**MINISTRY OF HEALTH**

**ACTIVITY REPORT**

**Covid-19 Antigen RDT Training report**

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| **Instructions:** Please complete the form below fully. Certain aspects need to be completed at the beginning of the activity, some aspects during the activity and some aspects after the activity is done. The completed form needs to be submitted promptly to CHAI/CPHL. |

1. **Basic Details of Activity**

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|  | **Details on Activity** | | | | | | | | | |
| **Activity title** | Covid-19 Antigen RDT training | | | | | | | | | |
| **Activity dates** |  | | | | | | | | | |
| **District/Location** |  | | | | | | | | | |
| **Activity venue** |  | | | | | | | | | |
| **Details of Facilitators** | **First name** | | | **Last name** | **Gender**  **M/F** | **Telephone** | | | **Email** | | |
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1. **Number Participants for Activity**

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| **Targeted number of participants** |  |

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|  | **Day 1** | **Day 2** |
| **Number of actual participants** |  |  |

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| **B) Summary of achievements** |
| 1. |
| 2. |
| 3. |
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| **C) Summary of challenges** |
| 1. |
| 2. |
| 3. |
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| **D) Summary of lessons learned** |
| 1. |
| 2. |
| 3. |

1. **Information on Participants (Contact List – Day One)**

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| **No.** | **First name** | **Last Name** | **Sex**  **(M / F)** | **Cadre**  **(Title/position)** | **District** | **Health facility** | **Phone Number** | **Signature** |
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| **No.** | **First name** | **Last Name** | **Sex**  **(M / F)** | **Cadre**  **(Title/position)** | **District** | **Health facility** | **Phone Number** | **Signature** |
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**Pre-Test and Post-Test scores**

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| **Participant Number and Name**  **(number should match what is on Contact List)** | **Pre-Test Score** | **Post-Test Score** | **Percentage Improvement**  **(between pre and post- test)** |
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| **Submitted by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Received by :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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