those decisions get made? (probe for collaboration with regional office, Jumpstart references, partner coordination, work with MOH)
        d) How is this the same of different than "normal" operations? What is the same, what has changed?
        e) Where did the resources come from to support the response?
        f) How did the country office decide which of the ongoing activities would receive additional support?

4) What has been the role of partners in UNICEF's response? Partner coordination?
    a) How were partner roles defined?

5) How has the country office responded to COVID-19 in terms of resource allocation? Think about how financial and human resources may have changed as a result of the pandemic.

6) Taking a broad view of UNICEF's response – what is working? What is not?
    a) Where do you think you'll be in 6 months time? What will have been accomplished?
    b) What is lagging, hasn't started up as you hoped?
    c) Major lessons learned?
    d) What would you do differently if another pandemic arose?

JUMPSTART COMPONENTS

Thanks for this overview. Now I want to focus on some specific pillars of the COVID-19 response that I've been told are important in Sudan.

IPC

7) I understand that UNICEF has been a leader in supporting the MOH on infection prevention and control efforts.
   a) How did UNICEF get chosen to lead the IPC component of the all-partner workplan?
   b) How did you determine what activities to pursue?
   c) How is this the same or different than what was being done before COVID-19 started? How does this relate to the overall WASH strategy for Sudan and ongoing efforts?
   d) What partners are supporting these efforts?
      i) How are those partnerships operating? What are the coordination mechanisms? Any challenges? (UNHCR, SCI, MC also supporting)
   e) What are the monitoring mechanisms, if any?
      i) Ask for output documentation if any
   f) In your own opinion, what have been the successes? What has changed because of UNICEF?
   g) Any challenges or bottlenecks? Have any solutions been identified so far?

8) I know there have been new IPC protocols rolled out for PHC centers. What was UNICEF's role?
   a) Dates, timelier for the development and roll out?
   b) Coverage?
   c) What other partners are supporting?
   d) In your opinion, how effective has this been?
      i) What is the output? Outcome?
   e) Any successes?
   f) Challenges?

9) Water supply and handwashing stations have been set up at PHCs. What has been UNCIEF's role?
   a) Dates, timelier for the development and roll out?
   b) Coverage?
   c) How were facilities selected?
   d) What other partners are supporting?
   e) What is the output? Outcome?
   f) Any successes?
   g) Challenges?

H&N SERVICES

10) I've been told that one of UNICEF's pillars of COVID-19 support is the continuity of essential primary care and nutrition services. How has this been done in Sudan?
   a) How did you determine what activities to pursue?
   b) How is this the same or different than what was being done before COVID-19 started?
      i) How does the COVID response impact challenges that are pre-COVID, or not COVID specific?
   c) What partners are supporting these efforts? (probe for WHO listed in partner workplan)
      i) How are those partnerships operating? What are the coordination mechanisms? Any challenges?
   d) What are the monitoring mechanisms, if any?
   e) What is the coverage of these activities? I've seen various figures, including 400 prioritized facilities
      i) How were those facilities selected?
   f) How effective to you think UNICEF's support has been in maintaining service continuity? Why?
   g) In your own opinion, what have been the successes? What has changed because of UNICEF?
   h) Any challenges or bottlenecks? Have any solutions been identified so far?

11) One document mentioned catch up immunization campaigns. Can you tell me more about that?
   a) Coverage

b) Dates
c) Monitoring mechanism
d) Outputs, outcomes?
e) How effective?

12) Distribution of therapeutic food extended from one week to 2-4 weeks. How was that change made, what was UNICEF's role?
    a) Are there other changes like this due to UNICEF, that you would like to share?

C4D

13) Another pillar that may be relevant is communications for development (C4D). Can you describe the C4D work related to COVID-19?
    a) What specifically is taking place as it relates to COVID-19 and essential service continuity?
        i) Types of messages
        ii) Medium
        iii) Coverage
        iv) dates
    b) How did you determine what activities to pursue?
    c) How is this the same or different than what was being done before COVID-19 started?
        i) Probe on July 2020 C4D strategy which did not mention COVID-19
    d) What partners are supporting these efforts?
        i) How are those partnerships operating? What are the coordination mechanisms? Any challenges?
        ii) I noted that UNHCR and SIR were also key partners in RCCE in the July partners coordination workplan. How is the coordination, who does what?
    e) What are the monitoring mechanisms, if any?
    f) In your own opinion, what have been the successes? What has changed because of UNICEF?
    g) Any challenges or bottlenecks? Have any solutions been identified so far?

14) I was given a C4D cross-cutting strategy developed July 2020. How was that impacted by COVID-19?
        i) How does the C4D TOC link to COVID-19 activities?

15) RCCE is in the partner work plan – where did this originate? From MOH, UNICEF? This document was put together in July 2020 – how does this align with Jump Start initiation?
    a) UNICEF is the leading financial contributor to RCCE – are those Jump Start resources, or reprogrammed country office funding?
    b) UNHCR, and SCI are other funding partners – do they collaborate on the RCCE Jump Start?

PPE

16) What about PPE support from UNICEF?
    a) What are the PPE challenges and how have they evolved?
        i) In documents, it was mentioned that Sudan did not receive shipments of PPE as hoped for before rainy season. Has this challenge been resolved?
        ii) Probe for challenges with sanctions, lack of ability to buy on the international market, delays in receiving supplies
        iii) Probe on domestic manufacturing support
    b) How did you determine what activities to pursue?
    c) How is this the same or different than what was being done before COVID-19 started?
    d) What partners are supporting these efforts?
        i) How are those partnerships operating? What are the coordination mechanisms? Any challenges?
    e) What are the monitoring mechanisms, if any?
    f) In your own opinion, what have been the successes? What has changed because of UNICEF?
    g) Any challenges or bottlenecks? Have any solutions been identified so far?

17) I read about domestic manufacturing. Is UNICEF supporting this?

18) What about national quantification exercises? How is UNICEF supporting?
    a) Capacity of MOH?
    b) Logistician support?

CLOSING THE INTERVIEW

19) Can you share any documents, especially any M&E documentation like outputs, outcomes, theories of change or logic models, with me?

20) Do you have other topics you want to discuss or experiences you want to share with me?

21) Do you have questions?

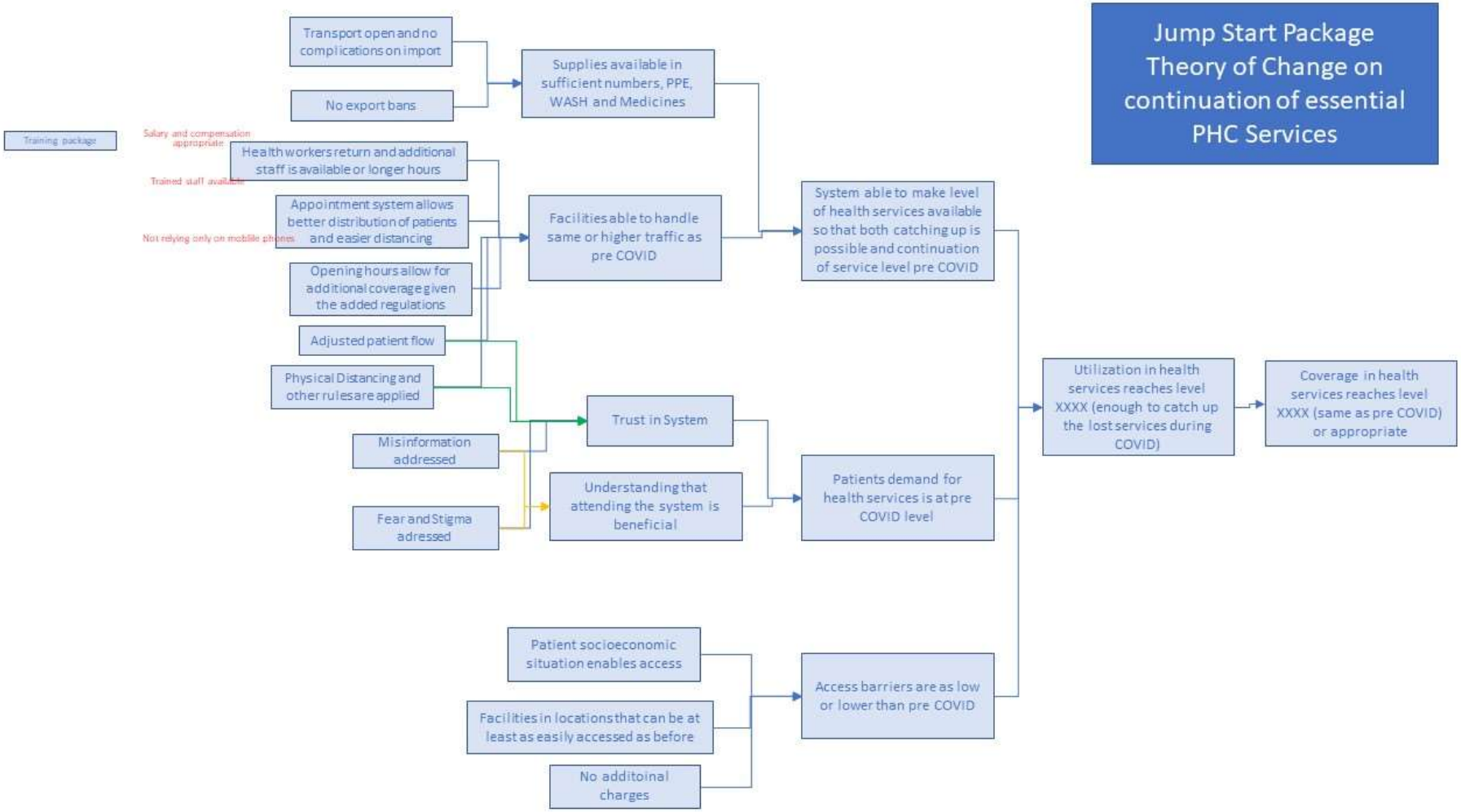
Thank you so much for speaking with us. If you think of anything else, or have any questions after we leave, please feel free to contact me.

Annex 2 UNICEF Jump Start Indicators and Targets Round 10 HPM Reporting 24 September 2020

Response Pillar	Global COVID-19 SitRep. Indicators	Target September	Actual (24 September)	Current?
Infection Prevention and Control (IPC): 1	Number of people reached with critical WASH supplies (including hygiene items) and services.	300,000	418,037	
Infection Prevention and Control (IPC): 2	Number of healthcare facilities staff and community health workers provided with Personal Protective Equipment (PPE).	7,920	11,993	
Infection Prevention and Control (IPC): 3	Number of healthcare facility staff and community health workers trained in Infection Prevention and Control (IPC).	2,880	3,708	
Risk Communication and Community Engagement (RCCE)	Number of people reached through messaging on prevention and access to services	30,000,000	25,200,000	
Risk Communication and Community Engagement (RCCE)	Number of people engaged on COVID-19 through RCCE actions	1,000,000	898,589	
Risk Communication and Community Engagement (RCCE)	Number of people sharing their concerns and asking questions/ clarifications for available support services to address		NA	

	their needs through established feedback mechanisms			
Support the provision of continued access to essential health and nutrition services for women, children and vulnerable communities	Number of healthcare providers trained in detecting, referral and appropriate management of COVID-19 cases	3,300	2,394	
Support the provision of continued access to essential health and nutrition services for women, children and vulnerable communities	Number of children and women receiving essential healthcare, including prenatal, delivery and postnatal care, essential newborn care, immunization, treatment of childhood illnesses and HIV care through UNICEF supported community health workers and health facilities	987,700	985,624	
Support the provision of continued access to essential health and nutrition services for women, children and vulnerable communities	Number of caregivers of children aged 0-23 months reached with messages aiming to protect breastfeeding in the context of COVID through national communication campaigns		NA	
Support the provision of continued access to essential health and nutrition services for women, children and vulnerable communities	Number of children 6-59 months admitted for treatment of severe acute malnutrition (SAM)	300,000	93,082	

Annex 3: Jump Start Theory of Change



Annex 4: Review Participants

Regional Office:

- Anirban Chatterjee, H&N
- Chris Cormency, WASH
- Esmaeil Ibrahim, WASH
- Neha Kapil, C4D

Country Office:

- Rasha Al-Ardi, H&N
- Kannan Nadar, WASH
- Eman Eltigani, C4D
- Philippa Morgan, Multi Country Evaluation Specialist, based in Sudan