DREF Final Report

Chad_Cholera outbreak



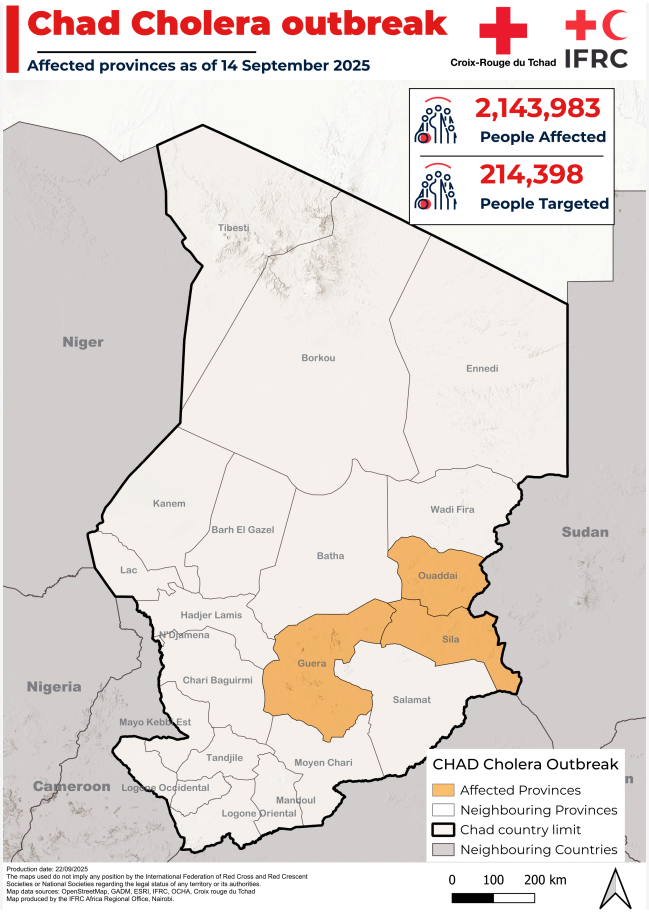
Engagement with communities during epidemic cholera 2025 @CRC

Appeal: **MDRTD025**	Total DREF Allocation: **CHF 468,269**	Crisis Category: Yellow	Hazard: **Epidemic**
Glide Number: -	People Affected: **2,143,983 people**	People Targeted: **214,398 people**	People Assisted: -
Event Onset: **Slow**	Operation Start Date: **23-09-2025**	Operational End Date: **31-03-2026**	Total Operating Timeframe: **6 months**

Targeted Regions: **Ouaddai, Sila**

The major donors and partners of the IFRC-DREF include the Red Cross Societies and governments of Australia, Austria, Belgium, Britain, China, Czech, Canada, Denmark, German, Ireland, Italy, Japan, Luxembourg, Liechtenstein, Malta, Norway, Spain, Sweden, Switzerland, Thailand, and the Netherlands, as well as DG ECHO, Mondelez Foundation, and other corporate and private donors. The IFRC, on behalf of the National Society, would like to extend thanks to all for their generous contributions.

Description of the Event



Date when the trigger was met

15-09-2025

What happened, where and when?

The cholera outbreak in Chad began with a suspected case notified on 13 July 2025 in Chokoyane Health District (Ouaddaï Province). Vibrio cholerae O1 Ogawa was confirmed by culture on 24 July, and the Ministry of Public Health and Prevention officially declared the outbreak on 25 July. Cross-border transmission from Darfur (Sudan) is considered the most likely source. The Chad Red Cross (CRT) monitored the situation from the declaration onwards.

Initially concentrated in Ouaddaï (Chokoyane, Hadjer Hadid, Adré), the outbreak escalated sharply in early September. Cases rose from 1,891 on 9 September to 2,165 cases and 137 deaths (CFR 6.3%) on 18 September. Community mortality remained high. By mid-September, the outbreak was active in 8 districts across 3 provinces: five in Ouaddaï (Chokoyane, Hadjer Hadid, Adré, Farchana, Amleyouna), two in Sila (Abdi, Goz Beïda) and one in Guéra (Bitkine). Under the National Response Plan, the Government called on partners for support and prepositioning. CRT was asked to help contain the geographical spread and reduce community-level mortality. The DREF trigger was met on 15 September 2025, and the operation started on 23 September.

During the operation, transmission declined in the initial hotspots. The last cases were notified in Hadjer Hadid on 21 September, Adré on 26 September, Abéché on 29 September, Abdi on 1 October and Chokoyane on 7 October. Weekly new cases fell from about 270 in mid-September to about 30 from mid-October onwards. However, the outbreak continued to spread westward with population movements. It reached Amdam, Marfa and Abougoudam (Ouaddaï), Tissi (Sila), and from October Hadjer Lamis (Bokoro, Massaguet, Gama, Moyto) and Barh El Gazel (Moussoro). Bitkine (Guéra) became the second-largest focus, with 437 cases.

The last confirmed case was notified on 19 November 2025 in Amdam. As of 7 December, the cumulative total was 2,979 cases and 167 deaths (CFR 5.61%), across 18 districts and 98 health areas in 5 provinces. 95% of patients recovered. The Ministry declared the end of the

outbreak on 15 December 2025. In line with its post-epidemic recommendations, CRT, with IFRC support, reoriented its remaining activities towards community-based surveillance, RCCE and hygiene promotion until the end of the operation on 31 March 2026.

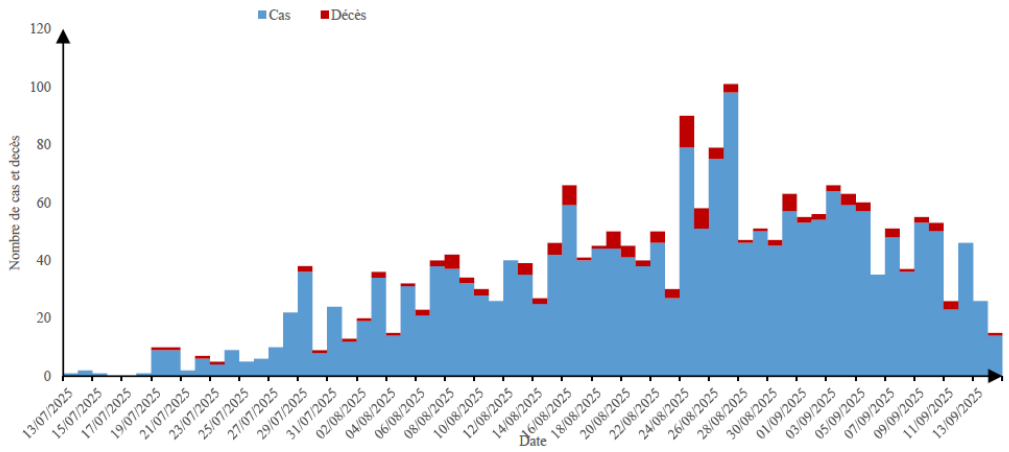


Figure 2 : *Courbe évolutive des cas et des décès de choléra (**N=2081**)*

**Mise à jour de la liste lineaire en cours*

@SITREP of 15 July MoH

Scope and Scale

The cholera outbreak in Chad began with a suspected case notified on 13 July 2025 in Chokoyane Health District (Ouaddaï Province). Vibrio cholerae O1 Ogawa was confirmed by culture on 24 July, and the Ministry of Public Health and Prevention declared the outbreak on 25 July. Cross-border transmission from Darfur (Sudan) is considered the most likely source.

Situation at launch. The DREF trigger was met on 15 September 2025, during the most intense phase of the outbreak. Cases rose from 1,891 on 9 September to 2,165 cases and 137 deaths (CFR 6.3%) on 18 September, with about 270 new cases per week. The outbreak was active in 8 districts of 3 provinces (Ouaddaï, Sila, Guéra). Community mortality was high, and about 91% of patients reached health facilities with moderate to severe dehydration.

Evolution during the operation. After mid-September, transmission slowed in the initial hotspots. The last cases were notified in Hadjer Hadid on 21 September, Adré on 26 September, Abéché on 29 September, Abdi on 1 October and Chokoyane on 7 October. Weekly new cases fell from about 270 in mid-September to about 150 between mid-September and mid-October, then to about 30 between mid-October and early December. At the same time, the outbreak spread to new areas, following population movements westward: Amdam, Marfa and Abougoudam (Ouaddaï), Tissi (Sila), and from October onwards Hadjer Lamis (Bokoro, Massaguet, Gama, Moyto) and Barh El Gazel (Moussoro). Bitkine (Guéra) became the second-largest focus, with 437 cases. On 15 October, 2,753 cases and 155 deaths had been reported, with 11 active districts.

Situation at closure. The last confirmed case was notified on 19 November 2025 in Amdam. As of 7 December, the cumulative total was 2,979 cases and 167 deaths (CFR 5.61%), across 18 districts and 98 health areas in 5 provinces. 95% of patients recovered, and no patient remained hospitalised. After more than 28 days without a new confirmed case, the Ministry officially declared the end of the outbreak on 15 December 2025.

As the risk of reintroduction from Sudan remained high, the Ministry asked partners to continue post-epidemic activities: surveillance in border areas and camps, WASH and risk communication, monitoring at points of entry, readiness for a rapid response, and an After-Action Review. In line with this request, CRT, with IFRC support, reoriented its remaining activities towards community-based surveillance, RCCE and hygiene promotion until the end of the operation on 31 March 2026.

Scope and scale of the event

Burden. Ouaddaï carried 76% of cases (2,279 cases, 121 deaths). Chokoyane remained the epicentre (1,229 cases, CFR 4.15%), followed by Hadjer Hadid (705 cases, CFR 7.23%). Bitkine in Guéra (437 cases) had a low CFR (2.29%). The highest CFRs were recorded in Sila (13.9%; Abdi 14.4%) and in the districts affected late, Moussoro (20%) and Hadjer Lamis (9.1%). This points to late care-seeking in newly affected

areas with weaker preparedness. The national attack rate was 89 per 100,000.

Who was most affected. The median age of cases was 23 years. People aged 5–14 and 15–44 accounted for 64% of cases. Women were more affected than men (sex ratio F/M 1.6). Overall, 88% of patients arrived with moderate to severe dehydration. Close to half of all deaths (78 of 167) occurred in the community. Contrary to the initial assumption, 85% of these community deaths (66) were among host community residents and 15% (12) among refugees. Refugees in camps had better access to treatment centres supported by partners. The host population, especially in remote and newly affected areas, faced greater delays in reaching care.

Contribution of the operation. The operation started on 23 September, after the peak in Ouaddaï. Its main contribution was therefore to accelerate the decline and prevent resurgence in the 8 targeted districts:

548 volunteers were trained (293 in RCCE, 255 in community-based surveillance) and deployed, with CBS covering 8 districts. 45,980 people were reached with cholera prevention messages (target: 30,000). 1,788 households (10,739 people, 53% women) received hygiene promotion in Hadjer Hadid. 100 community leaders were mobilised.
Social mobilisation for oral cholera vaccination took place in 8 districts.

In the targeted districts, no new case was notified after mid-October.

Residual risks at closure. Cholera remains endemic in Sudan, and refugee arrivals and back-and-forth movements continue. Internal movements (transhumance, travel to Abéché and N'Djamena) carried the outbreak westward in 2025. Water and sanitation gaps in camps, host villages and informal settlements remain largely unresolved, and the next rainy season will again increase the risk.

Source Information

Source Name	Source Link
1. UNHCR on OCHA RELIEFWEB site as of 8/8/2025	https://reliefweb.int/report/chad/cholera-outbreak-among-refugees-sudans-darfur-urgent-funding-needed-enar%20UNHCR
2. IFRC Child protection case study Eastern Chad 2025	https://pgi.ifrc.org/sites/default/files/media/document/2025-09/chad-cfs-case-study-en-2025.pdf
3. UNICEF	https://www.unicef.org/media/173101/file/Chad-Flash-Update-Refugees-01-Aug-2025.pdf
4. WHO Country office's site and the various sitreps since the begining of the outbreak	https://www.afro.who.int/fr/countries/chad/publication/rapports-de-situation-de-lepidemie-du-cholera-au-tchad-juillet-2025
5. Latest SITREP from the Ministry of Public Health for the period from December 1 to 7, 2025.	https://www.afro.who.int/sites/default/files/2025-12/SITREP_097_du_01_au_07_DEC_2025.pdf

National Society Actions

Have the National Society conducted any intervention additionally to those part of this DREF Operation?	No

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC CAR & Chad Cluster Delegation maintains an office in Chad with staff based at CRT headquarters. In 2025, the IFRC is increasingly called upon to support the National Society's strategic and programmatic engagement in epidemic response. This includes: - Supporting the National Society to mobilise resources through this DREF and the Federation's Country Plan. - Providing technical expertise and guidance in epidemic response under DREF. - Actively participating in the Cholera Partners Task Force to strengthen coordination and ensure complementarity of actions and resources. IFRC enables Movement coherence by providing technical leadership, ensuring complementarity of interventions, mobilising resources, and acting as a platform for coordination both internally (with PNS/ICRC) and externally (with the Cholera Task Force and government/UN actors). IFRC Operations and funding coordination: Currently, the IFRC supports the CRT in implementing six projects across the country. Most of these are located outside Ouaddaï, Sila, and Ennedi East. The ongoing projects currently in the eastern region include the child protection and education project for children affected by armed conflict, as well as the Emergency Appeal on Population Movement implemented since 2023, which covers the WASH, migration, and health sectors. However, epidemic prevention was not fully covered by these two projects. Initial awareness-raising activities had been interrupted due to underfunding of the Appeal. The Cholera DREF aimed to fill this critical gap in epidemic response in the East. Volunteers deployed at the Adré humanitarian service point were also mobilized to deliver cholera prevention messages to new arrivals. Technical support and quality oversight: For ongoing projects, the IFRC ensures close monitoring and technical support through an operational base in Bongor (Mayo-Kebbi East), hosting dedicated staff. However, although no such structure exists in the provinces of Ouaddaï and Sila, the technical support provided by the IFRC is mainly delivered remotely, complemented by short, targeted or temporary missions and staff reallocations, including surge personnel. Within the framework of this DREF, the IFRC deployed two surge staff members, one in Health and one in WASH. These two surge personnel provided support to the branches involved in the response and took part in the joint CRT-IFRC supervision mission carried out in the localities covered by the Cholera DREF.
Participating National Societies	Partners National Societies present in country or supporting the CRT in country includes French Red Cross; Luxemburg Red Cross and the British Red Cross. All PNS Participate in the Red Cross and Red Crescent Movement meeting where information and positioning are being discussed and agreed for effective resource management. IFRC is actively involve in the cholera response coordination across the health intervention ongoing in their provinces of priority. They also - Participates in coordination meetings with external structures and the Government. - Pre-positioning of kits. - Organized the community-based surveillance training of trainers at the national level. - Supported the drafting of the response strategy with the CRT. Luxemburg Red Cross and the British Red Cross are also beside then CRT to give their

	technical and material support to CRT(CRC) in the response to this outbreak to the available resources that they could release in country.

ICRC Actions Related To The Current Event

ICRC Action:
- Support to the Chad Red Cross in first aid equipment and logistical support.
- Support NS in developing integrated activities around water points and RLF posts in the east, including psychological support as part of existing protection and WASH projects.
- Participation in the Red Cross and Red Crescent Movement meeting.

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	They have the lead of the response and coordinate the response. The EOC for the cholera epidemic outbreak that has been established and is working and producing daily sitrep on the response operation.
UN or other actors	WHO, UNICEF, UNHCR, WFP, CDC. Africa are each in their respective domain supporting the response with technical support, drugs, materials for the treatment centers, food for the patients, wash and IPC materials and supplies. On the ground in relation to some major pillars of the response, you have other actors like: Alima and SMF for case management, the NGO SAKAL for WASH & IPC just to name those in the SITREP.

Are there major coordination mechanism in place?

From the very first hours after the epidemic were declared, national coordination under the leadership of an incident manager was established at the Public Health Emergency Operations Centre (COUSP). This is supervised by the strategic coordination team led by the Minister of Health, with the participation of United Nations agencies and international NGOs. This coordination structure is reinforced by sectoral coordination at the level of areas of responsibility under the direction of district chief medical officers. At this level, strategic supervision is provided by the management teams of the health delegations.

The Chad Red Cross actively engages in district, health cluster, and national coordination mechanisms for the cholera response, alongside IFRC's participation in the WHO-led Task Force. Its involvement ensures effective monitoring, alignment, and complementarity of partner actions.

A national response plan has been developed, and all partners have aligned themselves with the priorities identified in the plan by the COUSP according to their area of expertise. In view of the evolving situation and the programmatic gaps identified in the response, the government, through the Ministry of Health, has asked partners to provide their support by indicating their positioning according to their pillars, also specifying the funding mobilised or in the process of being mobilised during the week of 17 September 2025, so that they could be compiled for the high-level coordination meeting chaired by the Minister of Public Health and Prevention, scheduled for Friday 19 September 2025.

With the escalation, the National Society has been formally called to support the response, building on interventions since 2023 in camps and for displaced people. If external funding is secured, DREF-supported activities will be scaled up across eight health districts and extended to new affected areas, targeting priority gaps identified with partners.

Needs (Gaps) Identified

Health

The outbreak, which began in mid-July, intensified as it spread across five provinces, namely Ouaddaï, Sila, Guéra, Hadjer Lamis, and Barh El Gazel. The total number of cases increased to 2,979, with a case fatality rate of 5.61% by the end of November 2025.

1) Persistent transmission and prevention

Transmission remained high, both within the five affected provinces and across borders, requiring strengthened surveillance and prevention measures. The outbreak, which affected overcrowded camps with limited WASH infrastructure, was also a major factor in the spread of the disease.

Initially confined to Chokoyane, the epidemic rapidly spread across the five provinces, affecting a total of 18 districts over five months. These affected districts each host between 50,000 and 300,000 refugees or returnees and are located near the Sudanese border, where cholera transmission in Darfur remains critical. As of August 8, 2025, Darfur had reported more than 4,300 cholera cases and 113 deaths (ReliefWeb, UNOCHA). Given the higher number of cases in Sudan and the continued formal and informal population movements, preparedness at points of entry was strengthened to reduce the spread.

2) Reduction of community mortality

High community deaths and late consultations with severe cases were the main drivers of mortality.
Epidemiological data showed that most patients arrived with moderate to severe dehydration, indicating delayed healthcare-seeking behavior. For example, during the first half of September, between 84% and about 91% of cases admitted to health facilities presented with moderate to severe dehydration, contributing to high mortality.
In addition, a significant proportion of deaths (78 out of 167) occurred at the community level. This indicates delayed access to treatment and may reflect low community engagement, fear within communities, or limited awareness of cholera symptoms and available treatment services.

3) Health facility capacities and gaps

Beyond the humanitarian crisis, the cholera outbreak placed additional pressure on already overstretched health services. Response efforts were coordinated through several facilities, including Adré Urban, Hadjer Hadid Urban, and clinics supported by MSF. Laboratory analyses confirmed 112 cases by culture out of 233 samples tested (48% positivity rate) and 365 cases through rapid diagnostic tests (RDTs) out of 588 tests conducted. Despite this organization, health services remained heavily strained.

4) Intensification of case management and community engagement

Health services were strengthened to safely isolate and manage patients and bring life-saving care closer to households. According to the Ministry of Health's SITREP summarizing constraints and gaps, there was insufficient isolation capacity. To address this, tents and basic infrastructure were installed to expand CTC/UTC spaces and accommodate additional staff. Despite these expansions, challenges related to lack of equipment for proper setup and the need for tents/isolation spaces persist.

Infection prevention and control (IPC) in health facilities and at the pre-hospital stage were reinforced through team briefings, supervision, and appropriate supplies, including systematic decontamination of frequently touched items (e.g., motorcycle taxis, clothing).

Given the severe dehydration at admission and the number of community deaths, community points were established and supplied with oral rehydration salts (ORS), with clear referral mechanisms to enable early rehydration and reduce mortality.

5) Testing and vaccination planning

Vaccination campaigns were conducted in Abéché, Abdi, Goz-Beïda, Hadjer Hadid, Amdam, and Bokoro. Social mobilization was necessary and adapted case by case depending on the evolving situation and the availability of additional external resources.

Diagnosis was limited by stockouts of rapid diagnostic tests (RDTs) and the risk of shortages of culture reagents, which slowed the rapid

confirmation of cases and timely triage. It was therefore essential to maintain sampling capacity and surveillance logistics. This component was coordinated by the Ministry of Health and WHO.

Water, Sanitation And Hygiene

These health districts each have a population of over 100,000 people, including a large number of refugees who have been arriving since 2023, to the extent that in some areas, refugees outnumber the host population. These refugees live in overcrowded camps, while in some host communities there are informal settlements (slums) and highly vulnerable populations who lack even basic sanitation facilities and sufficient access to safe water for domestic use and consumption-conditions that favor the spread of the disease.

Refugees continue to arrive from Sudan, where cholera was introduced and has remained highly active. At times, some refugees leave the camps to return to Sudan before coming back again, which poses a high risk of introducing new imported cases and spreading the disease to new areas.

Addressing gaps in water, sanitation, and hygiene (WASH), particularly access to water, low hygiene levels, and poor sanitation conditions observed in camps and in communities in general was a critical necessity to interrupt transmission and strengthen prevention. It was essential to improve hygiene and sanitation in communities where cases had been identified, as well as in those at risk, including public places.

Gaps in the availability of latrines were observed in some public places and in overcrowded areas such as refugee camps and informal settlements in major cities like Adré and Abéché, as well as in some resource-limited households.

It should be noted that on July 25, following the outbreak declaration, the Ouaddaï Red Cross provincial committee conducted a field mission in the Dougui camp and surrounding villages, in collaboration with local health authorities. This mission identified 216 cases and 10 deaths in Chokoyane, 15 cases and 2 deaths in Hadjer Hadid (Tréguine camp), and 3 cases of gastroenteritis in Adré. Observations from this mission also showed that the rainy season hindered access to safe drinking water as well as mobility, thereby contributing to the spread of the outbreak.

Protection, Gender And Inclusion

Eastern Chad has experienced a massive influx of refugees and returnees since April 2023, over one million in the Ouaddaï province alone, in a context of pre-existing vulnerabilities, exposing children to separation, violence, exploitation, and psychosocial distress. The overall complex humanitarian context in eastern Chad has made already vulnerable groups even more exposed to protection and gender-related challenges. In light of the resurgence of cholera observed, safeguarding and protection priorities have been maintained and have contributed to their enforcement, updating, and integration into the design of other sectors of intervention, as well as into key awareness-raising activities.

Awareness campaigns targeting beneficiaries were conducted to prevent incidents related to sexual exploitation and abuse (PSEA) during the delivery of assistance, and to encourage the reporting of any potential abuses.

Community Engagement And Accountability

Late consultation at health centers and the high mortality rate at the community level indicate either fear or reluctance to accept care, or a lack of knowledge about the disease, notably with gaps in the early identification of symptoms that would enable timely alert.

In both cases, community engagement has played a crucial role in prevention efforts, particularly in complex settings such as displacement areas in the eastern regions of the country. It is necessary to increase knowledge of the disease's symptoms. A first gap concerns awareness and alert mechanisms for early detection of the disease, which is essential. Awareness-raising, prevention, and early detection can be strengthened if communities are involved in disseminating information on symptoms and risk factors, thereby contributing to active case finding. This includes teaching populations what to do in case of illness, how to properly treat water, handle food, clean the environment and latrines, and use them correctly.

A feedback system has been established, enabling the monitoring, understanding, and response to perceptions, knowledge, and gaps, thereby addressing questions or concerns from communities and integrating them into the Community Engagement and Accountability

(CEA) approach.

In addition to understanding communication channels and systems, it is also necessary to assess the level of understanding of the disease within communities, identify perceptions or misconceptions, and pinpoint knowledge gaps that may explain community behaviors. Furthermore, to effectively apply this approach, understanding the context, community systems, and communication channels is essential to make the CEA approach more effective and communication with affected populations more targeted.

It is important to raise awareness among populations about appropriate attitudes, practices, and actions to prevent high mortality due to the disease, reduce the duration of illness, and decrease the number of people affected and infected within communities. Based on gaps identified by the Ministry of Health, risk communication requires strengthening the teams deployed for preventive communication, enhancing social mobilization around the oral cholera vaccine (OCV), and diversifying communication materials (audio, visual, leaflets) as well as the languages used.

Adapting materials and languages is essential to promote understanding and acceptance. Therefore, priority should be given to identifying and using the most local communication channels and those best suited to the languages of the communities.

Operational Strategy

Overall objective of the operation

Over a six-month period, this DREF complemented the national cholera response by addressing community-level gaps that contributed to transmission and the high case fatality rate in the Ouaddaï and Sila provinces. This intervention relied on critical Health and WASH actions, while mainstreaming strengthened Risk Communication and Community Engagement (RCCE) approaches, as well as protection, gender, and inclusion principles. The intervention targeted 214,398 people.

Operation strategy rationale

The Chad Red Cross carried out interventions in the following areas: Health; Water, Sanitation and Hygiene (WASH); Protection, Gender and Inclusion; and Risk Communication and Community Engagement (Community Engagement and Accountability). These pillars were prioritized based on the main priorities of the national plan and the identified needs and gaps. Urgent interventions in these areas helped to control transmission and reduce community-level mortality in health districts affected by the ongoing outbreak, while also improving and accelerating preparedness and response capacities in four health districts at high risk of an outbreak.

1) Health

SITREPs indicated a rapid increase in cases in Ouaddaï and Sila (as well as Guéra), a high case fatality rate (~6.5%), many community deaths, and very late care-seeking. The strategy therefore prioritized efforts at the community level, particularly risk communication to promote early care-seeking and the adoption of preventive measures, while strengthening early detection and referral to reduce both deaths and new cases.

The strategy began with the training of volunteers and community focal points on ECV, RCCE, SBC, and ORP/ORS modules in line with IFRC standards. This enabled them to recognize symptoms early, deliver key prevention messages, correctly prepare ORS, and follow clear referral pathways. Trained volunteers were then deployed.

Main areas of intervention included:

Community and event-based surveillance was scaled up to generate rapid alerts from villages, markets, schools, and places of worship, with same-day notification to health authorities. National Society volunteers raised awareness among communities and leaders on early case detection and referral to treatment centers.

In very high-incidence areas, the operation established Oral Rehydration Points (ORPs) and a community-based ORS distribution system to initiate rehydration quickly and refer patients to CTCs/CTUs.

In parallel, screening and referral were strengthened at points of entry in high-risk districts to promptly detect suspected cases and limit further spread.

Psychosocial support was provided to patients and bereaved families, ensuring confidential and culturally appropriate assistance and

referral to specialized services when needed.

Each ORP or screening point was managed by a mixed team of six volunteers (three women and three men) working on a rotation basis.

SBC and screening teams operated in rotation to ensure continuous, safe, and accountable service delivery.

The operation supported the scale-up of social mobilization for oral cholera vaccination (OCV), complementing resources from other funding sources.

2) RCCE

Community representation systems were mobilized to ensure effective risk communication. The CRC worked closely with local leaders and influencers to promote key messages on preventive behaviors, health measures, and early care-seeking. In addition, intensive community engagement accompanied all WASH activities. Demonstrations and awareness sessions on water treatment, maintenance, and sanitation were adapted to local languages, with clear dosage instructions. Jerrycans were distributed to the most vulnerable households to ensure safe storage of treated water.

During household visits, campaigns, and demonstrations, volunteers worked with local leaders to promote preventive measures, OCV acceptance, early care-seeking, prompt referral to treatment facilities, and positive behavior change.

3) WASH

The National Society reduced immediate WASH-related vulnerabilities by ensuring access to, use of, and sustainability of safe water, sanitation, and hygiene practices in high-transmission areas.

Main priorities included:

Restoring and expanding access to safe drinking water by rehabilitating eight water points and providing household water treatment solutions to 1,000 high-risk households, alongside practical training (boiling and chlorination).

Establishing routine water quality monitoring (free residual chlorine and sanitary inspections) at public points and household level, with weekly data used to adjust interventions.

Strengthening sanitation in communities and high-traffic public areas (water points, latrines, health centers, markets, schools, places of worship, refugee camps, etc.), particularly in Adré and Abéché.

Promoting hygiene through installation of handwashing facilities and distribution of soap and bleach to 1,000 households, covering at least two months of basic hygiene needs.

Raising awareness on critical handwashing moments (after toilet use, before food preparation/eating, after caring for a sick person).

Training volunteers on water treatment, sanitation, and IPC, while scaling up community outreach on hygiene practices and environmental cleanliness.

4) PGI (Protection, Gender and Inclusion)

The PGI strategy ensured inclusive, survivor-centered assistance based on the “do no harm” principle, guaranteeing safety, dignity, and equitable access for all groups (women, men, children, older persons, and people with disabilities).
CRC interventions were adapted to the context, using mobile approaches and culturally appropriate messaging accessible to both refugees and host communities. The DREF strengthened protection activities by promoting reporting and referral mechanisms. Resources were invested in strengthening local capacities, including the training of volunteers and community leaders (with strong participation of women and youth) on PGI, PSEA, child safeguarding, confidentiality, and safe referral systems. Finally, CRC established integrated referral pathways linking protection, education, and mental health services. These efforts complemented existing mechanisms under the Population Movement Emergency Appeal, including Child-Friendly Spaces (CFS) established in several refugee camps.

5) CEA (Community Engagement and Accountability)

CEA was integrated into health RCCE interventions. In addition to risk communication, CRC established mechanisms to collect and manage community feedback through existing channels such as community committees, door-to-door engagement, and protection service points. CRC mobilized communities through representative structures and feedback channels to co-design services, address harmful norms, and strengthen accountability.

Targeting Strategy

Who was targeted by this operation?

Operational Targeting

1) Geographical targeting:

In Ouaddaï province, the districts of Abéché, Chokoyane, Hadjer Hadid, and Adré, which had been affected by the outbreak, were targeted with the full package of DREF activities. In addition, within the same province, the districts of Abgoudam, Farchana, Abdi, and Amelyona, identified as high-risk areas, were targeted for preparedness and prevention activities.

Geographical targeting prioritized affected districts and high-density areas where transmission and overcrowding coincided (notably Adré, Abéché, refugee camps, major markets, transport hubs, schools, and places of worship). A light package of prevention activities was also extended to neighboring at-risk localities.

Refugee camps constituted the main transmission hotspots, while an increase in cases was also observed in surrounding host communities. This dynamic was considered in the targeting, which included displaced populations, points of entry, camps, and surrounding areas. Geographical targeting was adjusted in line with the evolution of the epidemic when necessary. Overall, eight health districts were targeted, with intensified actions in the three most affected districts.

2) Priority groups for direct assistance and intensified activities:
Interventions primarily targeted:

Refugees and displaced or mobile populations, who were both affected and at risk.
Women, identified as the most affected group due to higher mortality rates.
The most vulnerable age groups, based on disaggregated data as the epidemic evolved.
Populations vulnerable to waterborne diseases, including children.
Communities of case origin, high-traffic public places, vulnerable households with limited resources, and health district systems.

3) Community engagement and leadership:

To ensure the effectiveness of the response, particularly in terms of prevention and promotion of protective behaviors, the National Society placed a strong emphasis on community leaders and representatives. These actors were mobilized to promote and strengthen surveillance messages, WASH and IPC practices, safe behaviors, and acceptance of oral cholera vaccination (OCV).

Explain the selection criteria for the targeted population

1) The geographical target is based on High-risk zones identified based on trend of outbreak and projected scenario evolution following past experience. Eastern border districts (Ouaddaï) adjacent to Sudan having an overall elevated cholera incidence and refugee camp congestion which is a high vulnerability factor.

Also, Abeché is the capital of the province and high mobility with Djamena and neighbiring while Chokoyane account for the high number cases in the Ouidai.

The criteria to select a given health district was the fact that it had a cholera epidemic outbreak or that it is at hyper-high risk of having one (bordering the Darfur region of Sudan with a lot of movement between the and Sudan, having a high number of Sudanese refugees moving between the 2 countries, overcrowded refugee camps, existence of slumps, the water scarcity in the area, the flux of population movement between the health district and the already affected health districts). The 8 health districts need strengthening of the preparedness of the health areas not yet affected.

2) For the groups targeted, the selection is based on:

- The risk and underlying factors or contextual vulnerabilities associated to specific groups. That's the case for refugee camps population prioritized due to underlying factors such as the Overcrowded conditions in Chokoyane, Hadjer Hadid, and Adré increase transmission risk.

- The scope and scale of the impact towards specific demographics. Communities identified as the most at impacted based on current attack rate, death and cases repartition, Demographics of fatalities. Therefore, explaining the target priority to Women, young people, kids and elderly which are the most vulnerable.

Total Assisted Population

Assisted Women	-	Rural	**0.5%**
Assisted Girls (under 18)	-	Urban	**0.6%**
Assisted Men	-	People with disabilities (estimated)	-
Assisted Boys (under 18)	-		
Total Assisted Population	-		
Total Targeted Population	214,398		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**Yes**
Does your National Society have prevention of sexual exploitation and abuse policy?	**Yes**
Does your National Society have child protection/child safeguarding policy?	**Yes**
Does your National Society have whistleblower protection policy?	**Yes**
Does your National Society have anti-sexual harassment policy?	**Yes**

Please analyse and indicate potential risks for this operation, its root causes and mitigation actions.

Risk	**Mitigation action**
The raining season will be a big challenge to the geographic access to some of their sites by rendering roads difficult to access with the mayos and Ouadis. In addition, access to some communities limited by seasonal waterways, reducing reach of sensitization.	To mitigate the situation, movements will be done in convoy of at list 2 vehicles when there are sun and the water level in the mayo's have reduced. Community level volunteers.

Insecurity in the area could at times limit movements in the area due to some movement of uncontrol arms with the population movement across the border with Sudan.	Security check in the area will be done and movement done when the security analysis shows that they could use the road to deliver goods but will use the humanitarian flights to get to areas where it is possible to go by air.
Delay in the time of response which will lead to more people exposed to the disease and may result in reputation damage of the national society and the RCRCS movement.	Will anticipate and put together the technical and logistic resources of the red cross movement (ICRC, IFRC, PNS, NS) to coordinate and support the NS in the implementation of this response to Cholera.
Safeguarding risk: Risk of harm, exploitation, or abuse of participants, especially vulnerable groups, may result in reputation damage.	We will co-develop safeguarding strategies with Ministry of Health and partners, adopt safeguarding tools and codes of conduct, implement referral/reporting mechanisms and conduct safeguarding self-assessments.
Reputational risk: Miscommunication or program failures could damage the organization's credibility and stakeholder trust.	We will: - Develop a tailored communication strategy. - Define approval structures and clear messaging guidelines. - Train staff on communications and stakeholder engagement. - Use CEA feedback mechanisms for risk monitoring.

Please indicate any security and safety concerns for this operation:

Affected areas presents security risks that are considered for the intervention. For instance, both Ouaddaï and Sila are high risk areas. Main threat profile relevant to these provinces includes Kidnapping history; Car-jacking risk, typically at dusk/night; wider volatility on eastern borders (proximity to Sudan/CAR) with periodic cross-border incidents. As per security analysis, situation can also change quickly for areas in stressed phases.

The areas have some occasional security incidence that takes place. Ouadai and Sila are all in red security phase and require for IFRC mission a security clearance in accordance with existing procedure and a set of documents (medical evacuation, CIM Plan, security risk assessment).

Safety measures and Access on the field for intervention/monitoring:
- The IFRC security regulation protocols will be followed for both response team management and for assets management and movement. Include vehicles. Security confirms status with Security before any mission.)
- In Ouadai only Farchana, Adre, Hadjer Hadid and Abeche have been evaluated, and monitoring mission can be operated following the measures in place. For other locations where missions and presence may be needed for this operation, there will be assessment conducted by security before undertaking the mission.
- The access, security assessment and clearance measures in Farchana, Adre, Hadjer Hadid and Abeche allow already significant access for IFRC Monitoring and support on the field, Include for the surge.
- In addition, the operations will be done mostly by the local branches in the area who knows the context and are less exposed.

In terms of staff displacements, the following logistic measures are required such as:
- Ensuring security and operational full pre-mission brief (route threats, safe havens/contacts, roles, emergency kit, comms, contingency routes) and halt if any team member doubts conditions.
- If using convoys, keep vehicles in sight and follow driven rules as per specified in security regulation and fleet security rules.
- All deployments requiring strict planning and communication discipline, with extra vigilance for carjacking and kidnap risks near Abéché and Goz Beïda.
- By default, carry two independent comms (e.g., phone + satphone) and maintain tracking: check in at departure, hourly/at checkpoints, on arrival, and twice daily; overnights need Cluster security approval.
- Operation in the targeted areas require minimum 1 radio per each vehicle in the convoy.

Has the child safeguarding risk analysis assessment been completed?	**Yes**

Implementation

Health

Budget: CHF 165,912
Targeted Persons: 30,000
Assisted Persons: 45,980
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
%tage of people referred to PFA services who received support	100	100
# of volunteers trained and deployed in health intervention/activities (PSS, Risk communication, OCV mobilisation, CBS)	540	548
Number of people reached with health prevention messages	30,000	45,980
% of people reached with awareness visits/messages who confirmed knowing at least 3 ways to identify and prevent cholera	80	151
# of community leaders/representatives engaged in OCV social mobilization activities.	100	100
# of volunteers and supervisors trained on ORP management and ORS administration.	240	240
% of dehydratated suspected cases referred to ORP by volunteers	100	0
# of functional Oral Rehydration Points (ORPs) established and actively supporting communities.	5	0
% of suspected cases identified and referred within 24H by NS to the authorities and health services for actions	100	100
# volunteers who submitted a weekly report to supervisor for consolidation	240	240
% of confirmed/presumed cases identified via NS supported CBS activities	100	28
# of districts covered by CBS volunteers deployed	8	8

% of community rumours or misinformation about OCV addressed or acted upon	100	100
# awareness raising activities conducted with OCV social mobilisation messages as a support to the campaigns in the 8 districts	8	8

Narrative description of achievements

As part of the Cholera DREF operation, the Chad Red Cross (CRT) strengthened its community-level health response in the eight targeted health districts, with a focus on prevention, early detection and referral of suspected cases.

Volunteer capacity. 293 volunteers were trained in Risk Communication and Community Engagement (RCCE), close to the target of 300, and 255 volunteers were trained in Community-Based Surveillance (CBS) and Epidemic Control for Volunteers (ECV), above the target of 240. The training enabled volunteers to recognise cholera symptoms early, deliver key prevention messages, raise alerts and refer suspected cases to health facilities, including in border and high-risk areas.

Prevention and community engagement. Trained volunteers carried out regular household visits and community meetings, using IEC materials. They visited 9,196 households and reached 45,980 people (target: 30,000) with key messages on the disease, its signs and modes of transmission, hygiene and handwashing, safe water use and early care-seeking. This strengthened the link between communities and health facilities and improved acceptance of health interventions.

Community-based surveillance and referral. CBS was active in all eight districts. 240 CBS volunteers, working in pairs, submitted weekly reports to their supervisors. Following their alerts, 51 suspected cases were referred to health facilities within 24 hours (Adré 16, Goz Beïda 12, Chokoyane 9, Hadjer Hadid 6, Abéché 4, Amleyouna 2, Farchana 1, Abdi 1) and were also directed to psychological first aid services. During the joint CRT–IFRC supervision mission in February 2026, volunteers in Goz Beïda also detected and referred a suspected measles case, showing the value of CBS beyond cholera.

Oral rehydration and vaccination. Oral Rehydration Points (ORPs) were not set up. Their budget was approved only in the revised budget, after the Ministry of Health declared the end of the outbreak on 15 December 2025, when ORPs were no longer justified. In agreement with the Ouaddaï and Sila health delegations, the ORS purchased were pre-positioned in health centres and at border points, to be given systematically to patients with suggestive symptoms.
There are no suspected cases of dehydration referred to the ORP as the latter was delivered with delays coinciding with the official end of the outbreak. Therefore, all cases reported by volunteers were referred to the nearest health center in each area of responsibility. Of the 204 reported and referred by volunteers under community-based surveillance, 57 were confirmed, representing 28% of the total reported cases. 159 feedback relating to the vaccine were received and processed by the team of volunteers.

Overall, these actions strengthened the operational capacity of the National Society, extended community coverage and supported a timelier response to the outbreak and to the post-epidemic surveillance requested by the Ministry of Health.

Lessons Learnt

1. Timing of the response. The operation started after the peak of the outbreak in Ouaddaï, and funds reached the field late; the outbreak was declared over on 15 December 2025, before most activities were fully implemented. → In cross-border epidemic contexts, the National Society should trigger the DREF (or an anticipatory/imminent DREF) as soon as the first cases are confirmed, with pre-trained volunteers and pre-positioned supplies ready for deployment.

2. Community-based surveillance. CBS volunteers proved effective: 51 suspected cases were referred within 24 hours, and a suspected measles case was also detected. However, data collection tools arrived late, data were not validated by district chief medical officers, and reporting was irregular until weekly reporting was introduced in February 2026. → Standardised tools, weekly reporting and a validation circuit with the district health team must be in place from day one.

3. Oral Rehydration Points. ORPs were included only in the revised budget, approved after the end of the outbreak, and were therefore not set up. Pre-positioning ORS in health centres and at border points proved a practical alternative. → ORPs and ORS stocks should be part of the initial budget whenever community deaths and late care-seeking are observed.

4. Oral cholera vaccination. Social mobilisation for OCV could not be implemented because it was not aligned with the Ministry of Health's campaign calendar. OCV support should be planned jointly with the Ministry and WHO from the outset, with a flexible budget line that can follow the campaign schedule.

5. Field presence and monitoring. The absence of a project assistant in the field and irregular supervision weakened follow-up joint supervision should take place within the first month, and a dedicated field focal point should be deployed in the operational area.

6. Measuring results. No KAP survey or post-distribution monitoring was conducted, which limited the documentation of behaviour change. A simple baseline and endline KAP survey, or a PDM, should be planned and budgeted.

Challenges

1. Late start and early end of the outbreak. Health activities started about one month behind schedule, after the peak in Ouaddaï, and the Ministry of Health declared the end of the outbreak on 15 December 2025. The emergency phase was therefore short, and activities were reoriented towards community-based surveillance and risk communication. As a result, the deployment of SBC volunteers was reduced to two months instead of three.

2. ORPs not set up. The ORP budget was approved only in the revised budget, after the end of the outbreak, when ORPs were no longer justified. ORS were purchased but arrived late in the districts; they were then pre-positioned in health centres and at border points.

Water, Sanitation And Hygiene

Budget: CHF 93,454
Targeted Persons: 5,000
Assisted Persons: 75,215
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Number of vulnerable households who benefited from containers to collect, treat and store water	1,000	900
Number of vulnerable households who benefited from tablet, PURE or concentrated Chlorine to treat their water	1,000	900
Number of handwashing kits installed in public or community areas	80	80
Number of households made aware of good hygiene practices.	1,000	17,109
Number of water point management committees equipped with chlorination and water quality testing equipment	4	4

Narrative description of achievements

In the eight targeted districts, the Chad Red Cross focused WASH activities on hygiene promotion, household water treatment and the improvement of water and sanitation conditions in high-risk areas.

Volunteer capacity. 100 volunteers were trained in hygiene promotion, and 100 members of hygiene and water point management committees were trained in chlorination and water point management. 200 volunteers were then deployed for awareness and demonstration sessions.

Hygiene promotion. In December 2025, volunteers visited 17,109 households and reached 75,215 people in the eight districts on four topics: water collection, transport, storage and treatment; management of water points (wells, boreholes and other sources);

maintenance of latrines and showers; and personal and environmental hygiene. In Hadjer Hadid alone, 1,788 households were reached (10,739 people, of whom 5,701 women and girls, or 53%).

Water, sanitation and hygiene supplies. With DREF funding, the CRT rehabilitated water points, provided sanitation kits to health facilities, and procured HTH chlorine, soap and bleach, handwashing devices for public and community places, and pool testers for four water point management committees to monitor water quality. 900 vulnerable households out of the 1000 planned have benefited from containers to collect, treat and store water and water purification products at home.

Lessons Learnt

1. Pre-position WASH supplies. Late delivery of chlorine, PUR sachets and hygiene kits reduced their impact. Contingency stocks of household water treatment products and hygiene kits should be pre-positioned in Abéché and in high-risk branches before the rainy season, and framework agreements used to speed up procurement.

2. Measure behaviour change. Without a KAP survey or post-distribution monitoring, the effect of hygiene promotion could not be measured. A simple baseline and endline KAP survey, or a PDM, should be planned and budgeted in future WASH responses.

Challenges

Late procurement and delivery of supplies. HTH chlorine, PUR sachets, soap, bleach, handwashing devices and pool testers were procured late and reached the districts after the peak of the outbreak, which shortened the distribution period. Indicators affected: households receiving water treatment products, handwashing kits installed, committees equipped with water quality testing equipment.

Protection, Gender And Inclusion

Budget: CHF 15,970
Targeted Persons: 24,000
Assisted Persons: 75,215
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
percentage of PSEA cases signaled and managed	100	0
%tage of targeted population reached with safeguarding messages and Protection services	80	0
Number of personel and volunteers (disagregated data) trained on PSEA, safeguarding and PGI standards	160	0
% of personel and volunteers (disagregated data) briefed/refreshed on minimum PGI standards	100	100

Narrative description of achievements

The specific PGI activities planned (training of 160 staff and volunteers on PGI/PSEA, briefing on minimum standards, revision of communication material) were not implemented. Funds were not available when these activities were scheduled, and the operation was then reoriented, at the Ministry of Health's request, towards community-based surveillance, risk communication and hygiene promotion after the outbreak ended. PGI principles (do no harm, PSEA, child safeguarding, confidentiality and safe referral) were nevertheless integrated into volunteer training and awareness sessions, and into the referral pathways used for the 51 suspected cases.

Lessons Learnt

Protect PGI from being deprioritised. As a separate budget line scheduled late in the operation, the PGI activities were dropped when funds were delayed and the operation was reoriented. In epidemic responses, PGI should be integrated from the start into the core volunteer trainings (CBS, RCCE, hygiene promotion) as a mandatory module, rather than planned as a separate activity that can be postponed.

Community Engagement And Accountability

Budget: CHF 24,953
Targeted Persons: 100,000
Assisted Persons: 75,215
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Number of volunteers and supervisors trained on RCCE for the control of cholera in their community.	416	300
Number of communities leaders engaged and mobilised alongside volunteers for the risk communication/households messages	100	100
Number of schools sensitized on cholera	100	2
Number of public places(markets, mosques, churches, mariage places etc.....) sensitized on cholera	400	27
Number of interactive talks made on community radios on cholera	48	0
% of community suggestions and feedback addressed or otherwise acted upon	100	0

Narrative description of achievements

Community engagement and accountability (CEA) was integrated into the risk communication activities of the operation. 300 volunteers and supervisors were trained in RCCE to deliver cholera prevention messages and collect community feedback, and 100 community leaders were mobilised alongside volunteers to relay key messages on prevention, early care-seeking and acceptance of oral cholera vaccination.

Feedback mechanism. Feedback was collected through direct listening by volunteer focal points, community committees and CRT branch offices, in the languages chosen by communities. During the operation, 532 feedback items were received: 159 on cholera vaccination (mainly concerns about side effects), 141 on safe water, hygiene and sanitation, 126 on access to care and case management, 76 on prevention and modes of transmission, and 30 expressing thanks to the Red Cross.

Response to community concerns. The main concerns related to access to and conditions of care, availability of safe water and hygiene products, and fears about the side effects of the cholera vaccine. They were addressed through proximity awareness sessions with the support of health workers, reinforced by Ministry of Health messages broadcast through mobile operators and radio.

Communication materials. 160 image boxes were produced to support household awareness sessions on cholera prevention and hygiene promotion.

Challenges

No interactive radio talks on cholera were organised by the CRT (0/48). This activity was not carried out because the operation was reoriented after the end of the outbreak on 15 December 2025, towards community-based surveillance and household-level awareness. Radio messages on cholera prevention and vaccination were nevertheless broadcast by the Ministry of Health, and CRT volunteers relayed them during household visits.

Coordination And Partnerships

Budget: CHF 0
Targeted Persons: 1
Assisted Persons: 1
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Numberof coordination meetings for the control of the cholera epidemic outbreak the NS has participated at in different area of the health pyramid	8	8
Launching of the DREF Cholera reponse in Chad event	1	1

Narrative description of achievements

As soon as the epidemic was officially declared on June 18, 2025, the State set up a coordination unit involving all actors in the health field, including members of the Red Cross movement. The main achievements are:
• Regular coordination meeting to assess the epidemiological situation and plan/readjust response activities. At the peak of the epidemic between the end of July and the beginning of August 2025, meetings are held daily from Monday to Friday.
• Sharing information with all members of the coordination. A SiteRep has been developed and published regularly by the Ministry of Public Health and Prevention (MSPP).
• A joint assessment mission was carried out on 23 June 2026 in Karal.
• The launch of the DREF launch was organized by the CRT with the participation of all relevant stakeholders and relayed by the national/social media and thus made it possible to raise awareness and mobilize the public around the NS's response.

Challenges

The main challenge remains the availability of members, who often have different agendas. There is also the challenge of reporting and sharing information. To face these challenges, a digital information sharing platform has been created to keep everyone informed.

Secretariat Services

Budget: CHF 116,378
Targeted Persons: 30
Assisted Persons: 30
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
A cholera response team with decentralized structure in the 6 targeted health districts	1	1
A daily Chad Red Cross sitrep of the response produced.	183	12

Narrative description of achievements

The IFRC deployed two surge staff (Public Health in Emergencies and WASH), who supported the branches and took part in the joint CRT–IFRC formative supervision mission three vehicles were provided for the operation, together with office, banking and communication support. Daily sitreps were initially planned; because of limited connectivity, access constraints and delays in data reporting, weekly reporting was adopted instead, and 12 sitreps were produced.

National Society Strengthening

Budget: CHF 40,817
Targeted Persons: 300
Assisted Persons: 740
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
Number of branches and HQ strengthened on Cholera epidemic outbreak response.	8	8
Number of people trained	400	740
Number and type of equipment donated or rehabilitated at each branch and HQs	0	0

Narrative description of achievements

A total of 740 volunteers were trained: 300 in risk communication and community engagement, 240 in community-based surveillance and ECV, 100 in hygiene promotion and 100 in water point management, against a target of 400. Eight branches were involved in the response. Personal protective equipment was procured for volunteers. Planned overhead costs, visibility items and the lessons-learned workshop were not funded under the DREF.

Financial Report

DREF Operation
Final Report (CHF)

Date from: 1 Sep 2025 to 21 Sep 2026

MDRTD025 - Chad - Cholera Outbreak

Operating timeframe: *Start date: 23-Sep-2025 End date: 31-Mar-2026*

Appeal launch date: *13-Oct-2025*

I. Summary

	Actual (CHF)
Opening Balance	**0**
Funds & Other Income	**468,269**
DREF Response Pillar	468,269
DREF Anticipatory Pillar	
Expenditure	-325,303
Closing Balance	**142,966**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			
PO02 - Livelihoods			
PO03 - Multi-purpose Cash			
PO04 - Health	174,433	224,756	-50,323
PO05 - Water, Sanitation & Hygiene	79,230	105,206	-25,976
PO06 - Protection, Gender and Inclusion	14,995	-5,104	20,099
PO07 - Education			
PO08 - Migration			
PO09 - Risk Reduction, Climate Adaptation and Recovery	28,580		28,580
PO10 - Community Engagement and Accountability	23,430	13,613	9,817
PO11 - Environmental Sustainability			
Planned Operations Total	**320,668**	**338,471**	**-17,803**
EA01 - Coordination and Partnerships			
EA02 - Secretariat Services	109,275	106,878	2,397
EA03 - National Society Strengthening	38,326	-120,046	158,372
Planned Operations Total	**147,601**	**-13,168**	**160,769**
Total	**468,269**	**325,303**	**142,966**

III. Expenditure by budget category & group

Prepared on 21-Sep-2026

Page 1 of 2

Click here for the complete financial report

Please explain variances (if any)

The variance in transfers to the National Society is due to a reorientation of activities at the end of the epidemic. In line with the Ministry of Public Health's recommendations, activities focused on community-based surveillance, risk communication and community engagement (RCCE), and hygiene promotion. As a result, CHF 209,874 was transferred to the National Society against a budget of CHF 329,420, a difference of CHF 119,546. This balance will be returned to the DREF in line with current procedures.

Contact Information

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Click here for reference