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World Health
Organization

Field Handbook of Epidemiological Monitoring Events of Acute Flaccid Paralysis Cases for Workers in Communicable Diseases Monitoring and Control



DISCLAIMER

This handbook was prepared for the Primary Health Care Project in Iraq (PHCPI) funded by the United States Agency for International Development (USAID) in collaboration with the Iraqi Ministry of Health and in coordination with the World Health Organization 2014 (WHO)

Preamble

As part of the major campaign to reduce the spread and transmission of acute flaccid paralysis virus within Iraq, the Ministry of Health, in collaboration with the Primary Health Care Project In Iraq, which is funded by the United States Agency of International Development and the World Health Organization, has prepared this field handbook of acute flaccid paralysis.

This handbook is part of an ongoing series of efforts focused on promoting the provision of primary health care services in Iraq.

We thank all those who contributed to the preparation and review of this handbook.

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Preamble

The World Health Assembly launched in 1988 the global polio eradication initiative in order to free the whole world of the polio epidemic. At the onset and with the assistance of the World Health Organization and the UNICEF, the Ministry of Health organized a quick response to the polio outbreak in 1999 whereby it conducted two successful rounds of vaccinations for eligible children through the so-called National Immunization Days during the months of October and November of 1999. Consequently, it was possible to minimize the spread and transmission of the virus in a record time.

Since then, the successful immunization rounds continued through the National Immunization Days from one house to another whereby 95% of children under the age of five were vaccinated as a result of these intensive and joint efforts. One of the indicators of success of the National Immunization Days is the lack of any case of polio caused by wild poliovirus in Iraq since 28 January 2000. This is deemed a remarkable achievement, given the difficult conditions experienced by the country.

At the request of the Ministry of Health, the World Health Organization has followed closely the restoration and furnishing of the polio laboratory and ensured the availability of all the necessary equipment, supplies and reagents. The National Polio Laboratory was awarded the recognition of the regional office as a national laboratory by June 2006.

Moreover, the World Health Organization continues to provide all the support, whether technical or other, to ensure the full implementation of all the polio eradication strategies, including the action plan of acute flaccid paralysis epidemiological monitoring.

In General, the cadres of the Ministry of Health must be commended at various levels for their active role in maintaining Iraq free of polio and achieving the indicators of acute flaccid paralysis case monitoring, which exceeded the targets despite the current difficult circumstances.



Polio Disease

Acute Polio Disease

Polio is a highly infectious disease caused by the polio virus (poliomyelitis virus).

Polio virus

The polio virus is a subset of enteric viruses. There are three serotypes of the polio virus (P1, P2 and P3). Heat, formaldehyde, chlorine and ultraviolet rays deactivate the polio virus quickly.

Three Related Enteric Viruses

Type One: Usually causes outbreaks and is likely to cause paralysis (P1)

Type Two: Easier elimination / eradicated since 1999 (P2)

Type Three: An often lengthy eradication process (P3).

Epidemiology

Reservoir of Infection

Human beings are deemed the only known infection reservoir of the polio virus, as it moves mostly by way of people with latent infections.

Infection Methods

The polio virus is transmitted through means of fecal oral transmission, which is deemed the most important transmission method despite the mouth to mouth (oral) transmission that is considered the means of transmission in some cases, or through the respiratory system in rare cases.

Time Pattern

The polio virus reaches its peak during the summer months in temperate climates. There is no seasonal pattern in tropical climates.

Polio can be classified, depending on the sites of paralysis, into a spinal, bulbar or spinal bulbar disease.

Clinical Features

The incubation period of polio ranges from 7 to 10 days, noting that it can vary between 4 to 35 days.

Indistinct Asymptomatic Infection

Up to 95% of polio infections are non-paralytic (not clinical).

- **Simple Disease (Abortive Polio)**

It constitutes approximately 5% of the polio cases. It is a disease without any clinical or laboratory signs that indicate the injury of the central nervous system and the full recovery is within less than one week. It includes:

- 1- **An upper respiratory tract infection** (throat infection and fever)
- 2- **Gastrointestinal disorders** (nausea, vomiting, abdominal pain, constipation or rarely diarrhea)
- 3- **Flu-like symptoms.**

- **Aseptic Meningitis Unaccompanied by Paralysis**

It occurs after several days of signs similar to the above simple disease which occurs in 1%-2% of polio infections. These symptoms will last from two to 10 days, followed by a full recovery.

- **Paralytic Polio**

Less than 1% of all polio afflictions result in flaccid paralysis. In General, polio symptoms begin from one to ten days after the initial symptoms and last for two or three days. No paralysis generally occurs after the temperature returns to normal.

Symptoms of Disease

Some initial signs and symptoms may include

- Fever, aches and severe muscle spasms in the limbs or the back. The disease progresses to become flaccid paralysis with diminished deep tendon reflexes and asymmetrical. Patients do not experience a sensory loss or changes in perception.
- Paralyzing polio is dangerous to 2% to 10% of cases.

Laboratory Diagnosis

Viral Isolation

- The polio virus can be isolated from stool or the throat.
- A stool specimen is cultured in isolation culture media to determine if one of the three serotypes is of the polio virus.
- If the polio virus is isolated from a person suffering from acute flaccid paralysis, further testing must be conducted to differentiate between wild polio viruses and vaccine viruses (Sabin like) using the ELISA test method or the polymerase chain reaction (PCR) test method.

Polio Disease Eradication Strategies:

1- Vaccination with the oral polio vaccine, which includes



Specimen of oral polio vaccine

a- Observance of the Routine Schedule



b- National Campaigns / National Days NIDS



c- Precautionary Campaigns



2- Epidemiological monitoring of acute flaccid paralysis cases



Epidemiological Monitoring of Acute Flaccid Paralysis Cases

Epidemiological Monitoring of Acute Flaccid Paralysis

Acute Flaccid Paralysis

Any case of children, under the age of 15, who suffer from acute flaccid paralysis or when the doctor suspects the presence of a polio case in other age groups.

Acute Flaccid Paralysis

Acute: sudden onset **Flaccid:** loss of muscle strength

Paralysis: weakness, loss of voluntary movement

Indications of Acute Flaccid Paralysis Presence

- Sudden onset of paralysis
- Weakness
- Inability to stand
- Inability to walk
- Inability to move legs and arms
- Heaviness in limbs
- Inability to sit
- Paralysis of facial muscles
- Paralysis of neck muscles ... etc.

Differential Diagnosis of Acute Flaccid Paralysis Cases

- Polio
- Guillain–Barré Syndrome (GBS)
- Transverse myelitis
- Encephalomyelitis
- Tuberculosis meningitis
- External strain on nerve
- Hypokalemia
- Occurrence of partial paralysis: occurrence of sudden flaccidity for a short period and its healing
- Other

Where Epidemiological Monitoring of Acute Flaccid Paralysis Is Conducted Intensively

High Risk Areas

- Places of holy shrines (Najaf and Karbala), as well as Saladin (Samarra and Balad)
- The villages located on the border between provinces and districts
- The areas that border countries where polio is endemic (Nineveh and Al-Anbar) due to the discovery of polio in Syria recently
- Areas with a weak health infrastructure
- Areas with low monitoring indicators of acute flaccid paralysis cases
- Areas where there are polio cases that are verified and laboratory confirmed within the last two to three years
- Kurdistan Province (Erbil, Sulaymaniyah and Dohuk) due to the presence of Syrian refugee camps

High Risk Community Segments

- Ethnic or religious minorities
- Immigrants (refugee camps)
- Aggregations which are in contact with disease endemic countries
- Segments which refuse immunization
- Internally displaced persons

Mechanism of Commencing Acute Flaccid Paralysis Epidemiological Monitoring

Meeting with directors of hospitals and sectors / rehabilitation centers for the purpose of initiating epidemiological monitoring activities of flaccid paralysis cases, which include:

a- Hospitals

- To obtain the assistance of the Director of the establishment in order to notify all the cadres of the epidemiological monitoring activities of acute flaccid paralysis cases
- To meet with pediatricians, neurologists, internal medicine doctors, physical therapists, intensive care unit staff and other health professionals who may deal with polio cases
- To meet with the main employees involved in medical records
- To allocate a liaison point in hospitals for reporting flaccid paralysis cases
- To designate a medical or health officer responsible for prompt reporting, inquiry and specimen collection and dispatch to the National Polio Laboratory
- To offer and to provide the forms used in prompt reporting and the case investigation forms
- The liaison point in every hospital must begin sending weekly report, even the reports on absence of cases (minor reports) and the instant notifications when monitoring cases

b- Sectors

- To obtain the assistance of the Director of the establishment in order to notify all the cadres of the epidemiological monitoring activities of acute flaccid paralysis cases
- To meet with the Communicable Diseases Officer in the sector
- To designate a medical or health officer responsible for visiting the hospital on a weekly basis in order to measure the effectiveness of the weekly epidemiological monitoring:
 - For the purpose of early detection of unreported cases
 - To meet with the liaison point on a weekly basis in an attempt to overcome difficulties, if any
 - To increase hospital staff knowledge of the activities of epidemiological case monitoring
 - To follow-up specimen taking and their dispatch method
 - To ensure the absence of unreported cases

The person, investigating any acute flaccid paralysis case, must submit the following:

- An inquiry form and a laboratory application form, Form No. (2, 3) respectively.
- The vaccine box
- Ice blocks
- A waterproof marking pen
- Identifying stickers for vessels
- An anti-leak container with lid
- Plastic boxes
- A temperature control device, if any

The person, investigating any acute flaccid paralysis case, must perform the following functions:

- To complete a prompt notification report on the case and to refer to the acute flaccid paralysis monitoring liaison point at the Health Department or to notify him by telephone or through the internet.
- To complete a case inquiry form, Form (2), in agreement with the Epidemiological Monitoring Unit Officer at the County Health Department.
- To examine the case with the available doctor.
- To note down the detailed address of the patient for tracking purposes by the sixty-day teams.
- To offer advice to parents on the need to follow-up the case.
- To start collecting stool specimens and to arrange for their transport to the Polio National Laboratory.
- To facilitate the access to rehabilitation services. The persons conducting the case investigation shall caution the parents about the benefits of early rehabilitation for their child.

Stool Specimen Collection

If more than two months do not lapse since the onset of paralysis, collect two stool specimens from the patient at 24 to 48 hour intervals between the two collections processes.

When to collect specimens of an acute flaccid paralysis case?

Stool specimens must be collected within 14 days from the onset of paralysis in order to get the best opportunity for virus isolation. Try to take the first specimen at the same time when the case inquiry is conducted. If the patient is unable to provide a specimen, leave a pot and a box with ice blocks for the mother or the child's caregiver in order to subsequently obtain the specimen from the patient. The second specimen must be obtained 24 to 48 hours after getting the first specimen.

Stool specimen collection

Use a tightly sealed screw tube with a lid. Remove the tube from the cooled box and close the lid of the box.

If possible, try to collect new stool in a baby diaper or try to make the child defecate on the paper.

Collect a stool quantity, the size of two phalanxes of the thumb of an adult amounting to (8-10 grams).

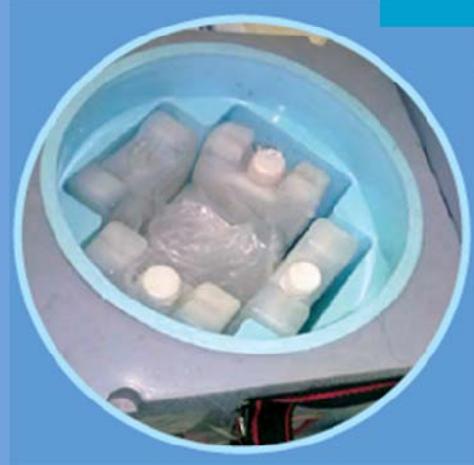
Use a paper or a spatula (designated for a specimen collection tube) for placing the specimen in a clean tightly covered anti-leak screw tube.



An identification label with the patient name, date and time of specimen collection must be placed on the side of the tube, not on the lid. Use a waterproof pen to mark the specimen tube.

Send the specimen to the National Polio Laboratory (within 72 hours from the first specimen collection date).

After obtaining the specimen, it must be placed immediately in the refrigerator for preserving and transporting it or in a cooled box amidst ice blocks at a temperature of (4 to 8 degrees Celsius). The specimens must arrive at the laboratory within 72 hours from the collection date. If this proves to be difficult, the specimens must be kept frozen (at -20 degrees Celsius) and then transported while frozen. It is preferable to keep them frozen with dry ice or ice blocks at (-20 degrees Celsius) and then to complete the laboratory application (Form 3) for every case.



Do not mix the cooled boxes

Avoid storing specimens in refrigerators or cooled boxes used to store vaccines or other medications. If this is not available, ensure placing the specimens in three layers of plastic bags and separating them from vaccines or other drugs. This also applies to transporting specimens, whereby a cooled box or a special carrier must be used and marked in order to know that it is used for that purpose. Boxes designated for vaccines should not be used for transporting stool specimens. If contamination is discovered, the refrigerators, cooled boxes, vaccine carriers and ice blocks can be disinfected by using one part of bleach (powder) to 10 parts of water.

Dispatching specimens

When you complete the procedure of specimen transportation, wrap the specimen vessel with a moisture absorbent material, seal it tightly in a plastic bag and place it in the cooled box with ice blocks while placing a temperature monitor device, if any, among the specimens. Then place the laboratory forms in an envelope and the envelope in another plastic bag.

Send the specimens to the laboratory through the quickest transportation method available.

The specimens must arrive at the laboratory within 72 hours from their collection date or they must be frozen at a temperature of 20 below zero degrees Celsius and then transported while frozen (in order to arrive within 72 hours from the collection date).

The Search for other cases

- Ask the parents if they know of other acute flaccid paralysis cases, this while you conduct the vaccination events. You can also make use of the home visits during the oral inoculation campaign in order to educate parents and advisers about the importance of immunization and the polio eradication initiative.
- If more than two months from the onset of paralysis lapse, specimens must be taken from contacts and then transported to the National Polio Laboratory.

Provision of feedback

The provision of weekly, monthly and quarterly feedback on information about monitoring, by medical and health staff and other involved persons, is deemed necessary for effective monitoring.

Contact with Acute Flaccid Paralysis Cases

Definition of contact: children, under fifteen years of age, who are in direct contact with the acute flaccid paralysis patient.

The investigation of contacts with an acute flaccid paralysis patient for the wild polio virus helps to increase the accuracy of epidemiological monitoring of acute flaccid paralysis and provides a greater opportunity for the National Polio Laboratory to isolate the polio virus.

Enquiry procedures of acute flaccid paralysis case contacts are initiated upon:

- The death of a patient who suffers from acute flaccid paralysis prior to collecting two stool specimens within the first fourteen days from the onset of paralysis and their arrival at the laboratory in good condition.
- The patient's discharge from the hospital or his death prior to collecting two stool specimens within the first fourteen days from the onset of paralysis and their arrival at the laboratory in good condition.
- A critical (hot) illness condition is an acute flaccid paralysis case characterized by the following:
 - 1- Age less than 5 years (the younger segments)
 - 2- Presence of fever at the onset of paralysis
 - 3- The paralysis case is asymmetrical
 - 4- Non-immune or insufficiently immune to the oral polio vaccine.
 - 5- A rapid progression of the case
 - 6- Upon the initial diagnosis (polio or suspected polio) by the treating doctor

Contact investigation mechanism

(3-5) contacts are investigated. One stool specimen is taken from every person and is sent to the National Polio Laboratory in the same manner followed in acute flaccid paralysis cases. Stool specimens must be collected prior to conducting the immunization. The following points must be taken into account when selecting the contacts:

Age: Everyone must be under the age of fifteen (especially for those under the age of five), and it is preferable to choose the younger ones.

Site: The location must be the same where the acute flaccid paralysis patient is. If the required number of contacts is not available at the patient's home, children must be found at neighboring houses; otherwise, the same zuka must be searched. If this proves to be difficult, contacts must be searched for in the same village or town.

Immunization status: It is preferable to collect stool specimens from unimmunized persons or contacts who have the least received polio vaccine doses.

The information to be provided for each of the contacts is the name of the acute flaccid paralysis patient whose contacts are being investigated, also the following data for every contact: (name, age, degree of contact kinship in relation to the patient, the number of administered polio vaccine doses, the date of the last administered polio vaccine dose and Form No. (6)).

Follow-up Examination after 60 days (Sixty-day Examination)

After approximately 60 days from the onset of paralysis, all acute flaccid paralysis cases must be reexamined in anticipation of any residual paralysis. The presence of remnants of paralysis after this time does not mean that the polio virus is the cause for paralysis, but rather that the current classification of the cases is the viral classification which is laboratory confirmed, and not the clinical classification.

In order to conduct a follow-up examination, the investigator must:

- Ascertain from the parents that the information contained in the inquiry form is correct.
- Ask the parents whether any change has occurred to the paralysis condition.
- Monitor how the child moves his limbs or body parts affected by paralysis (look for body parts afflicted with muscular dystrophy and watch the child's gait, if possible).
- Verify that the paralysis is of the flaccid type.
- Make sure that the sensation is normal.
- The clinical examination date, in addition to the final diagnosis, must be added in the form.

Effective Weekly Epidemiological Monitoring Event Murals for Monitoring Diseases Covered by the Expanded Immunization Program:

- The percentage of sites informed of the weekly notice. Completeness
- The percentage of sites notified at the specified time every week. Timelines
- Weekly communication data analysis (weekly statistics of effective monitoring events) and follow-up.
- Verifying the credibility of the effective monitoring weekly statistics.
- Follow-up of establishments failing to give the weekly form of effective weekly monitoring, especially if the percentage is less than 80% and it has recurred for consecutive weeks.
- Making a list of site monitoring (the names of the establishments covered by the effective weekly epidemiological monitoring).
- Adding the training health centers to the site monitoring list.
- Updating the epidemiological map every month depending on the number of detected cases.

The imperative presence of murals in the sector and district health departments

Functions and Duties of the Liaison Officer in Sector and Hospital

- To continuously educate doctors about the importance of reporting acute flaccid paralysis cases.
- To promptly report any detected case.
- To maintain patient records.
- To continue taking stool specimens under sanitary conditions.
- To check with the statistics departments, including hospital records, in search of any probable unreported cases.

Functions and Duties of the Monitoring Officer in the District

- To follow-up central instructions.
- To issue the district's monthly bulletin indicating the district activity, the preparation of detected cases with their epidemiological analysis and their communication to all the health establishments affiliated to its geographic location, in addition to sending a copy of every activity to the Immunization Division at Ministry headquarters.
- Ongoing field follow-up with the liaison points at hospitals and sectors.
- To send the periodic reports to the central level within the specified deadline.
- To conduct epidemiological inquiries, including effective screening and case investigation.
- To continue taking specimens under the required conditions.
- To ensure conducting the sixty-day examination for all cases within the specified deadline.
- To monitor the performance indicators and to take the necessary actions for their upgrade.
- To develop a training curriculum for staff at health establishments and sectors.
- To set up an awareness program about the importance of the program for pediatricians, in particular, and to follow-up its implementation in order to ensure the continuous reporting of cases.
- Feedback with hospitals and sectors.
- To sustain records and certification documents.
- To prepare a monthly report on the progress of work and to submit it to the Immunization Program Director and the Director General, specifying therein the problems and the support required for their resolution.



Annex

The Republic of Iraq

The Ministry of Health
Public Health Department

Center for Monitoring Communicable Diseases / Epidemiological Monitoring Division

Form for Prompt Notification of a Communicable Disease (Form No. 1 includes the diseases of the first group)

Health Department of District	
Primary Health Care Sector	
Name of health establishment	
Patient name (three parts)	
Patient nationality	
Age	
Gender	
Profession	
Diagnosis	
Date of case diagnosis	
Date of case notification	
Full address of patient:	
District	
Sector	
Quarter	
Mahalla or village	
Inoculation status and number of doses for diagnosed disease	
Date of last vaccine dose	
Name of treating doctor	
Outcome of patient condition	
Name and signature of Monitoring Unit Manager at the District	

Covered Diseases:

1- Suspected cholera condition 2- suspected hemorrhagic fever condition 3- malaria 4- diphtheria 5- suspected meningial meningitis condition 6- congenital tetanus 7- suspected measles or German measles (rash and maculopapular rash) 8- acute flaccid paralysis 9- whooping cough 10- rabies 11- suspected epidemic flu (H1N1) 12- suspected bird flu (H5N1) 13- anthrax (both cutaneous and pulmonary types) 14- food poisoning and according to its standard definition (the affliction of two or more persons complaining of the same symptoms with the same food intake) 15- upon the occurrence of any communicable disease outbreaks (the occurrence of a number of unexpected cases in a certain place at a certain time) 17- unusual health accidents or unusual deaths (i.e. any ambiguous diagnosis case where the cause is suspected to be communicable) Unusual Health Event 18- suspected Corona virus flu.

Patient nationality signifies: Iraqi or from another nationality mentioned in the designated field.

Patient outcome signifies: deceased at the health establishment, transferred to another hospital, hospitalized or administered the necessary treatment.

Note:

This form shall be sent by the health establishment or its content shall be communicated to the higher health level within a maximum of 24 hours from diagnosis through any available means of communication.

The Epidemiological Monitoring Unit in the district shall enter the prompt notification form information in the EPI INFO program template and send the template through the internet to the Epidemiological Monitoring Division at the Center for Communicable Diseases Control.

The information shall be precise, complete and verified by the Epidemiological Monitoring Unit in the district prior to dispatch. The health establishment, the primary health care sector and the Health Department must apply the preventive procedures to every disease according to its nature, even in suspected cases. These procedures shall be emphasized upon confirmation of the case in the laboratory or epidemiologically.

Form (2): Case Investigation Form for Acute Flaccid Paralysis Patient

Health Department _____ **Primary Health Care Sector** _____

EPID#		Date of investigation	Day	Month	Year
Patient's Name		Mother's name			
Address	Province	District	Mahalla		
	Zukak	House #	Tel. No.		
	Mokhtar's name		Food ration distributor's name		
Date of birth	Day	Month	Year	If birth date unknown, age in months	
				Sex	Male Female
Date the case was first reported to a government/private health office			Day	Month	Year
Name of notification site			Name and specialty of treating/reporting doctor		
Provisional Diagnosis					
Date of onset of paralysis			Day	Month	Year
If the patient died /date of death					
How many days from time of paralysis onset to full installation of paralysis					
Is paralysis acute)?			Yes	No	Unk
Is paralysis flaccid? (i.e. floppy)?			Yes	No	Unk
If paralysis is not acute and flaccid, stop investigation. Specify diagnosis, if known					
Was there fever at onset of paralysis?			Yes		Unk
Is the paralysis asymmetrical?				No	Unk

Site of paralysis	Lft. Leg	Yes	No	Unk	Breathing muscles	Yes	No	Unk	
	Rt. Leg	Yes	No	Unk	Neck muscles	Yes	No	Unk	
	Lft. Arm	Yes	No	Unk	Facial muscle	Yes	No	Unk	
	Rt. Arm	Yes	No	Unk	Other specify				
Where was paralysis in arms					Proximal	Distal	Both	Neither	Unk
Where was paralysis in legs?					Proximal	Distal	Both	Neither	Unk
Was there any sensory nerve function loss?							Yes	No	Unk
History of travel (more than 10 KM 30 days) before onset							Yes	No	
If yes Specify the place		governorate			Address				
Date of visit	dd/mm/yy	/	/	/200					
Number of routine OPV doses received (exclude zero dose)					Doses		Unk		
Number of OPV doses received during campaigns?					doses		Unk		
Date of last OPV dose					Day	Month	Year	Unk	
History of intramuscular injection before date of onset							Yes	No	unk
Site of intramuscular injection			Rt. Gluteil Region		Lt. Glutail Region		Both		
Date of intramuscular injection					Day	Month	Year	Ink	
Date of 1 st stool specimen collection					Day	Month	Year	Ink	
Date of 2 nd stool specimen collection					Day	Month	Year	Ink	

Prior to arrival at the concerned establishment, the patient was examined by:

	Name of Doctor	Name of Health Unit and District	Date of First Visit / Admission	Is the Health Unit among Sites That Are		If Notified, Notification Date from Site	Monitoring System That Detected the Case			Required Procedures in Case of Non-notification or Delay
				Inactive	Active		Prompt Notification	Inactive / Routine Monitoring	Active Monitoring	
1										
2										
3										

NEUROLOGICAL CLINICAL EXAMINATION

Sign or Symptom			
Diarrhea		Yes	No
Nausea		Yes	No
Vomiting		Yes	No
Coryza (cold, runny nose)		Yes	No
Tonsillitis		Yes	No
Constipation		Yes	No
Sphincter control		Yes	No
Neck stiffness		Yes	No
Ankle clonus		Yes	No
Babiniski sign		Yes	No
Kernig's sign		Yes	No
Brudzinski sign		Yes	No
Muscle tone/grade		Rt.....	Lt.
Reflexes	brisk	Rt.....	Lt.
	exaggerated	Rt.....	Lt.
	normal	Rt.....	Lt.
Cranial nerves examination			

CSF RESULTS:

Name of investigator

Date / /

signature

Form (3): Laboratory Application Form
Health Department Primary Health Care
Sector In

Paragraph (a)

This form must accompany specimens to the central public health laboratory in Baghdad					
EPID Number					
Patient's name		Sex	Male	Female	
Address					
District		Province			
			Day	Month	Year
Date of birth					
Date of onset of paralysis					
Date of first stool specimen collection					
Date of second stool specimen collection*					
Date stool specimens sent					
Date of last OPV dose					
Provisional diagnosis of the AFP case					
Send results to					

* If specimens sent on separate days, complete separate form for each specimen.

Section (B) should be completed by a virologist at the laboratory.

	Day	Month	Year
Date specimens received at laboratory			
Condition* of 1st specimen upon receipt at lab	Good	Poor	Unknown
Condition* of 2nd specimen upon receipt at lab	Good	Poor	Unknown
Name of person receiving specimens at laboratory			
Signature			

* Criteria for good condition = adequate volume, no leakage, no desiccation, reverse cold chain was maintained, and adequate documentation.

Form (4): Conducting a Follow-up Examination of an Acute Flaccid Paralysis Patient after 60 Days

Health Department Primary Health Care Sector in

EPID#		Recommended date of follow-up	Day	Month	Year
Patient's name					
Was 60-day follow-up examination conducted?				Yes	No
If no, why?	Patient died				
	Patient was lost to follow-up				
	Other specify				
Date of examination			Day	Month	Year
Results of examination			Residual paralysis		
			No residual paralysis		
			Unk		

Name of investigator	Specialty	Signature
Name of investigator	Specialty	Signature
Name of investigator	Specialty	Signature

Form (5): Final Classification of Case (by an Expert Committee)

EPID #		Date of final examination	Day	Month	Year
Patient's name		Province	District		
Final classification of case (check only one)			Confirmed		
			Discarded		
			Compatible		
Based on what criteria? (check all that apply)		Wild poliovirus			
		No wild poliovirus from adequate stool			
		Inadequate stool specimen			
		No stool specimen			
		Residual weakness after 60 days			
		No residual weakness after 60 days			
		Died after polio-compatible illness			
		Lost to follow-up and compatible illness			
If classified as "discarded" specify final diagnosis					
Name of expert committee chairperson					
Signature					

Stool Specimen Collection from Children in Contact with Patients Afflicted with Acute Flaccid Paralysis

Name of child afflicted with acute flaccid paralysis:

Date of onset of paralysis:-

Reason for stool specimen collection from contacts

- Death of patient prior to collecting two stool specimens in good condition from him within 14 days from the date of the of paralysis.
- Loss of patient prior to collecting two stool specimens in good condition from him within 14 days from the date of the onset of paralysis.
- The first clinical diagnosis of the patient by the treating doctor is probable polio.
- Hot case.

Children in contact whose stool specimens were collected

S	Name	Age in onths	Number of OPV Doses	Date of Last Dose	Date of Form Collection

Epidemiological Monitoring Officer for acute flaccid paralysis cases at the Health Department

Name:

Signature:-

Date:

(Form 6) Contact Investigation Form

Primary Health Center in

District Province

EPID number of index case			
Name of the index case			
DETAILS OF CONTACT			
Name		Date of Birth	
Age in months		Sex	Male Female
Country :	District :	Province :	
Area – Village of Town:		Contact 's Address :	
Contact s number :			
CONTACT AND INDEX CASE			
Contact's relation to index case			
Contact's period of exposure to index case:			
Exposure within √ days prior to onset of paralysis			
Exposure within √ weeks after onset of paralysis			
IMMUNIZATION STATUS OF CONTACT			
OPV doses received –Routine EPI			
OPV doses received –NIDs/SIAs			
Date of last dose of OPV			
SPECIMEN COLLECTION FROM CONTACT :			
Stool specimen number			
Date of stool collection			
Date stool sent to lab.			
LABORATORY COLLECTION OF CONTACT SPECIMEN			
Date stool received at lab.		Stool Condition	
L20B isolate			
P1 result		P3 result	
P2 result		Enteroto result	
Date culture result sent to EPI			
Date ITD result sent to EPI			
COMMENT			
Contact Comment			

Name & signature of investigator:

Date:

Position of investigator:

Form (12): Weekly Active Visit Form

Weekly Form for Effective Epidemiological Monitoring of Expanded Immunization Program Diseases

District Health Department Primary Health Care Sector in

Week ()

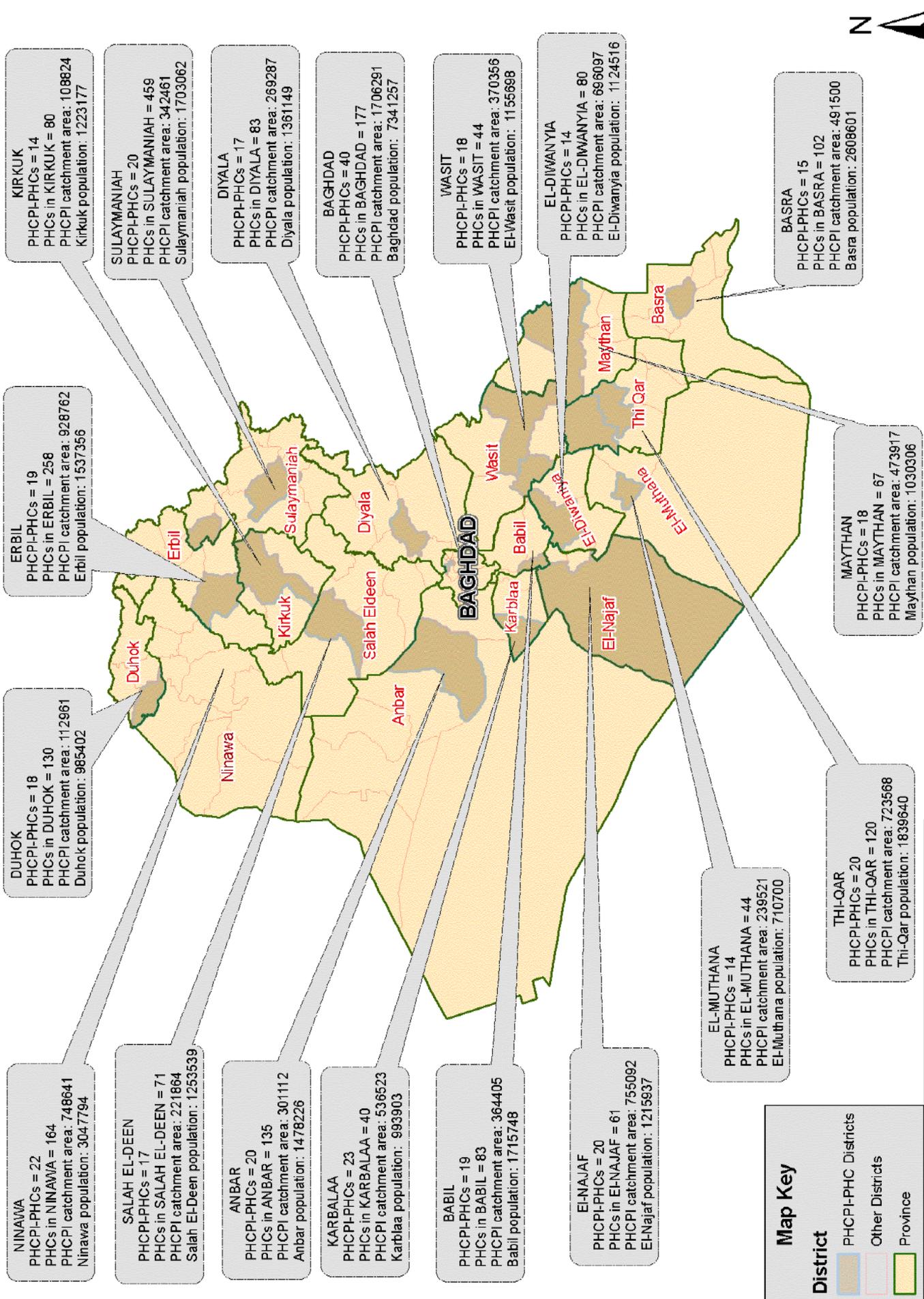
Month ()

Year ()

Name of investigator and signature	
Name of facility visited	
Date of visit	
Type of facility (hospital , rehabilitation center)	
Director of fever hospital queried (signature)	
Hospital inpatient records searched (yes/no)	
Hospital outpatient records searched (yes/no)	
Chief of pediatric queried(signature)	
Pediatric inpatient records searched(yes/no)	
Pediatric outpatient records searched(yes/no)	
Medical Records Department (signature)	
inpatient records searched(yes/no)	
outpatient records searched(yes/no)	
Head of physical therapy queried (signature)	
Physical therapy records searched(yes/no)	
Intensive respiratory care unite (signature)	
Inpatient records searched (yes/no)	
Chief of neurology queried(signature)	
neurology inpatient records searched(yes/no)	
neurology outpatient records searched(yes/no)	
Total number of AFP cases found since last visit*	
Total number of these AFP cases unreported *	
Total number of (neonatal tetanus) cases found since last active visit	
Total number of these (neonatal tetanus) cases unreported	
Total number of (measles) cases found since last active visit	
Total number of these (measles) cases unreported	
Total number of (diphtheria) cases found since last active visit	
Total number of these (diphtheria) cases unreported	
Total number of (whooping cough) cases found since last active visit	
Total number of these (whooping cough) cases unreported	



PHCPI-PHCs population mapped to IRAQ population



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