

**ACUTE FLACCID PARALYSIS (AFP) SURVEILLANCE SYSTEM FORM**

**TO BE FILLED BY COMMUNITY INFORMANTS (CI) AND VOLUNTEER COMMUNTY MOBILIZERS (VCMs)**

1. State (Jiha): Kano ⃝ Kaduna ⃝ Katsina ⃝ Yobe ⃝ Borno ⃝
2. LGA (Karamar Hukuma):………………………………………………………………………………………
3. Settlement (Mazaba):……………………………………………………………...............................
4. Date (Kwanan Wata):……………………………………………………………………………………………
5. Child Biodata (Bayanin Yaro/Yarinya):

|  |  |
| --- | --- |
| Name of childSunan Yaro/Yarinya |  |
| Date of BirthRanar Haihuwa |  |
| Sex/Jinsi | M/N ⃝ F/M ⃝  |
| Address/Adireshi |  |

1. Name of caregiver (Sunan Mai Kula da Yaro/Yarinya)……………………………………………………………………
2. Relationship of caregiver with child (Please, tick as appropriate)

Dangantaka da Yaro/Yarinya (Zabi Daya Daga Ciki)

* Mother/Uwa ⃝ ●Father/Uba ⃝ ●Other relation/Dan Uwa ⃝
1. Child’s complaint (Tick the one which best describes the child’s problem)

Lalurar Yaro/Yarinya /Zabi Daya daga cikin yanayin Lalurar)

* + Inability to walk/Kasa Tafiya ⃝ ● Cannot use both legs/Kasa Yin Amfani da Kafafu ⃝
	+ Inability to run/Kasa yin Gudu ⃝ ● Cannot use one leg/Kasa Yin Amfani da Kafa Daya ⃝
	+ Inability to stand/Kasa Tsayuwa⃝ ● Cannot use both hands/Kasa Yin Amfani Da Hannaye ⃝
	+ Cannot use one hand/Kasa Yin Amfani Da Hannu Daya ⃝
1. What is the duration of the complaints in 6 above:
* 1 week/Mako Daya ⃝ ● 2 weeks/Mako Biyu ⃝
* 3 weeks/Mako Uku ⃝ ●1 month/Wata Daya ⃝
* 2 months/Wata Biyu ⃝
1. Was the Child taken for Check Up? (An kai Yaro/Yarinya wajen kula da Lafiya?)
* Yes/I ⃝ ● No/A’a ⃝
1. Where was the Child taken to? (Ina aka kai Yaro/Yarinya?)
* Clinic/Asibiti ⃝ ● Bone Setter/Wurin masu dori ⃝
* Prayer House/Wurin Malamai ⃝ ●Traditional Healer/Wurin Mai maganin Gargajiya ⃝
1. What was done to the Child? (Me aka yi wa Yaro/Yarinyar?)
* Drugs/Maganin Asibiti ⃝ ● Traditional Medicine/Maganin Gargajiya ⃝

Bone Setting/Gyaran Targade ⃝ ● Prayers/Addu’a ⃝