**Flow chart for case detection**

**Step 1**

**Case detection: does the patient fit case definition?**

Provide hygiene promotion messages and information about cholera. Send home

Does the patient have diarrhoea?

Diarrhoea is defined as three or more loose stools within 24 hours

No

Yes

Does the patient have diarrhoea since more than two weeks?

Yes

Refer to a health centre

No

Potential Cholera case, proceed with dehydration assessment

Refer to a health centre

Yes

Is there blood in the stool?

No

**Flow chart for dehydration assessment**

It is a potential cholera case.

Is it a child <5 years of age or pregnant women?

* immediately refer to CTC/CTU or health centre
* Whilst waiting for transport and during transport start with ORS treatment according to treatment plan

Yes

No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Step 2**  **Assess dehydration status** | | **Assessing dehydration** | | |
| Patient has diarrhoea but no signs of dehydration | **Some dehydration**  (Patient has 2 or more  of the below signs) | **Severe dehydration**  (Patient has 2 or more of the below  sings) |
| **Look at or ask** | General  condition | All normal, well alert  and drinks eagerly | Restless, irritable. Less alert, still able to speak | Does not/little react or  unconsious; floppy |
| Tears | Absent | Absent |
| Mouth and tongue | Dry | Very dry – like sand  paper |
| Thirst | Thirsty, drinks eagerly | Drinks poorly or not able to drink |
| **Feel** | Skin pinch | Goes back slowly | Goes back very slowly or remains in  place |
|  |  | **Home Treatment** | **Referral to Health Center / Cholera Treatment Center/Unit** | |

**Flow chart for ORS treatment**

|  |  |  |  |
| --- | --- | --- | --- |
| **Home Treatment** | | | |
| Age | After each loose stool | **Within** the first 4 hours | **After** the first 4 hours for the rest of the 24 hours |
| > 5 and < 10 years old | 1 cup (200 mL) | 1L (5 cups) | 1L / day (5 cups)  **1 ORS sachet** |
| > 10 years or older | At least 200 mL (1 cup) or as much as wanted | 2L (10 cups) or more | 2L / day (10 cups)  **2 ORS sachets** |

|  |  |
| --- | --- |
| **Amount of ORS to drink during transport to the health center or CTC/CTU** | |
| **0 to 6 months** | **50 – 150 mL per hour** |
| **6 months to 2 years** | **150 – 200 mL per hour** |
| **2 years to 5 years** | **200 – 300 mL per hour** |
| **5 years to 15 years** | **400 – 500 mL per hour** |
| **More than 15 years** | **1000 mL per hour** |

* **50 ml = ¼ cup, 100 ml = ½ cup, 200 ml = 1 cup**

**Key messages**

* Give ORS for 3 days
* Explain / Show how to prepare ORS at home
* Explain to discard old ORS solution after 24h (at the end of the day) and prepare a new the next day
* Ask to come back if not improving / not able to drink/eat
* Explain that mothers should continue breastfeeding
* Explain that ORS should be given regularly in small amounts
* Explain if the patient vomits, wait 10 minute and continue to give ORS but more slowly
* Explain if vomiting continuous consult to CTC/CTU/health centre directly
* Explain patient to advise family members or friends that have diarrhoea to consult to the ORP
* Explain patients to come back to the ORP in case diarrhoea continues and no ORS is left
* Provide hygiene behaviour change messages