DREF Operation

Cholera Outbreak in Chad - 2026

Mobilisation des volontaires de la CRT à Karal

Appeal: **MDRTD026**	Hazard: **Epidemic**	Country: **Chad**	Type of DREF: **Response**
Crisis Category: Yellow	Event Onset: **Slow**	DREF Allocation: **CHF 375,000**	
Glide Number: -	People Affected: **124,300 people**	People Targeted: **124,300 people**	
Operation Start Date: **23-07-2026**	Operation Timeframe: **5 months**	Operation End Date: **31-12-2026**	DREF Published: **27-07-2026**

Targeted Regions: **Hadjer Lamis, N'Djamena**

Description of the Event

Date when the trigger was met

15-07-2026

What happened, where and when?

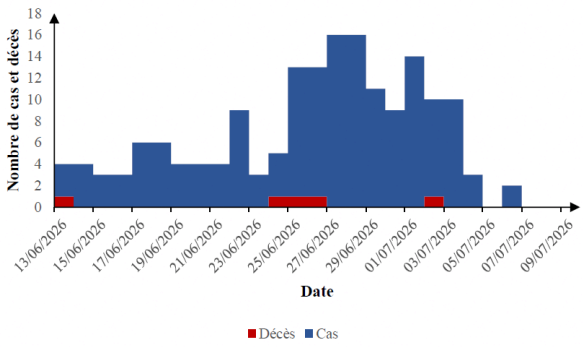
On 15 July 2026, the Secretary General of the Ministry of Public Health and Prevention (MoPHP), through the Public Health Emergency Operations Centre (COUSP), issued official correspondence No. 2533/MSPP/SE/SG/COUSP/2026 requesting urgent support from technical and financial partners to strengthen cholera preparedness and response efforts in Chad. The letter called for the mobilization of additional resources to support the national response plan and prevent further spread of the outbreak to other provinces of the country and beyond its borders.

The request was made in the context of an ongoing cholera outbreak in Karal Health District, Hadjer-Lamis Province. Following the notification of the first suspected cases on 13 June 2026, laboratory confirmation of Vibrio cholerae O1 Ogawa, and the official declaration of the outbreak on 18 June 2026, transmission has continued to evolve. As of 9 July 2026, a cumulative total of 167 cases and 5 deaths, including 3 community deaths, had been reported, corresponding to a 3 per cent case fatality rate (CFR). The outbreak is currently concentrated in four active health areas: Karal 1, Karal 2, Baltram and Alkouk where 23 villages and neighbourhoods have reported at least one cholera case. The Epidemic Response Committee meeting referenced in the document shared on 7 July reported suspected cases in N'Djamena, which further supports the risk of the outbreak spreading to health areas close to Karal.

The absence of a new situation report (SitRep) does not allow for an assessment of how the situation has evolved to date. However, the letter from the Ministry of Health requesting support as well as all coordination in place reinforces the fact that the situation is not yet fully under control. Vigilance must therefore be maintained.

Despite ongoing efforts by health authorities and partners, important operational gaps remain. The risk of further expansion remains high due to significant population movements, commercial exchanges, the mobility of nomadic populations, and the presence of vulnerable communities and displacement sites in the area. Health authorities have also highlighted inadequate sanitation conditions and limited access to safe water as factors increasing the likelihood of transmission to neighbouring health areas, districts and provinces. The Ministry's request for support therefore seeks to reinforce response activities in affected communities while strengthening surveillance, early warning and prevention measures in surrounding high-risk areas to contain the outbreak and prevent further geographical spread

Provision of a sprayer to the Karal Health District



Epidemic curve of deaths

Scope and Scale

Karal Health District is the epicenter of the outbreak at the moment. The districts counts 14 sub-districts or health areas. 4 currently affected with active outbreaks and continuous transmission (Karal 1, Karal 2, Baltram, and Alkouk). As of 30 June 2026, health authorities had reported a cumulative total of 129 cholera cases and 4 deaths across the four affected Areas of Responsibility, resulting in a case fatality rate (CFR) of 3.1 per cent. As of 9 July 2026, a cumulative total of 167 cases and 5 deaths, including 3 community deaths, had been reported, corresponding to a 3 per cent case fatality rate (CFR). This shows a sustained transmission despite relatively limited surveillance. No additional SITREP issued so far. This case fatality rate remains significantly higher than the WHO emergency threshold of less than 1%, highlighting the need for rapid screening, referral, and treatment of suspected cases.

Although the epidemic is currently concentrated in four active health zones—where 23 villages and neighborhoods have reported at least one case of cholera, there is a significant risk of expansion of the outbreak beyond the 4 health areas. The 10 others health areas are considered at high risk of expansion because they are highly connected with a maximum of 8-10 Km between them and their major population agglomeration made of very vulnerable groups leaving in conditions that will favor rapid spread of the outbreak. Include several IDP sites located within 8–10 km of affected areas. These 10 health areas have a densely population movement dynamic within Chad but also with the neighboring Cameroon areas where cholera is also ongoing. There is a high risk of rapid spread because of mobility and proximity, especially if IDPs starts reporting cases. This context was captured in checklist and now again better reflected in the document.

In addition, in early July, alerts in N'Djamena were reported in coordination meetings, with samples taken from suspected cases. The official confirmation and status of these cases are yet to be made official as no SITREPs have been issues since the latest of 5 July. The sensitivity around the international events hosted in Chad in week of 7th July have likely delayed further communications around the outbreak evolution, making the scope and scale of the outbreak not fully captured at the moment.

The affected and the at-risk communities are estimated to be approximately 124,300 people, made of the entire population of the four affected Karal health zones (estimated at 49,004 people), as well as areas at high risk of spread in the sub-prefecture of Karal and in health districts of N'Djamena near the affected areas.

Another risk factor being the general high population mobility within the province, with other province, include areas of n'Djamena and movement with border Cameroon. Noting that Cameroon also reports cholera outbreak. In another hand, the proximity of Lake Chad, the risk of flooding during the rainy season, inadequate water, sanitation and hygiene conditions in Karal and at-risk areas, represent significant concerns for a rapid geographical spread of the disease to currently unaffected areas but also a rapid escalation of the disease in general.

The most vulnerable groups include children under five years of age, pregnant and breastfeeding women, older persons, people living with disabilities, people with chronic illnesses, and poor households with limited access to basic services. Internally displaced persons (IDPs), mobile populations, and communities living along the shores of Lake Chad are also particularly vulnerable due to their often-precarious living conditions and frequent movements between the health districts of Karal, Mani, Bol, Douguia, and other neighbouring localities.

Source Name	Source Link
1. SITREP-Choléra_022_du 08 au 09 juillet_2026_ (1)	https://ifrcorg.sharepoint.com/:b:/s/RdactionduDREFCholra/IQBKKaIYE3_IRYmVDBxRQ8yAAfXEeqDK8ZXPLvXKMNME6ac?e=gq5uth
2. Note N°2533/MSPP/SE/SG/COUSP/2026 du 15 juillet 2026	https://ifrcorg.sharepoint.com/:b:/s/RdactionduDREFCholra/IQD2QfvGKQD7T6f_UBBP8KfuATujmu-MRlRaB_qCpkTMBIQ?e=048oCh

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	**Yes**

Did it affect the same population group?	No
Did the National Society respond?	-
Did the National Society request funding form DREF for that event(s)	-
If yes, please specify which operation	-

If you have answered yes to all questions above, justify why the use of DREF for a recurrent event, or how this event should not be considered recurrent:

-

Lessons learned:

Lessons learned from previous cholera outbreaks in Chad have been incorporated into the design of the current response in Karal in order to reduce the risk of transmission and mortality. Past experiences have shown that delays in case detection and referral for appropriate treatment contributed significantly to increased disease transmission. As a result, epidemiological surveillance, active case finding and contact tracing, as well as community-based investigations, were strengthened from the early days of the outbreak.

Previous outbreaks also highlighted the critical importance of community engagement and risk communication in promoting the adoption of appropriate hygiene and sanitation practices, as well as strengthening disease surveillance systems to ensure the timely detection, reporting, and response to suspected cholera cases. Accordingly, the current response places strong emphasis on Community-Based Surveillance (CBS), including early detection, reporting, and response, as well as community awareness-raising activities, dissemination of prevention messages in local languages, and promotion of oral cholera vaccination.

Furthermore, inadequate access to water, sanitation, and hygiene services was identified as one of the main drivers of transmission during previous outbreaks. Consequently, household disinfection, water source chlorination, water treatment, and Infection Prevention and Control (IPC) activities were implemented from the onset of the response.
Finally, previous operations demonstrated the importance of strong coordination among health authorities, partners, and communities. The current response therefore relies on regular coordination meetings, continuous sharing of epidemiological information, and joint interventions to ensure a timely, effective, well-coordinated, and adaptive response that evolves in line with the epidemiological situation.

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	Yes

Current National Society Actions

Start date of National Society actions

21-06-2026

Health	1. Deployment of six Chad Red Cross (CRC) volunteers to the Cholera Treatment Centre (CTC) to support outbreak response operations. 2. Support to local health authorities in the implementation of cholera response activities. 3. Contribution to the assessment of needs related to community-based case management and the establishment of Oral Rehydration Points (ORPs).

Community Engagement And Accountability	1. Deployment of approximately 12 Chad Red Cross volunteers to conduct community outreach and awareness-raising activities in Karal town. 2. Community sensitization on cholera prevention measures since the onset of the outbreak. 3. Community mobilization activities aimed at limiting the spread of the outbreak.
Coordination	1. Participation in joint outbreak assessment missions with health authorities and response partners. 2. Participation in coordination mechanisms established at the health district level. 3. Collaboration with administrative and health authorities in needs analysis and response planning. 4. Participation in coordination meetings organized by the Public Health Emergency Operations Centre (PHEOC) of the Ministry of Public Health and Prevention.
Assessment	1. Conducted an initial assessment of the epidemiological situation in Karal Health District. 2. Identified priority response needs, including: - Megaphones; - Personal Protective Equipment (PPE) (boots, gloves, and masks); - Sprayers; - Chlorine; - Vests and bibs for volunteers.
Resource Mobilization	- Mobilization of Chad Red Cross provincial and local committees immediately following the notification of the first suspected cases. - Deployment of volunteers, despite limited material resources, to support community awareness-raising activities and assist health authorities in the outbreak response.

IFRC Network Actions Related To The Current Event

Secretariat	The International Federation of Red Cross and Red Crescent Societies (IFRC) is present in Chad through its delegation based in N'Djamena and provides direct support to the Chad Red Cross (CRC) in responding to the cholera outbreak in Karal. The IFRC participated in the joint assessments conducted with the CRC and Movement partners to analyse the situation, identify priority needs, and define intervention priorities. At the strategic level, the IFRC supports the National Society in coordinating with health authorities, Movement partners, and other response actors, while also supporting the development and implementation of the DREF operation. The IFRC also provides technical support in the areas of health, Risk Communication and Community Engagement (RCCE/CEA), community-based surveillance, WASH, and the monitoring of response activities. In addition, it facilitates the mobilization of additional technical surge support based on the evolution of the outbreak and operational needs.
Participating National Societies	The French Red Cross (FRC) is the main Partner National Society involved in supporting preparedness and response efforts for the cholera outbreak in Karal. Together with the Chad Red Cross (CRC) and the IFRC, the FRC participated in the joint assessment mission that enabled an analysis of the epidemiological situation, the identification of priority needs, and the definition of potential areas of intervention for the Red Cross and Red Crescent Movement. The FRC also provides technical support to the CRC in needs assessment and response planning, particularly in the health sector, including Community Engagement and

	Accountability (CEA), Infection Prevention and Control (IPC), and Community-Based Surveillance (CBS). The Luxembourg Red Cross (LRC) participated in the first cholera crisis coordination meeting organized by the Chad Red Cross. This engagement helped strengthen information sharing, improve coordination among Movement partners, and explore opportunities for additional support to the response. Remotely, the IFRC, in collaboration with the French Red Cross, is supporting the Chad Red Cross in the development of the DREF operation, strategic analysis of the evolving situation, resource mobilization efforts, and coordination with Movement partners. At this stage, no other Partner National Society is directly engaged in operational activities in Karal. However, additional support may be mobilized depending on the evolution of the outbreak and the emerging operational needs.

ICRC Actions Related To The Current Event

- Probable support to the Chad Red Cross in first aid equipment and logistical support.
- 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	Following the laboratory confirmation of the first cholera cases, health authorities responded rapidly by officially declaring the outbreak on 18 June 2026 and deploying a multidisciplinary team from the Public Health Emergency Operations Centre (PHEOC) to support the response in Karal Health District. The deployed team strengthened key response pillars, including epidemiological surveillance, case management, laboratory services, Infection Prevention and Control (IPC), Risk Communication and Community Engagement (RCCE), and WASH interventions. The authorities established a daily coordination mechanism with field partners and reinforced active case finding, epidemiological investigations, and monitoring of the outbreak's evolution. They also ensured the management and treatment of cholera patients through the Karal Cholera Treatment Centre (CTC), in accordance with national treatment protocols. In addition, on 27 June 2026, the Ministry of Public Health and Prevention launched an Oral Cholera Vaccination (OCV) campaign, complemented by community awareness-raising and risk communication activities. WASH interventions were also implemented, including water chlorination, household and water-point disinfection, and the promotion of improved hygiene practices in affected communities. The authorities continue to mobilize partners and coordinate the response efforts in order to contain the outbreak and prevent its spread to neighbouring districts and the most vulnerable population groups. On 30 June 2026, the Ministry of Public Health and

	Prevention officially called for strengthened cholera prevention measures in view of the high risk of further spread of the outbreak.
UN or other actors	The World Health Organization (WHO), in support of the Ministry of Public Health and Prevention and the Public Health Emergency Operations Centre (PHEOC), is supporting response coordination, strengthening epidemiological surveillance, enhancing laboratory capacity, information management, the implementation of the oral cholera vaccination campaign, and the deployment of multidisciplinary technical teams. UNICEF is supporting Risk Communication and Community Engagement (RCCE) activities, oral cholera vaccination efforts, and WASH interventions aimed at reducing the risk of disease transmission. Médecins Sans Frontières (MSF) Holland is the main operational partner on the ground, managing the Cholera Treatment Centre (CTC), supporting case management, conducting community awareness activities, and implementing several WASH interventions. Other humanitarian partners are also supporting the authorities' response efforts through vaccination activities, disease surveillance, disinfection, water chlorination, and community mobilization initiatives to contain the outbreak and prevent its spread to neighbouring districts.

Are there major coordination mechanism in place?

The Ministry of Public Health and Prevention (MPHP) provides overall coordination of the response through the Public Health Emergency Operations Centre (PHEOC/COUSP), with support from WHO and UNICEF, which also co-lead the joint Health–WASH Cluster. The Health–WASH Cluster remains the primary coordination mechanism, bringing together UN agencies, NGOs, and operational partners on a regular basis in N'Djamena and at provincial level to facilitate the sharing of epidemiological information, harmonize interventions, and prevent duplication of activities.

Supported by the IFRC and Partner National Societies, the Chad Red Cross (CRC) plays a cross-cutting role at community level and serves as a key operational link between communities, health authorities, and response partners. CRC technical coordinators participate regularly in COUSP meetings and Health and WASH coordination mechanisms to ensure alignment with the national response strategy, identify operational gaps, and promote complementarity among interventions.

Managing the risks associated with cross-border transmission and population movements remains a key priority for both authorities and humanitarian partners. Furthermore, Oral Cholera Vaccination (OCV) campaigns, when implemented, are led by the MPHP with support from UNICEF, while the CRC complements these efforts through community mobilization, risk communication, awareness-raising activities, and support to outreach operations.

Needs (Gaps) Identified

Health

Outbreak epicenter of the outbreak is currently concentrated in 19 villages/neighbourhoods located within the Karal 1, Karal 2, Baltram and Alkouk health catchment areas. All being Health zones of Karal district. The Karal Health District is composed of 14 Health Areas (Areas of Responsibility), of which four are currently affected by the cholera outbreak (Karal 1, Karal 2, Baltram and Alkouk). While transmission is presently concentrated in these four areas, they maintain strong social, economic and population links with the remaining 10 non-affected Health Areas, with frequent movements of people between communities due to trade, livelihood activities, family ties and access to services. The relatively short distances between health areas facilitate regular population movements and increase the risk of rapid geographical spread of the disease beyond the currently affected locations. In addition, several internally displaced persons (IDP) sites and border areas with Northern Cameroon are located within 8–12 km of some of these Health Areas, further increasing the need for prevention as any transmission escalation will lead to a bigger crisis, vulnerability and the likelihood of escalation. In additional, as of 06 July, a confirmed case in Djamena is showing that there could be further transmission and cases, hence, need to steghten prevention in at least areas most at risk.

Although cholera case management is being supported by health authorities and partners, significant needs remain. The response is

largely dependent on a single Cholera Treatment Centre (CTC), creating a risk of overstretching available capacity should the outbreak expand. Strengthening community-based case management through Oral Rehydration Points (ORPs) and ensuring the availability of adequate medical consumables therefore remain critical priorities. In addition, fear of cholera among community members has contributed to delayed health-seeking behaviour, increasing the risk of severe illness and mortality. Children, who represent the most affected age group, as well as populations living in remote areas, remain particularly vulnerable.

The assessment also revealed significant gaps in surveillance capacity, particularly outside the currently affected areas. Shortages of cholera Rapid Diagnostic Tests (RDTs) in several locations limit early detection and increase the risk of undetected transmission. Resources for case investigation, active case finding, and sample transportation remain insufficient. These challenges are further compounded by population mobility and difficult access to remote locations, which hinder timely detection, reporting, and response activities.

Important Infection Prevention and Control (IPC) needs persist both in health facilities and communities in order to reduce the risk of further transmission. The assessment highlighted the need to strengthen household and health facility disinfection activities, increase the availability of Personal Protective Equipment (PPE) and disinfection supplies, and continue training health personnel on cholera IPC measures. Existing resources may prove insufficient should the outbreak spread to additional areas.

Water, Sanitation And Hygiene

The assessment identified significant gaps in the Water, Sanitation and Hygiene (WASH) sector, which remains one of the main drivers of cholera transmission.

Access to safe drinking water is limited, with approximately 32% of existing water points reported as non-functional. As a result, many households, including refugees, internally displaced persons (IDPs), and vulnerable host communities, rely on unsafe water sources. Inadequate household water treatment, storage, and handling practices further increase the risk of water contamination and disease transmission.

Sanitation conditions remain particularly concerning. Open defecation is still widespread due to the lack of adequate sanitation infrastructure, especially in overcrowded areas, rural communities, peripheral villages, and locations hosting displaced populations. Significant gaps persist in access to emergency, communal, and household latrines, as well as handwashing facilities in public spaces such as markets, schools, health facilities, and community gathering areas. Limited access to hygiene items and household water treatment products further reduces communities' ability to adopt and sustain preventive hygiene behaviours.

Karal's proximity to Lake Chad and the capital city, N'Djamena, combined with poor sanitation conditions, inadequate hygiene practices, and limited access to safe water, constitutes a major risk factor for cholera transmission and increases the likelihood of the disease spreading to new geographical areas. In addition, difficult access to certain locations, particularly the islands of Lake Chad, and the absence of comprehensive sanitation mapping limit the ability to effectively target and prioritize response interventions.

Community Engagement And Accountability

The assessment identified significant gaps in risk communication and community engagement capacities within the affected areas. Despite ongoing awareness-raising efforts, a number of villages, displacement sites and high-risk communities remain unreached, limiting the population's access to life-saving information on cholera prevention, early detection and timely care-seeking. Existing community engagement structures are insufficient to ensure adequate geographical coverage and sustained interaction with affected populations.

Community consultations and field observations have also highlighted persistent misconceptions, rumours and concerns regarding cholera transmission, treatment and the use of health services. These factors contribute to delayed referral of suspected cases, low uptake of preventive measures and reduced trust in health facilities in some locations. In addition, the absence of a structured community feedback mechanism limits the ability of responders to systematically collect, analyse and address community perceptions and barriers affecting the response.

The availability of adapted information, education and communication (IEC) materials remains limited, particularly for populations with low literacy levels and those living in remote or displacement settings. There is a need to strengthen community-based communication through locally appropriate channels and tools that facilitate understanding of cholera symptoms, prevention practices and available services.

To address these gaps, the operation will reinforce community engagement capacities through the recruitment, training and deployment of additional Red Cross community volunteers, the establishment of a community feedback mechanism, the production and

dissemination of adapted IEC materials, and targeted actions aimed at rebuilding trust between affected communities and health services. These interventions will support timely health-seeking behaviour, improve the adoption of preventive practices and contribute to reducing cholera transmission in the affected areas.

Any identified gaps/limitations in the assessment

Logistics
The response continues to face significant logistical constraints. Limited fuel availability, insufficient transportation resources, and difficult access to remote, island, and border communities affect the frequency and effectiveness of investigation, supervision, and response activities. These constraints may delay the deployment of teams and essential supplies to high-risk locations, particularly if the outbreak spreads to neighbouring districts or areas hosting internally displaced persons.

Coordination and Vulnerable Groups
While a multi-sectoral coordination mechanism is functional at district level, gaps remain in geographical and sectoral coverage due to the limited number of operational partners on the ground. As a result, some priority interventions and locations remain underserved. In addition, certain vulnerable groups may not yet be fully reached by ongoing response activities, including internally displaced persons, populations living in island and border communities, households with limited access to water and sanitation services, and women and children residing in hard-to-reach areas. Continued population movement further increases the vulnerability of these groups and the risk of disease spread.

Assessment Report

Operational Strategy

Overall objective of the operation

To contribute to breaking the chain of cholera transmission and reducing morbidity and mortality in the Karal Health District through improved access to Water, Sanitation and Hygiene (WASH) services, strengthened community-based surveillance, and timely community-level case management for affected and at-risk populations.

Operation strategy rationale

The strategy is based on the findings of the joint assessment conducted by the Chad Red Cross (CRC), the French Red Cross (FRC), and the IFRC, which identified critical gaps in Water, Sanitation and Hygiene (WASH), Infection Prevention and Control (IPC), community engagement, community-based surveillance, early case detection, and access to timely community-level cholera care. The assessment also highlighted the high risk of cholera transmission within affected communities and its potential spread to neighbouring health districts and vulnerable populations.

To address these challenges, the Chad Red Cross (CRC) will implement this operation in support of the national cholera response under the leadership of the Ministry of Public Health and Prevention (MPHP) and the Public Health Emergency Operations Centre (PHEOC/COUSP), in close coordination with government authorities and humanitarian partners involved in the response. The design of the intervention is based on the current outbreak scope and scale, and they may be revised according to the evolution.

1. Water, Sanitation and Hygiene (WASH) and Infection Prevention and Control (IPC)

WASH interventions constitute one of the main pillars of the response and will be centred around a WASH-led Case Area Targeted Intervention (CATI) approach integrating surveillance, RCCE, environmental sanitation, IPC, household disinfection, case referral and community engagement activities around each suspected or confirmed cholera case. CATI teams will carry out targeted interventions in the households of cholera cases as well as in neighbouring households at risk of exposure. Activities will include the distribution of WASH kits to targeted households, including soap, household water treatment products, water storage containers, and buckets with lids. Community clean-up and sanitation campaigns will also be conducted in affected areas to improve environmental conditions and reduce the risk of contamination. Although CATI is implemented through an integrated public health approach involving WASH, CBS, RCCE and referral mechanisms, it is operationally led through the WASH component as a case-triggered intervention designed to rapidly interrupt cholera transmission around suspected and confirmed cases.
The operation will further support the construction of emergency community latrine blocks, the installation of handwashing facilities at

Oral Rehydration Points (ORPs), and the regular chemical treatment of public water sources in the four high-risk areas. To strengthen Infection Prevention and Control (IPC) measures, teams will be equipped with sprayers, personal protective equipment (PPE), and the materials required for household disinfection around cholera cases, as well as for community sanitation activities.

2. Risk Communication and Community Engagement (RCCE/CEA)

RCCE activities will support the CATI strategy and health response by ensuring community acceptance, promoting early reporting of suspected cases, addressing rumours and facilitating access of CATI teams to affected households. A total of 150 community volunteers supervised by four supervisors will be deployed in affected and high-risk areas to conduct household visits, community awareness sessions, and activities promoting key cholera prevention practices. Volunteers will use appropriate Information, Education and Communication (IEC) materials, flipcharts, and community communication tools to disseminate key messages on cholera prevention, early case detection, and referral to health facilities. Four community feedback mechanisms will be established across the four intervention areas to collect community concerns, perceptions, and rumours and to adapt prevention messaging accordingly.
In addition, 30 members of community groups will be trained to strengthen community participation and ownership of the response.

3. Community-Based Surveillance, Active Case Finding and Referral

Through the CATI approach, the 150 volunteers will conduct community-based surveillance, active case finding, and rapid referral of suspected cases to health facilities.
Community teams will ensure the early detection of alerts, identify individuals presenting symptoms compatible with cholera, and promptly notify health authorities to facilitate an immediate response. Communication credits provided to volunteers will support the rapid reporting of alerts and enhance coordination of field interventions.

4. Community Case Management and Oral Rehydration

To reduce cholera-related mortality, the operation will establish eight Oral Rehydration Points (ORPs) in priority areas. The ORPs will be equipped through the procurement of eight specialized kits, tents, and the equipment required for their operation. A continuous supply of Oral Rehydration Salts (ORS) will be ensured throughout the duration of the operation. A total of 64 trained volunteers will be deployed to operate the eight ORPs. They will provide early ORS administration, conduct initial patient assessments, raise awareness among caregivers, and ensure the timely referral of patients requiring further treatment to Cholera Treatment Centres (CTCs).

5. Coordination, Operational Monitoring and Institutional Support

Overall coordination of the operation will be ensured by the Chad Red Cross, with support from the IFRC.
To strengthen implementation quality, the IFRC will deploy a Public Health in Emergencies (PHiE) surge and an Operations Manager surge for a period of two months.
Operational monitoring will include:

- Four IFRC supervision missions;
- Four Chad Red Cross supervision missions;
- Two joint supervision missions involving the Chad Red Cross and the Ministry of Public Health and Prevention.
- The PMER Officer recruited under the operation will be responsible for the collection, consolidation, analysis, and reporting of monitoring data.

Finally, a Lessons Learned Workshop will be organized at the end of the operation to document good practices, operational challenges, and recommendations for future epidemic response interventions.

Coordination in place

CRC is part of major coordination in place at national and district level. Therefore, current intervention has factor the positionning from other partners. This explains why CRC focuses on community surveillance, RCCE, ORPs support with ORS provision, referrals, household disinfection, community mobilization and feedback mechanisms. This is not conflicting with other partners support but bridge gaps for community level actions and expand the reach of what other partners are doing considering it remains limited. The call for extended support from Government and current expansion of the outbreak being the clear aknowledgement of the gaps. NS intervention also aligns with outbreak risk and uncovered key driver's such as support rehabilitation of non-functional water points when other partners essentially focus on soft WASH, delayed care-seeking by strengthening CEA strategies where CRC is strength is, scaling-up surveillance to cover gaps. This is among the main rationale for the designed intervention.

Targeting Strategy

Targeting Strategy Supporting Document

Who will be targeted through this operation?

The intervention targets 124300 people. The geographic focused being on Karal Health District in Hadjer-Lamis Province and areas in N'Djamena where alerts have been reported. Intervention priorities are divided as follows:

- Direct response activities in the four affected Health Areas of Karal (Karal 1, Karal 2, Baltram and Alkouk), where resources will be concentrated on ORPs, active surveillance, case investigation and referral, WASH support, household-level IPC measures, and intensive RCCE activities. They will also be the direct beneficiaries for WASH material. These concentration of integrated response and prevention actions will aim to interrupt transmission and reduce cholera-related morbidity and mortality.
- In the remaining 10 at-risk Health Areas within Karal District and N'djamena, activities will be limited for now to community-based surveillance, early warning, alert reporting, preventive hygiene promotion, and risk communication to support the early detection of new cases and prevent further geographical spread. The at-risk areas focus will be areas of Responsibility within an approximate 20 km radius of the communities with reported cases.

This targeted approach ensures that the majority of operational resources are directed towards areas with active transmission, while maintaining minimum prevention and preparedness measures in neighbouring high-risk locations due to population mobility, proximity of IDP sites, and the risk of rapid outbreak expansion. In the meantime, strengthening risk communication, community-based epidemic surveillance, and early warning mechanisms for the wilder 124,300 people targeted will contribute to limiting the geographical spread of the outbreak and supporting community level timely detection and alerts to suspected cases. In the scenario where alerts in N'djamena or other areas are confirmed by upcoming SITREPs, CRC will adjust its intervention as relevant to keep the above prioritisation effective.

For all interventions, particular attention will be given to especially vulnerable groups, including internally displaced persons (IDPs), mobile populations, migrants, and communities living near transit routes, islands, border areas, and other locations at heightened risk of disease spread. These populations face increased vulnerability due to precarious living conditions, overcrowding, limited access to safe water and sanitation facilities, and barriers to accessing health services. For WASH distributions and WASH facilities rehabilitation, CRC will prioritise families with limited access to safe drinking water, sanitation facilities, and health services. Special attention will be paid to children, women, older persons, persons with disabilities, and households most exposed to the impacts of the outbreak.

Red Cross volunteers will be trained to identify the most vulnerable households and to ensure that all population groups, particularly those at greater risk, have equitable access to information, referral mechanisms, and humanitarian services provided under the operation. Through a community-centred and inclusive approach, the operation will seek to reach the populations most exposed to cholera transmission while strengthening community resilience and preparedness against further spread of the disease.

Explain the selection criteria for the targeted population

The selection of target populations is based on an analysis of cholera-related epidemiological risks, vulnerability levels, and exposure patterns within the Karal Health District. Beneficiaries have been identified according to their likelihood of contracting the disease, their limited access to essential Water, Sanitation and Hygiene (WASH) services, and their reduced capacity to cope with the consequences of the outbreak.

Priority will be given to households living in areas that have already reported cholera cases, particularly within the four affected areas of responsibility: Karal 1, Karal 2, Baltram, and Alkouk, where transmission remains active and humanitarian needs are most acute. Communities with inadequate access to safe drinking water, limited sanitation infrastructure, and poor hygiene practices will be specifically targeted in order to address the key drivers of cholera transmission.

The operation will also target populations living in high-risk areas that have not yet reported any cases of cholera. These areas include the responsibility zones of Boutalgourous, Sidje, Gredaya, Nouar, Dandi, Miterine, and Guitté, as well as the responsibility zones of Ndjamena where alerts have been issued.

Strengthening preventive measures, community awareness, and early warning and surveillance systems in these locations will contribute to limiting the geographical spread of the outbreak and improving community preparedness. This preventive approach aims to detect and respond to emerging cases before widespread transmission occurs.
Particular attention will be given to the most vulnerable groups, including children under five years of age and adolescents who are particularly susceptible to diarrhoeal diseases; pregnant and lactating women; older persons; persons living with disabilities or chronic illnesses; poor households with limited access to healthcare, safe water, and sanitation services; as well as internally displaced persons (IDPs), mobile populations, migrants, and communities living near transit routes or in areas characterized by high population mobility. These groups often face heightened exposure to health risks and additional barriers to accessing essential services.

To ensure equitable access to assistance, Red Cross volunteers will implement community-based targeting mechanisms in close

collaboration with local authorities, community leaders, and health structures. Awareness-raising activities, community-based surveillance, WASH kit distributions, and referral mechanisms will be adapted to address the specific needs of vulnerable groups and promote their active participation in prevention and response activities. This approach will enable resources to be directed towards the populations most at risk while ensuring equity, inclusion, accountability, and the overall effectiveness of the humanitarian response.

Total Targeted Population

Women	62,274	Rural	-
Girls (under 18)	-	Urban	0%
Men	62,026	People with disabilities (estimated)	-
Boys (under 18)	-		
Total targeted population	124,300		

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
Rapid spread of the outbreak to neighbouring districts (Bol, Mani and other areas of Hadjer-Lamis Province, as well as the capital city, N'Djamena)	Strengthen community-based epidemiological surveillance, active case finding, risk communication and awareness-raising activities in high-risk areas and enhance coordination with neighbouring districts to ensure early detection and rapid response to new cases.
Increased mortality due to delayed healthcare-seeking behaviour.	Intensify Risk Communication and Community Engagement (RCCE) activities, promote early referral of suspected cases, and establish community Oral Rehydration Points (ORPs) to facilitate

	timely access to treatment and reduce the risk of severe dehydration and death.
Insufficient health facility capacity in the event of a major outbreak escalation.	Pre-position health supplies, including WHO peripheral cholera kits, train volunteers, support the expansion of community-based case management capacities, and strengthen referral mechanisms for suspected and severe cases.
Limited access to safe drinking water, non-functional water points, inadequate sanitation coverage, and persistent open defecation.	Scale up water chlorination activities, rehabilitate damaged and non-functional water points, promote hygiene practices, and implement community sanitation and environmental clean-up campaigns to reduce the risk of cholera transmission.
Security and operational access constraints.	Maintain regular security monitoring, coordinate field movements with local authorities, and adapt operational planning and deployment strategies according to access conditions and the evolving context.

Please indicate any security and safety concerns for this operation:

No major security incidents have been reported in the intervention area. However, the operation may be affected by limited access to some rural and island communities in the Karal Health District, logistical constraints, and high population mobility, which also increases the risk of disease spread.

The main risks include the exposure of volunteers and staff to cholera during field activities, as well as risks associated with frequent travel, long distances, and challenging environmental conditions. Mistrust and rumours related to the disease may also affect community acceptance of response activities in some areas.

To mitigate these risks, the Chad Red Cross will apply its existing security procedures, conduct security briefings before deployments, provide appropriate personal protective equipment (PPE) to volunteers and staff, and maintain close coordination with local authorities to monitor the security and public health situation throughout the operation.

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

Planned Intervention

Health

Budget: CHF 83,765
Targeted Persons: 124,300

Indicators

Title	Target
# of functional Oral Rehydration Points (ORPs)	8
# of volunteers trained in cholera case management	64
# of ORPs supplied with essential commodities	8

# of investigations conducted (reported alerts)	500
# of volunteers trained in Community-Based Surveillance (CBS)	218
% of CBS volunteers reporting on time (target 100%)	100
% of alerts investigated within 48 hours (≥ 90%)	90
# of catchment areas covered by surveillance activities	4
# of sprayers distributed	20
Percentage of true alerts reported within 24 hours (90%)	90

Priority Actions

• Establishment and operationalization of eight Oral Rehydration Points (ORPs).
• Provision of ORPs with ORS and infection prevention and control supplies.
• Training and deployment of volunteers on community-based cholera case management.
• Strengthening community-based surveillance and early case detection.
• Support to community alert reporting and notification systems.
• Supervision and monitoring of volunteer activities.
• Distribution of operational equipment to volunteers and supervisors.
• Production of visibility and community engagement materials.

Water, Sanitation And Hygiene

Budget: CHF 97,221
Targeted Persons: 25,000

Indicators

Title	Target
# of water points regularly treated	50
# of people benefiting from improved access to water	25,000
# of households receiving WASH kits	2,870
# of handwashing facilities installed	16
# of people reached with hygiene promotion and awareness activities	25,000
# of latrines constructed	16
# of waste bins installed	10
# of sanitation campaigns conducted	8

Priority Actions

• Distribution of WASH kits to affected households.
• Organization of community clean-up and sanitation campaigns.
• Construction of emergency community latrines.
•Training and deployment of community volunteers on the CATI approach.
• Installation of handwashing facilities at latrine sites and other strategic locations.
• Chlorination and treatment of public water sources.
• Disinfection of high-risk areas and community sites.
• Provision of Personal Protective Equipment (PPE) for WASH and sanitation teams.
• Provision of disinfection materials and equipment.
• Strengthening community solid waste management.
• Provision of sanitation tools and equipment for community clean-up activities.
• Distribution of household water collection, storage, and treatment containers.
• Support to environmental sanitation and infection prevention and control (IPC) activities in affected communities.•

Protection, Gender And Inclusion

Budget: CHF 11,968
Targeted Persons: 25,000

Indicators

Title	Target
# of volunteers trained on Protection, Gender and Inclusion (PGI)	218
% of complaints/feedback addressed and resolved (≥ 90%)	90
# of people reached with Protection, Gender and Inclusion (PGI) activities of people reached with Protection, Gender and Inclusion (PGI) activities	25,000

Priority Actions

• Briefing of volunteers and supervisors on Protection, Gender and Inclusion (PGI) and Prevention of Sexual Exploitation and Abuse (PSEA).
• Strengthening the integration of PGI and PSEA principles across all community-based response activities.
• Production and dissemination of PGI and PSEA information, education and communication (IEC) materials.
• Dissemination and promotion of the Code of Conduct among volunteers and supervisors.
• Strengthening community awareness on protection risks, gender-sensitive approaches, and prevention of sexual exploitation and abuse.

Community Engagement And Accountability

Budget: CHF 11,638
Targeted Persons: 124,300

Indicators

Title	Target

# of volunteers trained and deployed	218
# of people reached through awareness-raising activities	124,300
# of volunteers provided with flipchart communication kits (image boxes)	218
% of community members who know how to provide feedback on the operation	80
% of community feedback responded to and/or acted upon.	100
# of community engagement and participation meetings conducted.	12
# of community feedback collected and documented during the operation	450

Priority Actions

• Establishment and support of a community feedback and complaints mechanism across the four targeted areas.
• Training of community group members on cholera prevention, early case detection, and key water, sanitation and hygiene (WASH) practices.
• Strengthening community engagement and accountability through community-led awareness and risk communication activities.
• Production and dissemination of Information, Education and Communication (IEC) materials on cholera prevention and response.
• Provision of communication tools and materials to volunteers for community outreach activities.
• Development and distribution of flipcharts and visual aids for community sensitization on cholera case definition, early detection, referral, and prevention measures.
• Promotion of community participation and behavior change related to cholera prevention, hygiene, and safe water practices.
• Support for risk communication and community engagement (RCCE) activities in affected communities.

Coordination And Partnerships

Budget: CHF 0
Targeted Persons: 231

Indicators

Title	Target
# of activity coordination meetings organized (1 per week)	12
# of supervision/monitoring missions conducted	3
# of Situation Reports (SitReps) produced	12
# of workshops organized	1

Priority Actions

• Organization of coordination meetings.
• Organization of supervision missions.
• Preparation and dissemination of Situation Reports (SitReps).
• Organization of a lessons learned workshop.

Secretariat Services

Budget: CHF 70,467
Targeted Persons: 235

Indicators

Title	Target
monitoring mission	4
# volunteers insured	218
# SURGE deployed for PHIE for 2 months	2

Priority Actions

• Deployment of two Surge personnel (PHIE and Operations) to support coordination and overall response management.
• Operational and administrative support to ensure effective implementation of response activities.
• Provision of logistics support, including vehicles, fuel, and maintenance for field operations.
• Conducting field monitoring and supervision missions in collaboration with IFRC.
• Organization of a lessons learned workshop to capture best practices and recommendations.
• Strengthening communication and visibility activities throughout the operation.

National Society Strengthening

Budget: CHF 99,941
Targeted Persons: 235

Indicators

Title	Target
# Of technical and strategic monitoring	8
#LESSON LEARNT workshop organised and documented	1
#volunteers and staff with duty of care	230

Priority Actions

• Establishment and management of the operation coordination structure, including the deployment of an Incident Manager, Health Focal Point, WASH Focal Point, PMER Officer and Finance Assistant.
• Strengthening branch and volunteer operational capacities through the recruitment, training and deployment of 200 community volunteers for cholera response activities.
• Enhancement of monitoring, supervision and accountability systems through regular field supervision missions, PMER support and production of operational reports.
• Strengthening field coordination and support to the Hadjer-Lamis branch and local committees to improve community-level implementation and response management.

• Organisation and Documentation of lessons learned and institutional knowledge management. With Lesson learnt workshop.
• Volunteers Insurance.

About Support Services

How many staff and volunteers will be involved in this operation. Briefly describe their role.

In the framework of this operation, the Chad Red Cross will mobilize 214 volunteers and 4 supervisors to implement community-based cholera response activities. The intervention will primarily follow the Case Area Targeted Intervention (CATI) approach, a targeted strategy implemented around confirmed or suspected cholera cases to rapidly interrupt transmission at the community level.

The CATI approach consists of deploying rapid response teams to the households of identified cases and surrounding at-risk households within 24 to 72 hours of case notification. Interventions will include integrated Risk Communication and Community Engagement (RCCE) activities, community-based surveillance, active case finding, referral of suspected cases to healthcare facilities, as well as Water, Sanitation and Hygiene (WASH) activities, targeted household and environmental disinfection, and the promotion of key cholera prevention practices.

To implement this approach, 150 community volunteers, supervised by 4 supervisors, will be deployed in affected and high-risk areas. They will conduct household visits, community awareness sessions, early detection and referral of suspected cases, as well as WASH and disinfection activities around identified cases.

In addition, 64 volunteers previously trained in the use of the eight Oral Rehydration Point (ORP) kits will be deployed to operate Oral Rehydration Points in the most affected areas. These volunteers will contribute to the early management of acute watery diarrhoea cases, raise community awareness on danger signs, and ensure the timely referral of patients requiring further treatment to Cholera Treatment Centres (CTCs) or Cholera Treatment Units (CTUs).

This combination of targeted community interventions and early case management will strengthen rapid case detection, reduce the risk of transmission within communities, and improve access to essential cholera prevention and response services.

Does your volunteer team reflect the gender, age, and cultural diversity of the people you're helping? What gaps exist in your volunteer team's gender, age, or cultural diversity, and how are you addressing them to ensure inclusive and appropriate support?

The Chad Red Cross volunteer network broadly reflects the cultural and linguistic diversity of the communities targeted by the operation, as many volunteers originate from the affected areas and are familiar with local customs and languages. To strengthen inclusiveness, the operation will promote the participation of both female and male volunteers, with particular attention to increasing the involvement of women in community outreach, awareness raising, surveillance, and referral activities. Volunteers will be trained on community engagement, gender and inclusion, and protection principles to ensure that the specific needs of women, children, older persons, persons with disabilities, internally displaced persons, and other vulnerable groups are adequately considered. Community leaders and local stakeholders will also be engaged to ensure that the response remains culturally appropriate, inclusive, and accessible to all affected populations.

Will surge personnel be deployed? If yes, please provide the role profile needed.

Yes
To strengthen operational coordination and ensure the effective implementation of the response, the IFRC will mobilize for two months two surge resources: a Public Health in Emergencies (PHiE) specialist and an operations Manager. These deployments will support the overall coordination of the DREF operation, including operational planning, monitoring, management, and reporting. The surge

personnel will work closely with the Chad Red Cross, health authorities, and operational partners to ensure that interventions are aligned with the national cholera response strategy, strengthen coordination mechanisms, and ensure consistency across all response pillars.

In addition, through funding provided under the Population Movement Emergency Appeal supported by the United Arab Emirates, the Norwegian Red Cross plans to deploy a Water, Sanitation and Hygiene (WASH) surge specialist to provide technical support for the design, implementation, monitoring, and evaluation of WASH interventions. This resource could be mobilized in support of activities under this DREF operation, particularly to strengthen the National Society's capacity to improve access to safe water, reinforce sanitation infrastructure, promote good hygiene practices, and implement Infection Prevention and Control (IPC) measures. The specialist will also contribute to strengthening community-based cholera prevention and control activities in both affected areas and locations identified as being at high risk.

If there is procurement, will it be done by National Society or IFRC?

Procurement activities under this operation will be primarily carried out by the Chad Red Cross, with technical support and oversight from the IFRC, in accordance with the Movement's procurement procedures and regulations.

The majority of procurement will be conducted through local suppliers in order to ensure the timely availability of response items and to support local markets. The items to be procured include WASH kits, water treatment products, personal protective equipment (PPE), disinfection supplies and equipment, community-based surveillance materials, and communication and awareness-raising tools.

However, for specialized equipment or when the required items are not available on the local market in adequate quantities or at the required quality standards, IFRC support may be requested to facilitate procurement through regional or international suppliers, in line with applicable procurement procedures and regulations.

How will this operation be monitored?

The operation will be monitored through regular field supervision visits, activity reports, community feedback mechanisms, and the systematic collection of data by Chad Red Cross staff and volunteers. Monitoring will be coordinated by the Chad Red Cross Headquarters, with support from the Hadjer-Lamis branch and the Planning, Monitoring, Evaluation and Reporting (PMER) team.

Under this operation, four IFRC supervision missions, four Chad Red Cross supervision missions, and two joint monitoring and supervision missions involving the Chad Red Cross and the Ministry of Public Health and Prevention are planned. These missions will assess the progress of activities, verify the results achieved, identify operational challenges, and recommend corrective measures where necessary to improve the effectiveness and impact of the response.

The quality assurance of the operation will be ensured through all of these monitoring and supervision missions. The PMER Officer of the Chad Red Cross, recruited under this operation, will be responsible for the collection, consolidation, analysis, and management of monitoring data from all intervention areas. The PMER Officer will also ensure data quality, support the regular production of monitoring reports, and document results, best practices, and lessons learned throughout the operation.

Please briefly explain the National Societies communication strategy for this operation

The Chad Red Cross will ensure regular communication throughout the operation to support response coordination, accountability to affected populations, and community awareness. Internal communication will be maintained through regular coordination meetings, activity reports, and situation reports, ensuring continuous information sharing between the National Headquarters, the Hadjer-Lamis Branch, volunteers, and operational teams.

External communication will be primarily implemented through Risk Communication and Community Engagement (RCCE) activities. Volunteers will disseminate cholera prevention messages through household visits, community dialogues, local radio broadcasts, and mass awareness sessions. Community feedback mechanisms will also be established to collect concerns, rumours, and suggestions from affected communities and ensure that interventions are adapted accordingly.

The Chad Red Cross will document key achievements of the operation through reports, beneficiary testimonies, photographs, and success stories, while respecting humanitarian principles and data protection requirements.

The IFRC will provide technical support on communication and visibility, including the development of operational updates, documentation of results, and promotion of lessons learned and good practices to strengthen the visibility, transparency, and accountability of the response.

Budget Overview

IFRC

DREF OPERATION

MDRTD026 - Croix-Rouge du Tchad
Cholera outbreak - 2026

Operating Budget

Planned Operations	**204,592**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	0
Health	83,765
Water, Sanitation & Hygiene	97,221
Protection, Gender and Inclusion	11,968
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	11,638
Environmental Sustainability	0
Enabling Approaches	**170,408**
Coordination and Partnerships	0
Secretariat Services	70,467
National Society Strengthening	99,941
TOTAL BUDGET	**375,000**

all amounts in Swiss Francs (CHF)

Internal 7/24/2026 #V2022.01

Click here to download the budget file

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