STANDARD ACTIVITY REPORT FORMAT FOR IMPLEMENTING PARTNERS

ACTIVITY TITLE (as stated in the AWP)

Five Day (5) Training of Technical and Non Technical Staff (PHC, CHIPS, and Cementary Attendants) in 3 MAMI LGAs (Hong, Song and Numan) Adamawa State on Community Maternal, Perinatal, Child Deaths, Surveillance and Response (CMPCDSR) Held from 15th to 19th December 2026.

NAME OF IMPEMENTING PARTNER

Adamawa State Ministry of Health (SMOH) and State Primary Health Care Development Agency (ADSPHCDA). Supported by UNFPA

VENUE/LOCATION OF ACTIVITY

The activity was conducted in three selected MAMI LGAs of Song, Hong and Numan Primary Health Care Authority Halls.

DATE OF ACTIVITY

15th to 19th December 2025. Simoultenously

OBJECTIVES OF THE ACTIVITY (*The activity objective is what the activity aims to do, for example provide your perspective or deliver some sort of experience for the young people you work with***.)**

I. Sensitize and update relevant stake holders across the State, PHC Facilities and Communities on the approved guidelines and tools for PHC and CMPCDSR.

II. Improve understanding of roles and responsibilities of the PHC and CMPCDSR committees across the levels.

III. Facilitate the operationalization of CMPCDSR in PHC Facilities and communities.

BACKGROUND INFORMATION (*Overall background for understanding the activity***.** *Explain the background to this activity including why it was conceived, the problem you are trying to solve, backed up with relevant indices where applicable***)**

The Adamawa State Ministry of Health collaborate with State Primary Health Care Development Agency has developed a quarterly review meeting for Maternal, Perinatal and Child Death Surveillance and Response (MPCDSR) as recommended by WHO. Reporting and tracking Maternal, Perinatal and Child deaths remain a major challenge in the State. The first 28 days of Life, the Neonatal period is a critical period for Survival of the Child. It commonly accepted that the causes of Maternal, Neonatal, infants and under five mortality rates are preventable through systematic public Health Education and strengthening of Health Systems blocks, which deal with the three delays:

- Delay in seeking Care
- Delay in access to Health Care Facility and
- Delay in receiving quality Care

Based on the mentioned the collaboration aims to establish and strengthened quality and timely reporting of MPCDSR in Primary Health Care settings in the State since it is ongoing in secondary Health
Facilities.

Maternal Death By LGA

- Under reporting from the following LGA most especially on the appropriate Platform: NOQA
- Girei, Hong, Numan, Mubi North and Lamurde seems to have under reproting
- Mubi South, recorded the highest number because its serve as the referrals center to most of the Surrounding town including Cameron republic as most of the cases Might be mismanaged either from some Private clinics or PHCs before referrals
- No report on DHIS this year, this might be because it has converted to FMC and the new MRO has not been compiling result and submit to the LGA M&E
- There is need to report on the appropriate platform

	MD 20220	MD 2021	MD 2022	MD 2023	MD 2024	MD 2025
DEMSA		1	1	1	4	3
FUFORE			6	1		4
GANYE	1	10	3	15	22	16
GIREI	4	1				
GOMBI		1	4	2	1	8
GUYUK	3	1	2	2		
HONG		3	6			5
JADA		2	6	15	21	19
LAMURDE	1	1				
MADAGALI		1	3			3
MAIHA		2	5	9	8	4
MAYO/BELWA	6	12	8	11	8	13
MICHIKA	5	1	6	7	5	2
MUBI NORTH						
MUBI SOUTH		48	38	21	9	
NUMAN			7		1	3
SHELLENG	12	1		4		1
SONG	2	16	9	12	17	10
TOUNGO		6	5	3	2	4
YOLA NORTH	109	59	2	1	4	21
YOLA SOUTH	10	9	21	12	11	6

Comparative annual downloaded data 2020 to 2025 from DHIS2 showing the magnitute of maternal deaths in the State in the 21 LGAs.

KEY HIGHLIGHTS OF ACTIVITY PROCEEDINGS (*Provide the most important and noteworthy parts or moments that stand out during the course of the activity***)**

- A video session on why Mrs X died (which buttresses the need for death notification, review/audits, surveillance and response) was played and projected. There was intermittent pausing of the video to interpret the video audio in their native language so as to further aide the understanding of the participants as the audio was in Hausa.
- The session on Verbal autopsy is a method used to determine the likely cause of death when a person dies outside a health facility with no medical record or doctor's certification. They were also taught how to conduct a verbal autopsy.

ACHIEVEMENTS/OUTPUTS OF THE ACTIVITY (*The heart of the activity report is the presentation of the results and the discussion of those results. In discussing the results, you should explain how the results were obtained and also discuss the implications of those results i.e. does the activity resulted to key actions, increased knowledge, new ideas/innovations, decision-making/consensus on specific matters, led to identified solution or approaches to address existing challenges, resulted to changes in attitude or behaviors among beneficiaries, led to uptake of services, led to increased awareness – that is higher level of understanding or consciousness regarding specific issues or topic***).**

- The training provides participants with up to date knowledge of formation of community level committees and their roles and responsibilities.
- Through role plays participants were provided with basic information surrounding Deaths, Documentation & Record Keeping, Maintain accurate burial registers, Share monthly/weekly burial data with community focal persons, Help track silent or unreported deaths, Flagging unusual death patterns while ensuring confidentiality of information was discussed

AWP INDICATORS FOR THIS ACTIVITY/VALUES CONTRIBUTED

- AWP Indicator/Values:
- A role play done to help the understanding of the participants on the process of cMPCDSR illustrating activities from reporting a new maternal/perinatal/child death to the WDC, paying condolence visit, identifying the best respondent, conducting a verbal autopsy and data collection by cemetery attendant on maternal/perinatal/child death. The participants were then encouraged to ensure cMPCDSR is commenced immediately in their

communities

BUDGETED AMOUNT

ACTUAL EXPENDITURE

CHALLENGES/LESSONS LEARNED/GOOD PRACTICES:

CONCLUSION (*the "Conclusion "section discusses the results in the context of the entire activity. Usually, the objectives mentioned above are examined to determine how the activity met (or failed to meet) those objectives***.)**

1. Training should be for a minimum of 6 days to accommodate real time community visit for cMPCDSR.
2. Maintaining of two planning meetings to be conducted before training's: one planning meeting to be held 3 days before training commences and a second to hold on the day of arrival
3. The video of why Mrs X died should be translated into Hausa and other Nigerian languages to aid the understanding of the message in the video by the participants from the grassroot during cMPCDSR trainings.
4. Support supervision should commence immediately.
5. The Pre and Post test determines the level of learning showing least scored 25% and 100% respctively.

ANNEXE(S):

i. Attendance sheet, if applicable (Name, Designation, Office location, Signature, Tel. No.)

ii. Action Pictures, if applicable (Maximum 2 action pictures)

Name and signature of Reporting Officer: _____, _____

Distribution:

i. Name of UNFPA Office: ……

ii. Other recipients, if any, including government offices: ……..

N.B. Please note that the length of this Report must be maximum 4 pages excluding the Annexes.


A 5-Day
TRAINING ON COMMUNITY
MPCDSR IN 3 MAMII LGA'S (HONG, SONG & NUMAN)
IN ADAMAWA STATE
VENUE: NUMAN LGA
unicef
for every child


A 5-Day
TRAINING ON COMMUNITY