

**Interim Guidance and Resources**

**For Fixed Oral Rehydration Points (ORPs)**

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The GTFCC acknowledges the participation of the case management working group members who contributed to the development of this Fixed-ORP package, in particular the International Federation of the Red Cross and Red Crescent Societies (IFRC) who shared their Oral Rehydration Point guidance which inspired this package.

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# Summary

In cholera, providing rapid access to oral rehydration solution (ORS) saves lives. It is therefore critical to ensure initial access to ORS in the community as part of outbreak response.

How ORS is made available to the population will vary from one site to another, depending on existing public health structures and resources available. Options include distribution of ORS via existing community health workers or community volunteers and fixed or mobile oral rehydration points.

This document provides recommendations on how to set up fixed site ORPs as part of a multisectoral response to an outbreak.

**Objective:** ORPs provide first-line, community-level rehydration, as a highly decentralized element of case management services. For many patients, this is the first point of contact in a network of cholera treatment facilities during an outbreak:

* ORPs provide ambulatory oral treatment for patients with suspected cholera and refer all patients with some or severe dehydration, as well as all patients from select at-risk groups (regardless of hydration status), to cholera treatment facilities. One example of an at-risk group is pregnant women.
* Cholera Treatment Units (CTUs) and Cholera Treatment Centres (CTCs) provide standard oral and IV rehydration in an inpatient facility.

**Site selection:** Try to set up ORPs around a designated CTC/CTU (or other hospital facility) to which they refer patients for facility-based care. Epidemiological data and community consultation should drive initial site selection. The set-up of ORPs should not be delayed if there is no CTC/CTU. Patients can be referred to other health centres.

Working closely with risk communication and community engagement (RCCE), water, sanitation and hygiene (WASH) and infection, prevention and control (IPC) colleagues, community leaders and community representatives ensures that ORPs are set up on sites that are acceptable, accessible and do not pose a risk of community transmission. Issues such as distance to walk, access to clean water and a latrine or toilet for patients and staff must also be taken into consideration.

Agility is required: optimal ORP location will change over time as an outbreak evolves. Ongoing assessment of epi-data and ORP-CTC/CTU patient flows is necessary to identify changing needs. Set up ORPs in a way that it is possible move or expand the ORP network as required.

**Structure:** No specific structure is necessary for the delivery of ORS. ORPs can be fixed or mobile, using existing community structures, temporary structures (including tents) or integrated as part of a healthcare structure. If integrated into other structures, it may also be possible to insert a first IV line and initiate IV rehydration for patients with severe dehydration on site (stabilization).

**Hours of Operation:** ORPs usually provide care during all daylight hours, 7 days per week. There is no provision for overnight care for patients. At closing time, strict advice needs to be given to patients and caregivers about when/where to seek care.

**Hygiene:** ORPs should consistently implement infection prevention and control (IPC) measures. These include standard precautions during the care of all patients to prevent the transmission of healthcare associated infections. Other measures include a focus on water quality monitoring, and sanitation services available on site.

**Staffing:** Engage community health workers or community volunteers whenever possible. Specific training should cover preparation and distribution of ORS in the community, assessment and treatment of patients with no dehydration, recognition of patients with some or severe dehydration to be referred, referral pathways and prevention of cholera in the community.

**Messages on preventing cholera:** Any programme delivering community ORS via ORPs is also a good mechanism for delivering community health and hygiene education messages. Risk Communication and Community Engagement (RCCE) is therefore an ORP core activity and is extremely important to ensure key messages are passed to and implemented by the community. This is a key element of outbreak control.

This document is designed to support authorities, public health professionals and partners in affected countries to adopt a common guidance to set up an effective ORP network as quickly as possible. The document provides background practical recommendations and links to reference documents. Due to resources, regulations or local practice, adaptation may be necessary in each context.

# **Introduction**

In cholera, providing rapid access to oral rehydration solution (ORS) saves lives. It is therefore critical to ensure initial access to ORS in the community as part of outbreak response.

How ORS is made available to the population will vary from one site to another, depending on existing public health structures and resources available.

If community health worker or health volunteer programmes exist and are active in an area with a cholera outbreak or an area at risk for cholera, having them distribute and explain how to prepare and how to take ORS may be the most effective way to get ORS into a community. These workers are likely already known and trusted in the community and training, supervision and supply chain systems will already be in place.

If such systems are not in place, or if they are overwhelmed, it may be useful to establish specific mechanisms to deliver oral rehydration solution – this could be via mobile sites, in existing structures or in specially set up sites the community. All of these can be referred to as Oral Rehydration Points (ORPs).

Whatever the system put in place, the people distributing ORS will need to know how to apply the case definition for cholera, to evaluate dehydration and know which patients to refer to a higher level of care and where this care is available.

Whatever the system put in place to ensure early access to ORS in the community, it should be put in place as early as possible in an outbreak response (in parallel with higher level treatment structures such as cholera treatment centres (CTC) and cholera treatment units (CTUs).

The objective is for patients to have rapid access to oral rehydration solution. There are many ways to do this.

This document provides recommendations on how to set up fixed site ORPs as part of a multisectoral response to an outbreak.

# **ORP Objectives**

The overall objective of ORPs is to reduce morbidity and mortality due to cholera by providing rapid access to oral rehydration solution in the community.

ORP staff or volunteers are expected to:

1. Distribute essential ORS
2. , If available, distribute other commodities such as household water treatment supplies
3. Provide patients and their families with information on how to prevent cholera, and inform them of any cholera related events such as information sessions or vaccination campaigns
4. Assess dehydration, initiate early treatment with ORS, and refer patients to facility treatment as needed following local recommendations
5. Share data on the number of suspected cholera patients seen and referred to another treatment site as part of a community-based disease surveillance system. This helps to ensure all cases are recorded and reported

# **Key Planning Considerations**

## Site Selection

### Site

Cholera outbreaks frequently occur in populations with poor access to healthcare for geographic, economic, or social reasons. Organise ORP networks to improve equity of access and maximize rapid access to ORS treatment.

Position ORPs where healthcare is most limited, especially in those areas without easy access to a health centre or cholera treatment facility. Cholera can evolve quickly and rapid access to ORS can save lives. Any reported community death can be an indicator of insufficient access to treatment.

ORPs can also play an important role to reduce strain on cholera treatment facilities. Ensuring access to ORS in the community can reduce both the severity of patients (because they received ORS from an ORP) and reduce the number of patients going to a CTU / CTC because mild cases received treatment at an ORP.

Key considerations include:

* access to a nearby water source which can provide a minimum of 10L/patient/day
* a latrine or an area where a latrine could be constructed
* walking distances and population density. A rule of thumb has been that people are able to access ORS within one hour by foot. In remote settings this might mean one ORP site per village or community. In more dense populations such as in urban or semi-rural settings, one hour walking distance might mean too few ORPs are established.

Work with RCCE colleagues to identify a site for an ORP that will be accessible and acceptable for the population. Multiple ORPs may be necessary to meet community needs (e.g., near the market, near a large work site, near the health care centre). Community practices should also be taken into consideration. A CTC may be physically close, but community norms may mean that at risk population will not access the ORP.

### Surveillance data

Epidemiological data helps identify areas where an ORP may be necessary. The need for an ORP might be suggested by:

1. a high number of patients from one area dying soon after arrival at the cholera treatment facility
2. a high proportion of patients arriving from one area with severe dehydration
3. rumours of community deaths
4. an excess of patients from one area presenting to a treatment facility with no dehydration

Each of these situations might indicate inadequate local access to early treatment and health information. A multisectoral investigation to the area is necessary to identify reasons for late presentation for treatment and to discuss with the community the potential need to set up an ORP. Community engagement specialists should be part of the investigation team.

ORPs should be moved or newly established to provide better coverage. Do not forget that in addition to physical barriers, community behaviour will contribute to healthcare access. Additional support in the form of strengthening community engagement and education is often needed.

### Security

Insecurity, whether real or perceived, is a barrier to care and negatively impacts health seeking behaviour. Staff and patients may all be affected.

. It is recommended that teams work with RCCE colleagues.

### Structure

Choose the premises in consultation with community members. Consider repurposing existing facilities such as a dispensary (outpatient clinic), a local shop, religious facilities, or other community spaces. This may have an advantage in having pre-existing water and toilet facilities. Alternatively, use a tent on available land that is acceptable and accessible by the community.

Use a sign in the local language or using symbols to clearly indicate that the place is an ORP. If outdoors, ensure shelter from the rain/sun.

If the ORP is close to existing healthcare services (a dispensary, health centre etc.) ensure that cholera patients do not mix with those seeking healthcare for other reasons. Isolate the ORP with physical barriers such as reed fencing or barrier netting. If skilled staff and supplies are available, an ORP at another health care centre can be used as a ‘stabilization centre’ – IV rehydration can be initiated for patients with severe dehydration before referral to a CTC / CTU.

## Screening

If ORPs and other healthcare facilities are co-located, direct patients with diarrhoea to ORPs and cholera specific treatment facilities.

Why screen?

* To start oral rehydration of patients with suspected cholera as quickly as possible (they don’t wait in a general waiting room)
* To prevent patients with suspected cholera mixing with other patients and potentially infecting them with cholera.

Where/when is screening put in place?

* Screening is placed at the entrance to the healthcare compound
* Before entering the healthcare structure

Who should be screened?

* Everyone must be screened every time they wish to enter the healthcare compound/ structure. This includes:
  1. All patients (including babies and children)
  2. All visitors (including the accompanying family and friends of patients)

How?

* Ask the simple question: “do you have diarrhoea?”
* If yes to the question, direct the individual to the ORP. If no, direct the individual towards the health facility.
* Train non-medical staff such as guards or crowd controllers to ask the if individuals have diarrhoea and to direct them to the correct part of the health facility

An alternative, less resource dependent method, is to use a combination of signage and fencing. In this instance, we rely on people coming through the gates to self-screen.

## Staff

### Staff type and number

Care at ORPs can be delivered without highly trained medical or specialist nursing staff.

Depending on the country health system and availability of trained health workers, ORPs can be staffed by Community Health Workers (CHWs, or equivalent community-facing primary health care workers). In some contexts, nurses or auxiliary nurses may staff ORPs.

*Note: if staff at an ORP have the skills to insert IV lines, consider providing the materials to do this. Starting a first IV line before transferring a severely dehydrated patient to a CTU/CTC may save a life.*

To increase acceptance, it is recommended to use teams with majority volunteers who are trusted from the community.

Key considerations:

* Identify tasks
  + case management
  + health messaging
  + water and chlorine preparation
  + cleaning and waste management
* Decide responsibilities based on the team composition.
  + For example, you may wish to have all the volunteers capable of performing all the roles. This team could be supervised by a CHW.
  + If the ORP is within or adjacent to a health facility, another possibility might be to divide roles, for example: nursing assistants to perform health messaging and case management; cleaners for water, chlorine, cleaning, and waste management; and a nurse in the supervisor role. Such an ORP might have the skills and resources to even commence IV treatment in Plan C cases.
* Assign a supervisor to each ORP and be clear on their additional supervisory duties. These included assuring quality of care and education at the ORP, ensuring resupply, making the staff rota, and data reporting. If using CHWs as supervisors, they should aim to supervise all ORPs in their catchment area at least weekly.
* Sufficient staffing levels: have enough people in the team to work the ORP during daylight hours, 7 days/week. This is normally at least 4 people per site, but more may be needed if staff cannot be on site full time or if there are more patients.
* It is good practice to train additional people to help when there are more patients than one team can manage or if there are absences.
* Be clear whether you will be repurposing existing healthcare staff or recruiting new
* Be aware of culture and customs. Will you need single sex staffing?
* Be sure that volunteers have strong links with, and are trusted by, the local community. Willingness and a commitment to the community are the only essential requirements (at least a few hours every day over the course of the outbreak).
* A note on volunteer vs paid or remunerated individuals and staff: this is context specific and resource dependent. Countries will need to modify their approach accordingly.
* It is important that all partners supporting ORPs agree and follow the same rules for payment or non-payment of staff.
* It is not unusual that people working full time at an ORP request to be compensated for their time.
* Literacy is a benefit but not essential since reporting can be with simple tally sheets and picture-based tools

### Training

Give all staff and volunteers who will be seeing patients within ORPs cholera-specific [training](#_Staff_Training) which includes as a minimum:

* Introduction to ORPs
* Assessing dehydration, treatment, and referral
* IPC Standard Precautions (with attention to hand hygiene, waste management, cleaning, and disinfection)
* Preparing Safe Water
* Preparing ORS
* Safe Water Storage
* Safe Sanitation
* Food Safety (for prevention messaging, not because food is served in ORPs)

Individuals delivering patient education and community behaviour-change messaging will also need training or orientation on the [key cholera messages](#_Key_Messaging) and materials to be used.

The entire training package can be delivered in one to two days.

## Referral Systems

### Referral to cholera treatment facilities

Refer all patients who fit the cholera case definition and who have “some dehydration” or “severe dehydration” for facility-based care. Initiate ORS treatment at the ORP before the patient leaves the ORP.

Consider referral for facility-based assessment and treatment at-risk patients regardless of their hydration status. Protocols for this should be agreed at the national or subnational level. At-risk patient groups may include:

* pregnant women,
* children with severe acute malnutrition (SAM),
* in some contexts, all children under 5 years of age
* frail and/or elderly people
* people without caregivers
* if possible, people with heart failure, kidney failure, or diabetes, HIV or other immunocompromised status
* people with physical or cognitive impairment of any kind which might impact self-care or compliance with treatment
* anyone returning to the ORP on a second day with continuing symptoms.

### Referrals to other treatment services

Direct people with persistent diarrhoea lasting more than 2 weeks, or bloody diarrhoea with/without mucous to a health centre for treatment of non-cholera causes of diarrhoea. They should not be sent to a CTC/CTU.

### Referral pathway

Designate one cholera treatment facility as the referral destination for each ORP.

Wherever possible, provide transport to transfer patients between ORPs and treatment facilities to reduce time to access treatment. Consider either a system of ambulances (vehicle, motorbike, bicycle, or animal) or providing transport subsidies. Educate transport drivers about cholera prevention. Clean and disinfect any vehicle providing patient transport at the referral treatment facility.

Consider different transport needs:

* People able to self-refer during the day and use own or public transport
* Unconscious patients or patients who cannot sit/stand alone will need urgent transport at any time of day and usually need ambulance services

Consider transport distances and time. In locations where times to referral CTU/CTC are long, severe dehydration cases not tolerating ORS may benefit from the administration of intravenous fluid before and during transfer. If you have staff able to site an intravenous cannula and your resources allow it, provide the supplies needed. This may not always be possible, and it is not an expected competency of those working at ORPs. Thinking through the possible options before they occur will help clarify the best course of action in these emergencies.

Instruct all patients to continue drinking ORS during transport and provide it in a sealed clean container or bottle.

Complete a referral form for the patient to take with them to the treatment facility.

In addition, think about procedures for notifying a community-based death.

Supervisors should also know who to contact if the body of a person who died of cholera in the community is brought to the ORP.

You will find relevant an example [referral form](#_Referral_form) at the end of this document.

## Record keeping

Record keeping in a designated register might include:

* Patient name
* Village, locality, section, commune
* Age and sex
* Number of ORS packets and chorine tablets provided
* Outcome (for example: patient referred to cholera treatment facility, went home, or died at the ORP)

If ORP staff are illiterate, you will need picto-tally sheets instead. The number of male and female adults and children and the number referred is sufficient to record.

## Reporting

Report case count, referrals, drug/chlorine consumption, and supply needs to the designated network cholera treatment facility or ORP network coordinator daily or weekly.

Assign this task to the ORP supervisor.

Remember that ‘zero reporting’ is required. No patients presenting to the ORP during the reporting period is vital information.

## Risk Communication, Community Engagement

Risk Communication, Community Engagement (RCCE) is an ORP core activity and is extremely important to ensure key messages are passed to and implemented by the community.

Consider the community context and the population’s resources, knowledge, attitudes, and practices which are relevant for cholera and how it affects their ability, and willingness to implement preventative measures.

People’s understanding and beliefs about cholera can be the biggest barrier to stopping the outbreak. Empower communities through education and practical support to adopt practices which improve the cholera response. Volunteers are well placed at community level as trusted sources of information to influence change.

Work with the RCCE colleagues to develop locally adapted messages on how to prevent cholera and train the ORP staff.

Passing the *right message*, to the *right audience* through the *right channel* is essential. However, if the community does not have the *right tools* with which to implement preventive measures, RCCE alone will not achieve its goals. If a community does not have access for whatever reason, consider distributions of essential materials which support RCCE messaging eg soap for handwashing or chlorine for water treatment.

Fear is a common response in individuals and in the wider community during cholera outbreaks. Stigma can be high. Both reduce the effectiveness of a response because communities will be less likely to implement behaviour change, seek early treatment or work together on prevention activities. ORP staff are in a unique position to work with communities and help address fear, stigma, and misinformation as they are a trusted source of information visible in the community.

## Infection Prevention and Control

Implement IPC standard precautions to prevent ORPs from being a source of infection.

Key considerations are:

* Suitable patient flow
* Separate spaces for water supply management, ORS preparation, a well-ventilated or outdoor area for preparation of chlorine solutions and good quality latrines
* Supplies and protocols for safe and effective
  + cleaning, disinfection, and waste management
  + hand hygiene
  + PPE
* Adequate volume and quality of clean water for cleaning, hand hygiene, and decontamination
* Risk communication and health/hygiene education both within the ORP and surrounding community

## Resupply

The designated cholera treatment referral facility or local health facility is responsible for ensuring the ORPs in its network have adequate supplies and are resupplied regularly. This requires additional procurement and logistics, which can be complicated in a rapidly changing epidemic.

Do not forget to ensure supplies are secured overnight when stored on site.

## Re-assessing/Relocating

Frequently reassess the position of ORPs within the network as the outbreak evolves. This may involve opening, closing or moving ORPs based on epidemiological data, and from ORP and CTC/CTU records of patient numbers.

You want to be able to safely site ORPs in the right place and the right time. Coordination between Case Management, Epi, RCCE, Security and Protection colleagues is therefore essential. Undertake coordination meetings with a set agenda ensuring all information is captured.

ORP’s should not be seeing more than 15-30 patients per day. If an ORP is seeing more than this number of patients, discuss the need for additional ORPs or additional capacity within the ORP.

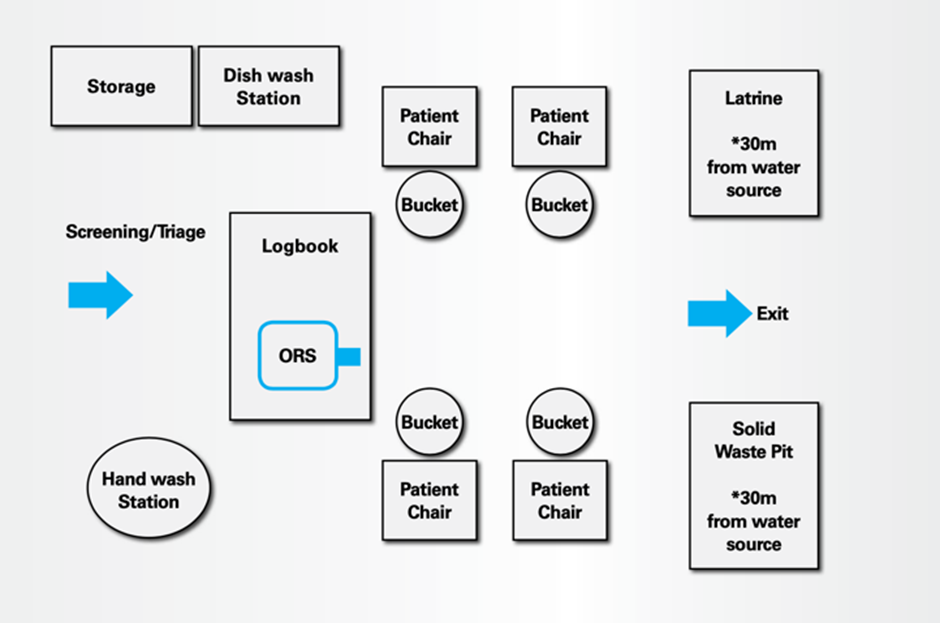
Try to ensure no patients are sitting directly on the ground, either when waiting for treatment, or when ORS is administered or when waiting for referral transport. This will of course depend on the structure and staffing levels and impact supply. Mats or benches may substitute for chairs in some contexts.

# **Set-Up**

When deciding the layout of an ORP, create separate areas for water treatment, ORS preparation and patient observation with adequate sanitation, hygiene, and waste disposal facilities. Take advice from your WASH and IPC colleagues.

Ensure that circulation of patients and staff is based on a floor plan adapted to the local context and accepted by the community. Think about patient privacy and dignity. If you can, use the physical space to promote this by employing screens or similar visual barrier.

An example generic floor plan for a fully equipped ORP is below. Countries may opt for much simpler plans, given their context and resources.



Clear [signage](#_Signage) is important.

### Supply for initial set-up

The WHO community kit contains the necessary supply for the initial response to a cholera outbreak at community level. Its small volume allows for rapid deployment to ORPs to improve access to ORS closest to the affected population.

The community kit is subdivided into 2 modules which include medical and logistic material for the oral rehydration of 100 patients with mild dehydration or to begin treatment for patients before referral. The medical and logistics modules can be ordered separately. Most of the content of the logistic module can be bought locally and an international order may not be necessary for these items.

In addition, for a fully equipped ORP, you will need furniture and other items for:

* Patient Care & Handwashing: cholera chairs, 2 buckets per chair (for stool and for vomitus), reusable plastic cups for drinking, 2 buckets per handwashing point (1 for the water or 0.05% chlorine solution and 1 for wastewater)
* Staff: chairs, table & shelving for staff station; stationery, register, pens & clock for documenting, referral,and reporting; standard and heavy PPE; phone credit for communication
* Solution Preparation & Covered Storage with Taps: 1 x 1 litre measuring jug, utensils, buckets, 1 x 120 litre container for potable water, 1 x 120 litre container for 0.05% chlorine solution, 1 jerrycan or bucket for 0.2% chlorine solution, 1 jerrycan or bucket for 2% chlorine solution, 1 jerrycan or bucket for detergent and water
* Cleaning, Washing Up & Waste: bucket and mop, absorbent material, basin, waste bin and bags
* Signage: ORP, entry/exit, handwashing, chlorine solutions & usage

For easier cleaning and better disinfection, plastic or metal items are preferred, rather than wooden or fabric.

# **Rolling out ORPs**

ORPs can be rolled out in large numbers over a short space of time. It is important to involve Epi, RCCE and WASH colleagues, health authorities, and community leaders and representatives end to end throughout the process.

Remember agility is also key. After initial rollout, ORP locations are likely to need to change depending on the outbreak evolution.

1. In your interdisciplinary team, analyse outbreak surveillance data and decide on priority areas for investigation.
2. Meet with relevant area health authorities and community leaders to discuss the diarrhoea situation and the potential to set up an ORP. Discuss requirements and identify personnel. Include the local health facility data focal point. It may be appropriate to have community engagement specialist make initial contact with the community before medical teams arrive.
3. Train the ORP personnel. This can be done in 1 to 2 days.
4. Together with RCCE colleagues and ORP personnel, meet community leaders and representatives to decide exact premises of ORP. Remember need for water and latrines. Involve your WASH colleagues during discussions and once premises are decided.
5. When premises are decided, bring personnel to deliver the set-up kit and materials. Orientate personnel to the contents of the kit and help set up with good flow/IPC.
6. Collect the names of staff and supervisor per ORP. Collect coordinates for all the sites. Note which referral CTU/CTC is designated, and which health facility that the ORP ‘belongs to’. Put all the information in a centralised database for easy sharing.
7. Ensure referral transport mechanisms are established and known
8. Ensure supply channels are established and known
9. Ensure data collection channels are established and known
10. Plan supportive supervision follow-up visits
11. Continuously assess and reassess ORP and outbreak data to assure most impactful location and number of ORPs

# **Closing ORPs**

If numbers seen in the ORP reduce, and investigation shows that cases are truly declining (rather than a result of healthcare avoidance), consider closing it. Involve the same people in the community who were involved in the decision to open an ORP in the decision to close an ORP.

Whether it is the tail of the overall outbreak or simply the geographical focus moving to another area will dictate whether that location closure represents shifting ORP locations or a reduction in the total overall number of ORPs.

Countries may choose various indicators for ORP closure.

Example closure indicators include:

* If an ORP sees no patients for two incubation periods, 14 days, it can be closed or moved elsewhere depending on outbreak evolution
* If an ORP sees no patients for one incubation period, 7 days, it can be closed or moved elsewhere depending on outbreak evolution
* If an ORP sees fewer than 2 patients daily on 7 consecutive days, consider CATI

As for rolling out ORPs, while assessing for closure and during closing, it is important to involve Epi, RCCE and WASH colleagues, health authorities, and community leaders and representatives end to end throughout the process. Each stakeholder will ensure their corresponding responsibilities are adhered to and achieved. For example, WASH colleagues will ensure the site closure follows IPC rules.

# **Resource Package**

## Tools

Please find links below to some useful resources:

1. Checklists (daily for ORPs and supervisors)

[https://www.gtfcc.org/wp-content/uploads/2024/03/gtfcc-fixed-orp-checklists.xlsx](about:blank)

1. Poster on how to prepare ORS

[https://www.gtfcc.org/wp-content/uploads/2024/03/gtfcc-fixed-orp-ors-preparation-poster.docx](about:blank)

1. Poster on how to make Cleaning, Disinfection and Hand Hygiene Solutions

[https://www.gtfcc.org/wp-content/uploads/2024/03/gtfcc-fixed-orp-cleaning-disinfection-hand-hygiene-poster.docx](about:blank)

1. Sample referral form

[https://www.gtfcc.org/wp-content/uploads/2024/03/gtfcc-cholera-fixed-orp-referral-ticket-template.docx](about:blank)

## Signage

Local contexts vary so greatly, it is difficult to provide sample signage that is universal. Suggested signage comprises:

* “ORP Here”
* Entry/exit
* Toilets
* Handwashing
* Chlorine Solutions 0.05%, 0.2% and 2% with use depicted pictorially
* ORS
* RCCE material