DREF Operation

Nigeria: cholera outbreak

NRCS Volunteers during house-to-house RCCE Activity

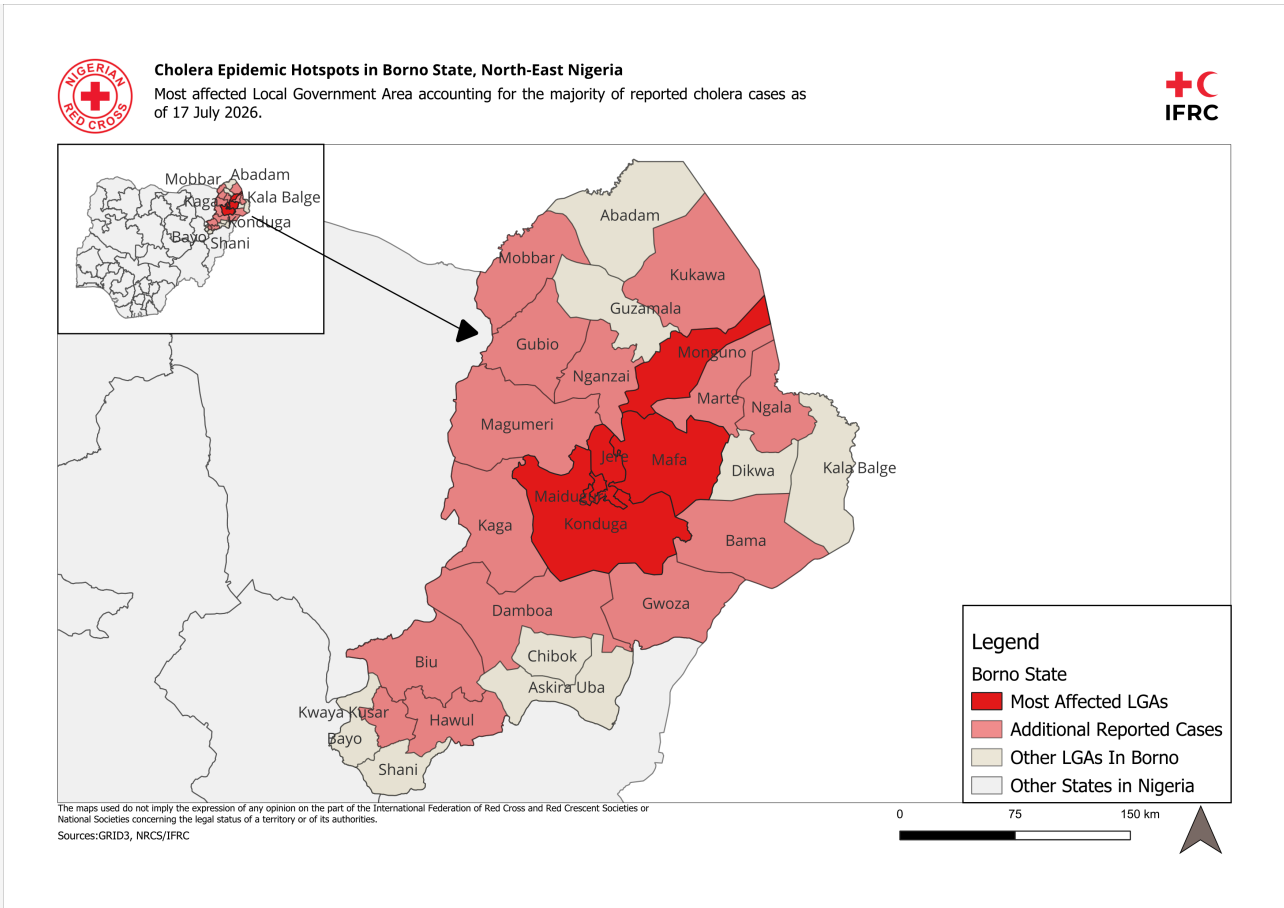
Appeal: **MDRNG046**	Hazard: **Epidemic**	Country: **Nigeria**	Type of DREF: **Response**
Crisis Category: Yellow	Event Onset: **Slow**	DREF Allocation: **CHF 374,988**	
Glide Number: -	People Affected: **2,151,990 people**	People Targeted: **1,000,000 people**	
Operation Start Date: **31-07-2026**	Operation Timeframe: **5 months**	Operation End Date: **31-12-2026**	DREF Published: **05-08-2026**

Targeted Regions: **Borno**

Description of the Event

Date when the trigger was met

15-07-2026



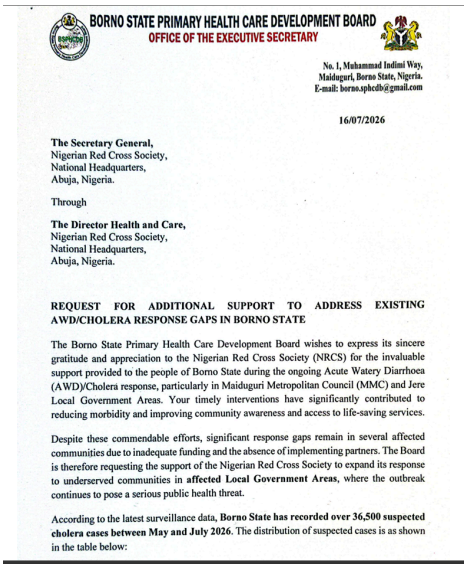
What happened, where and when?

The Nigeria Centre for Disease Control and Prevention (NCDC) and the Borno State Ministry of Health have been responding to the outbreak since the first cases were reported on 1 May 2026. The outbreak escalated rapidly from Epidemiological Weeks 21–22, with cases increasing significantly during the onset of the rainy season. By Epidemiological Week 29, national cumulative suspected cases had increased to 44,129, with Borno State remaining the epicentre of the outbreak with more than 97 per cent of all reported cases and more than 99 per cent of weekly reported cases. 20 LGAs affected out of 27 withing the state.

The Nigeria Centre for Disease Control and Prevention (NCDC), the Borno State Ministry of Health and humanitarian actors like Nigeria Red Cross have been responding to this outbreak in Borno since May 2026, but significant response gaps remain in several affected communities due to limited funding and insufficient partner presence. With the trend of the outbreak just at the onset of the worst transmission period, there is an urge to scale-up interventions.

On 15 July 2026, acknowledging the support from NRCS in Maiduguri and Jere LGAs, the Borno State Primary Health Care Development Board formally requested the NRCS to sustain and expand its response to underserved cholera-affected LGAs through strengthened Risk Communication and Community Engagement (RCCE), Oral Rehydration Point (ORP) services, active case finding, referral mechanisms, hygiene promotion and community-based surveillance.

The outbreak remains ongoing, with NCDC reporting increasing trends in key hotspot LGAs, particularly Monguno and Kukawa. Sustained and scaled-up interventions are therefore required to reduce transmission, improve early treatment- health seeking behaviour, prevent cholera-related morbidity and mortalities and support the government's efforts to contain the outbreak before the peak of the rainy season.



BORNO STATE PRIMARY HEALTH CARE DEVELOPMENT BOARD
OFFICE OF THE EXECUTIVE SECRETARY

No. 1, Muhammad Indimi Way,
Maiduguri, Borno State, Nigeria.
E-mail: borno.sphcdb@gmail.com

16/07/2026

The Secretary General,
Nigerian Red Cross Society,
National Headquarters,
Abuja, Nigeria.

Through

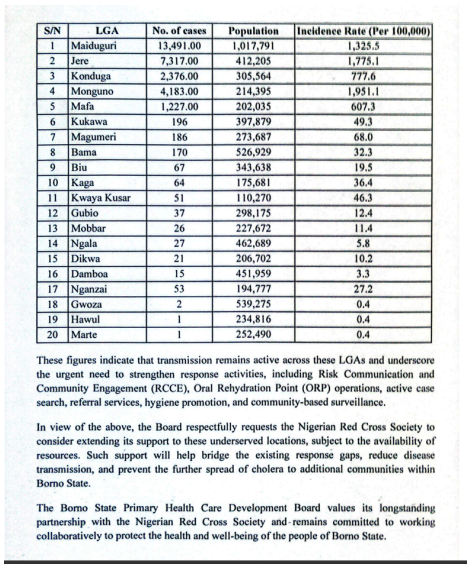
The Director Health and Care,
Nigerian Red Cross Society,
National Headquarters,
Abuja, Nigeria.

REQUEST FOR ADDITIONAL SUPPORT TO ADDRESS EXISTING AWD/CHOLERA RESPONSE GAPS IN BORNO STATE

The Borno State Primary Health Care Development Board wishes to express its sincere gratitude and appreciation to the Nigerian Red Cross Society (NRCS) for the invaluable support provided to the people of Borno State during the ongoing Acute Watery Diarrhoea (AWD)/Cholera response, particularly in Maiduguri Metropolitan Council (MMC) and Jere Local Government Areas. Your timely interventions have significantly contributed to reducing morbidity and improving community awareness and access to life-saving services.

Despite these commendable efforts, significant response gaps remain in several affected communities due to inadequate funding and the absence of implementing partners. The Board is therefore requesting the support of the Nigerian Red Cross Society to expand its response to underserved communities in **affected Local Government Areas**, where the outbreak continues to pose a serious public health threat.

According to the latest surveillance data, **Borno State has recorded over 36,500 suspected cholera cases between May and July 2026.** The distribution of suspected cases is as shown in the table below:

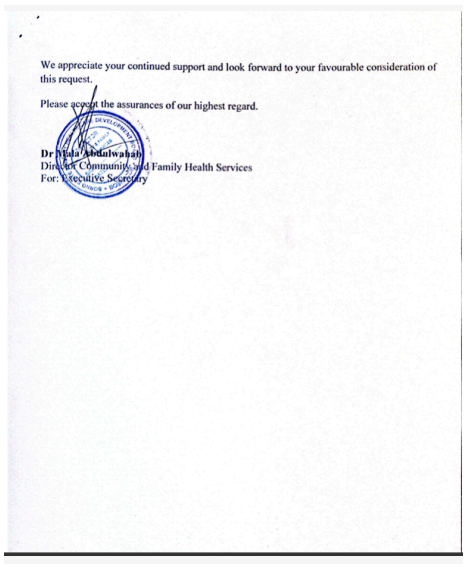


S/N	LGA	No. of cases	Population	Incidence Rate (Per 100,000)
1	Maiduguri	13,491.00	1,017,791	1,325.5
2	Jere	7,317.00	412,205	1,775.1
3	Konduga	2,376.00	305,564	777.6
4	Monguno	4,183.00	214,395	1,951.1
5	Mafa	1,227.00	202,035	607.3
6	Kukawa	196	397,879	49.3
7	Magumeri	186	273,687	68.0
8	Bama	170	526,929	32.3
9	Biu	67	343,638	19.5
10	Kaga	64	175,681	36.4
11	Kwaya Kusar	51	110,270	46.3
12	Gubio	37	298,175	12.4
13	Mobbar	26	227,672	11.4
14	Ngala	27	462,689	5.8
15	Dikwa	21	206,702	10.2
16	Damboa	15	451,959	3.3
17	Nganzai	53	194,777	27.2
18	Gwoza	2	539,275	0.4
19	Hawul	1	234,816	0.4
20	Marte	1	252,490	0.4

These figures indicate that transmission remains active across these LGAs and underscore the urgent need to strengthen response activities, including Risk Communication and Community Engagement (RCCE), Oral Rehydration Point (ORP) operations, active case search, referral services, hygiene promotion, and community-based surveillance.

In view of the above, the Board respectfully requests the Nigerian Red Cross Society to consider extending its support to these underserved locations, subject to the availability of resources. Such support will help bridge the existing response gaps, reduce disease transmission, and prevent the further spread of cholera to additional communities within Borno State.

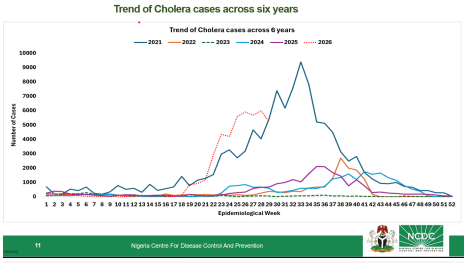
The Borno State Primary Health Care Development Board values its longstanding partnership with the Nigerian Red Cross Society and remains committed to working collaboratively to protect the health and well-being of the people of Borno State.



We appreciate your continued support and look forward to your favourable consideration of this request.

Please accept the assurances of our highest regard.

Dr Bala Abdulwahab
Director, Community and Family Health Services
For: Executive Secretary



Cholera historic trend analysis for the past 6 years as modelled by the NCDC.

Scope and Scale

The cholera outbreak in Borno State has rapidly evolved into the largest outbreak currently reported in Nigeria and represents an exceptional public health emergency that significantly exceeds normal seasonal patterns of recent years and local response capacity. Since the outbreak began escalating in late May 2026, transmission has increased rapidly and, as of Epidemiological Week 28 (17 July 2026), Nigeria had reported more than 37,000 suspected cholera cases and over 600 deaths nationally, with Borno State accounting for more than 97 per cent of all reported cases nationwide and majority of reported deaths.

- During Epidemiological Week 28 alone, Nigeria recorded 4,920 suspected cases and 73 deaths, of which more than 99 per cent of the weekly caseload originated from Borno State, highlighting the state's role as the epicentre of the national outbreak.
- As of Week 29, Nigeria has reported 44,129 suspected cholera cases nationally, including 5,257 new suspected cases during the reporting week. Borno State remains the epicentre of the outbreak, accounting for approximately 99% of the weekly national caseload and more than 35,000 suspected cases cumulatively. The outbreak is affecting multiple Local Government Areas (LGAs) across Borno State in north-eastern Nigeria. The most affected LGAs are Maiduguri Metropolitan Council (MMC), Jere, Monguno, Konduga and Mafa, which together account for approximately 92 per cent of all reported cases in the state. Additional transmission has been reported in Kukawa, Magumeri, Bama, Biu, Kaga, Kwaya Kusar, Gubio, Mobbar, Ngala, Dikwa, Damboa, Nganzai, Gwoza, Hawul and Marte LGAs. Maiduguri Metropolitan Council (MMC), Jere, Monguno, Konduga, and Mafa LGAs accounting for 92% of Borno caseload.

Compared to the same period in 2025 and recent years, suspected cases in Borno increased by 1,052 per cent, while reported deaths increased by 186 per cent, demonstrating a substantial departure from normal seasonal trends and confirming the exceptional scale and severity of the event. The outbreak poses a significant public health threat to an estimated 2.15 million people residing in these five LGAs and continues to show increasing transmission trends in key hotspot areas with pockets of controlled incidence recorded in few other states.

Although the most recent surveillance data indicate a modest decline in weekly reported cases, the 2026 curve remains way above average. The last week trend should also be interpreted with caution. The reduction is likely influenced by the recent OCV campaign which the Borno state government scaled up in Maiduguri Metropolitan Council and Jere - two LGAs among the five outbreak hotspots and occurs at a time when the annual cholera season is only beginning. Historically, cholera incidence in Borno State peaks later in the rainy season, typically between September and December. Unlike previous years, the current outbreak surged unusually early, with transmission already reaching unprecedented levels before the onset of the peak risk period. Given the forecasted increase in rainfall, heightened flood risk, persistent WASH vulnerabilities, and continued population movements, there is a substantial risk that case

numbers will rise again in the coming months, following patterns observed in previous epidemic curves. This suggests that the outbreak remains far from under control and that sustained response efforts are required to prevent further escalation.

The outbreak is being driven by a combination of structural and seasonal risk factors, including limited access to safe water, inadequate sanitation and hygiene infrastructure, overcrowding in urban and displacement-affected communities, population movements, and seasonal flooding. Borno State is recognized as one of Nigeria's flood-prone states, and the anticipated increase in flooding during the coming months is expected to further contaminate water sources, damage sanitation facilities, and accelerate the spread of cholera within and beyond currently affected LGAs. There is a significant risk that transmission could expand to additional LGAs and neighbouring states if prevention and response efforts are not rapidly scaled up.

The outbreak is further exacerbated by Borno's complex humanitarian context. Years of conflict, insecurity, and prolonged population displacement have weakened already fragile health, water, and sanitation systems, leaving large numbers of internally displaced persons (IDPs), returnees, and host communities dependent on inadequate public services. Many affected populations continue to live in overcrowded settlements with limited access to safe water, sanitation facilities, and healthcare services, creating ideal conditions for sustained cholera transmission and complicating outbreak control efforts, particularly in hard-to-reach and underserved areas. Population movements between LGAs, returnee flows, and interaction between displaced and host communities continue to increase the risk of further spread.

Based on previous outbreak patterns and current epidemiological trends, there is a high likelihood of continued transmission and the emergence of new hotspots unless community-level prevention and surveillance activities are urgently expanded. The most vulnerable populations include children under five years of age, school-aged children, pregnant and lactating women, older persons, persons with disabilities, internally displaced persons, and households living in overcrowded communities with poor access to water, sanitation, and healthcare services. National surveillance data indicate that children aged 5–14 years account for the highest proportion of reported cases, while women represent 51 per cent of recorded infections. These groups face heightened risks of severe disease outcomes, limited access to care, and significant socioeconomic impacts associated with illness and caregiving responsibilities.

The outbreak is also placing increasing pressure on already overstretched health services and response resources. At the same time, critical partner-supported interventions that have sustained community-level cholera response efforts are ending, with Norwegian Red Cross support concluding on 30 June 2026 and ICRC-supported activities ending on 21 July 2026. This creates a significant operational gap in community-based surveillance, Risk Communication and Community Engagement (RCCE), Oral Rehydration Point (ORP) services, active case finding, and hygiene promotion at a time when transmission remains active and the highest-risk season is only beginning. Without immediate additional resources, existing gains in outbreak control may be reversed, resulting in increased morbidity, mortality, and geographic spread.

In response, the Nigerian Red Cross Society (NRCS) will support the government-led response in the five most affected LGAs—Maiduguri, Jere, Monguno, Konduga, and Mafa—covering an estimated population of 2,151,990 people. The operation will focus on scaling up community-based surveillance, active case finding and referral, ORP services, Risk Communication and Community Engagement (RCCE), hygiene promotion, Case Area Targeted Interventions (CATI), and other public health measures aimed at reducing cholera-related morbidity and mortality, interrupting transmission, and preventing further geographical spread of the outbreak.

Source Name	Source Link
1. Cholera Source Information - NCDC surveillance report, Borno State Primary Health Care Development Board Request to NRCS for Support, Six years trend analysis.	https://ifrcorg-my.sharepoint.com/:f:/g/personal/sandra_zi_ifrc_org/IgCUsbQRMnVeRrdycHeZ8I5oAaw1s-MDixK6D_byaB5AE80?e=xDFHhy
2. Nigeria: Health Sector Cholera Outbreak Situation Report, Borno State	https://reliefweb.int/report/nigeria/nigeria-health-sector-cholera-outbreak-situation-report-borno-state-no-09-19-june-2026
3. Nigeria Cholera Outbreak: Situation Report	https://reliefweb.int/report/nigeria/nigeria-cholera-outbreak-situation-report-3-july-6-2026

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	**Yes**
Did it affect the same population group?	**Yes**
Did the National Society respond?	**Yes**
Did the National Society request funding form DREF for that event(s)	**No**
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:

Following previous interventions and the NRCS response actions:
1. House-to-house RCCE and active case finding improved early detection and referral of suspected cholera cases, highlighting the need for early deployment of trained community volunteers in outbreak hotspots.
2. Community misconceptions and delayed reporting of suspected cases reduced the effectiveness of early response efforts, highlighting the need for continuous community engagement and community feedback mechanisms.
3. Shortages of ORS, hygiene promotion materials and WASH supplies created operational delays in some communities, highlighting the importance of pre-positioning essential cholera response supplies and maintaining contingency stocks before peak transmission periods.
As a result, the NRCS team will strengthen house-to-house sensitization, contact tracing, active case finding and referrals. Issues of community misconceptions will be averted more deliberately through active engagement with community gatekeepers and minority groups while resources secured through this DREF would enhance optimum scale up of response interventions in affected/at-risk communities (ORPs, WASH supplies, capacity strengthening of Community based volunteers and teams, etc).

Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	**Yes**
What was the risk level for Child Safeguarding Risk Analysis?:	**Medium (3)**

Current National Society Actions

Start date of National Society actions

20-04-2026

Health	The Nigerian Red Cross Society (NRCS) has been actively supporting the cholera outbreak response in Borno State since before the outbreak escalated in May 2026. Through support from the Norwegian Red Cross and ICRC, NRCS has implemented community-based interventions in affected LGAs, particularly Maiduguri Metropolitan Council (MMC) and Jere, including Risk Communication and Community Engagement (RCCE), active case finding, community-based surveillance (CBS), operation of Oral

	Rehydration Points (ORPs), referral of suspected cholera cases, hygiene promotion, chlorination and disinfection activities, and volunteer deployment. NRCS volunteers have conducted house-to-house awareness campaigns, community dialogues, rumor management, and dissemination of cholera prevention messages to improve early health-seeking behaviour and promote the adoption of preventive practices. Through community-based surveillance and ORP services, volunteers have supported early identification, referral, and first-line management of suspected cholera cases while strengthening links between affected communities and government health services. The National Society continues to work closely with the Nigeria Centre for Disease Control and Prevention (NCDC), the Borno State Ministry of Health, and the Borno State Primary Health Care Development Board (BSPHCDB) through existing outbreak coordination mechanisms. NRCS participates in surveillance, RCCE, IPC/WASH, and community response coordination forums to ensure response activities complement government and partner interventions. While specialized Mental Health and Psychosocial Support (MHPSS) services are available through government and humanitarian partners, access remains limited in some underserved and hard-to-reach communities. NRCS volunteers provide basic psychosocial support during community engagement and household visits and refer individuals requiring additional support to available health and social service structures where appropriate. Additionally, the current malnutrition appeal, now in its final phase of implementation, is being implemented in four LGAs of Borno State: Bama, Gwoza, Kaga, and Mobbar. At present, none of these LGAs are among those identified as cholera hotspots affected by the ongoing outbreak. Nevertheless, cholera awareness and prevention messages have been integrated into activities across all appeal locations to strengthen caregivers' knowledge and adoption of preventive practices.
Water, Sanitation And Hygiene	The Nigerian Red Cross Society (NRCS) has been supporting cholera prevention efforts in Borno State through hygiene promotion, household sensitization, chlorination and disinfection activities, and targeted distribution of hygiene kits in affected communities. Through support from the Norwegian Red Cross and ICRC, approximately 400 hygiene kits were distributed to vulnerable households, while an additional 350 hygiene kits were mobilized from National Headquarters stocks to support ongoing response activities. NRCS volunteers have conducted community-based hygiene promotion activities focusing on handwashing, safe water handling, household water treatment, environmental sanitation, and cholera prevention. The National Society continues to coordinate closely with government authorities and WASH partners through existing outbreak coordination mechanisms to support cholera containment efforts.
Protection, Gender And Inclusion	The Nigerian Red Cross Society (NRCS) integrates Protection, Gender and Inclusion (PGI) considerations across its cholera response activities to ensure equitable access to assistance for vulnerable groups, including women, children, older persons, persons with disabilities, internally displaced persons (IDPs), returnees, and female-headed households. Volunteers are promoting inclusive community engagement and targeting vulnerable households through RCCE, community-based surveillance, ORP services, hygiene promotion, and hygiene kit distribution activities. NRCS also promotes safe and dignified assistance through the integration of Community Engagement and Accountability (CEA), Child Safeguarding, and Prevention of Sexual Exploitation and Abuse (PSEA) measures within ongoing response activities. Community feedback mechanisms are being used to identify barriers to access and ensure that vulnerable groups are reached with appropriate information and services.

Coordination	• The Nigerian Red Cross Society (NRCS) actively participates in government-led cholera coordination mechanisms at state and LGA levels, working closely with the Nigeria Centre for Disease Control and Prevention (NCDC), Borno State Ministry of Health, and the Borno State Primary Health Care Development Board (BSPHCDB). NRCS coordinates its interventions through the IPC/WASH-AWD response platform and other technical working groups to ensure complementarity, avoid duplication, and address identified response gaps. • NRCS also collaborates closely with the Country Support Platform (CSP) of the Global Task Force on Cholera Control (GTFCC), contributing to cholera preparedness, response coordination, information sharing, and implementation of priority interventions aligned with national cholera control efforts. Through this engagement, NRCS is able to strengthen coordination and collaboration with key stakeholders in the cholera response space, including government institutions, UN agencies, technical partners, research institutions, and humanitarian organizations involved in cholera prevention and control. • The National Society further maintains close coordination with IFRC, ICRC, Norwegian Red Cross, UNICEF, IOM, and other response partners through regular coordination meetings, surveillance reviews, RCCE forums, and operational planning sessions. These mechanisms facilitate joint planning, identification of underserved communities, information sharing, and efficient use of resources in support of the government-led cholera response.
National Society Readiness	The Nigerian Red Cross Society (NRCS) has established operational capacity in Borno State through its branch and divisional structures, supported by experienced staff and a network of trained community-based volunteers. Previous cholera response interventions supported by the Norwegian Red Cross and ICRC have strengthened volunteer capacity in RCCE, Community-Based Surveillance (CBS), active case finding, Oral Rehydration Point (ORP) operations, hygiene promotion, and outbreak response activities. The National Society maintains coordination mechanisms at branch and national levels and has technical support available through Health, WASH, PMER, Logistics, Finance, Communications, and PGI focal persons. Existing volunteer networks, operational procedures, and coordination arrangements with government authorities and Movement partners enable rapid mobilization and deployment during public health emergencies. In addition, NRCS has access to pre-positioned cholera response supplies, including hygiene kits and other essential materials, and plans to strengthen preparedness further through the replenishment and pre-positioning of additional stocks at branch level to support rapid response to current and future outbreaks.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC secretariate is present in-country and actively supporting the National Society through all its strategic mandates. Currently the IFRC health team is providing all necessary technical guidance and support through this DREF response application. The IFRC is coordinating with movement partners (ICRC, PNS-NorCross and NRCS) on current response and modalities for response scale up opportunities, as well as coordinating with the NRCS on engagements with the UN, partners and government agencies.
Participating National Societies	The Norwegian Red Cross (NorCross) supported the Nigerian Red Cross Society (NRCS) cholera response in Borno State until 30 June 2026, providing financial and technical support for community-based interventions including RCCE, active case finding, ORP

	operations, hygiene promotion, referral of suspected cases, volunteer capacity strengthening, and hygiene kit distribution in MMC and Jere LGAs. The intervention strengthened community awareness, improved early detection and referral of suspected cases, and enhanced community-based surveillance systems. Lessons learned and capacities established through this support continue to inform and strengthen the current NRCS cholera response.

ICRC Actions Related To The Current Event

The International Committee of the Red Cross (ICRC) supported the Nigerian Red Cross Society (NRCS) cholera response in Borno State through the pre-positioning of hygiene kits and essential cholera response supplies, as well as support for volunteer-led response activities. Up to 21 July 2026, ICRC supported the deployment of 46 volunteers for RCCE, active case finding, ORP activities, hygiene promotion, community disinfection, and chlorination activities across affected LGAs. The intervention strengthened community outreach, enhanced cholera prevention efforts, and contributed to improved response coverage in underserved communities. The capacities, supplies, and community networks established through this support continue to inform and strengthen the current NRCS response.

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	The Nigeria Centre for Disease Control and Prevention (NCDC), in collaboration with the Federal Ministry of Health, Borno State Ministry of Health, and the Borno State Primary Health Care Development Board (BSPHCDB), is leading the cholera outbreak response in Borno State. Government authorities have activated and strengthened outbreak coordination mechanisms at state and LGA levels to support surveillance, case management, laboratory testing, risk communication, and community-based response activities. Key actions undertaken by national and state authorities include: • During the first week of June 2026, health authorities and partners launched an Oral Cholera Vaccine (OCV) campaign in MMC and Jere LGAs, two of the main cholera hotspots in Borno State. An additional 2,230,059 OCV doses have been approved for reactive vaccination campaigns in Mafa, Konduga, Monguno, and Kukawa LGAs in Borno State, as well as Jos North and Mangu LGAs in Plateau State. These vaccinations are expected to contribute significantly to outbreak control and transmission reduction, with micro-planning and implementation to be jointly coordinated by government and partners. • Enhanced epidemiological surveillance, outbreak investigation, active case search, contact tracing, and community-based surveillance. • Coordination of Cholera Treatment Units (CTUs), case management, referral systems, and infection prevention and control (IPC) measures in affected LGAs. • Deployment of rapid response teams and technical personnel to support outbreak response and monitoring in hotspot areas. • Strengthening of data management, reporting, and analysis through routine surveillance and epidemiological updates. • Intensified Risk Communication and Community Engagement (RCCE), public awareness campaigns, and hygiene promotion activities aimed at reducing transmission and encouraging early healthcare seeking behaviour. • Mobilization of partners and stakeholders to address identified response gaps

	and expand interventions to underserved cholera-affected communities. • Formal request to the Nigerian Red Cross Society to support and expand community-based interventions, including ORP operations, active case finding, referral services, hygiene promotion, and community surveillance in affected LGAs. The Nigerian Red Cross Society continues to support these government-led efforts in its auxiliary role to public authorities, working closely with health authorities and other partners to strengthen the overall cholera response across affected communities in Borno State.
UN or other actors	The UN agencies such as the UNICEF, IOM are present and supporting the Borno state Government in responding to the outbreak through the State Ministry of Water Recourses, State Environmental Protection Agency, state Primary Health Care Development Agency. • Further to the campaign launched in june by local authorities, additional 2,230,059 OCV doses are expected as reported from Global Vaccine Alliance (GVA) for Nigeria to support a reactive vaccination campaign in Mafa, Konduga, Monguno, and Kukawa LGAs in Borno State, as well as Jos North and Mangu LGAs in Plateau State. These interventions would impact toward positive mitigation and further spread of the cholera outbreak. micro-planning for the vaccination campaign for these doses to be jointly coordinated with partners.

Are there major coordination mechanism in place?

Currently, the IPC/WASH-AWD Response Platform serves as the primary coordination mechanism for the cholera response in Borno, bringing together key government agencies, UN partners, humanitarian organizations, and technical partners. The Nigerian Red Cross Society (NRCS) is an active member of this platform and regularly participates in coordination meetings, information sharing, surveillance reviews, and joint planning processes at state and LGA levels.
NRCS also collaborates closely with the Country Support Platform (CSP) of the Global Task Force on Cholera Control (GTFCC) hosted by IFRC, which provides a valuable forum for engagement with major stakeholders involved in cholera prevention, preparedness, and response in Nigeria. Through the CSP, NRCS contributes to discussions on cholera control priorities, operational coordination, preparedness planning, and implementation of targeted interventions, while strengthening collaboration with government institutions, development partners, UN agencies, research institutions, and other organizations working in the cholera response space.

In addition, NRCS maintains close coordination with NCDC, BSPHCDB, State Ministry of Health, IFRC, ICRC, UNICEF, Norwegian Red Cross, and other partners to identify response gaps, avoid duplication, and ensure resources and interventions are directed to underserved and high-risk communities.

Needs (Gaps) Identified

Health

The cholera outbreak continues to place significant pressure on health services and community-based response systems across Borno State, particularly in Maiduguri, Jere, Monguno, Konduga and Mafa LGAs, which account for the vast majority of reported cases. While government authorities and partners continue to support surveillance and case management activities, important gaps remain in community-based prevention, early detection, referral and outbreak control interventions.

Previous NRCS interventions supported by the Norwegian Red Cross and ICRC demonstrated the effectiveness of volunteer-led RCCE, active case finding, community-based surveillance and ORP services. However, the NorCross-supported intervention ended on 30 June 2026, and the current ICRC-supported intervention ends on 21 July 2026, creating a significant gap in community-level response capacity while transmission remains ongoing especially with the upcoming flooding season.

The Borno State Primary Health Care Development Board has specifically requested NRCS support to expand interventions to underserved LGAs where response coverage remains limited despite continued transmission. Current operational gaps include inadequate numbers of trained volunteers to conduct RCCE, active case finding, community-based surveillance, CATI activities, referral of

suspected cases, ORP operations, community feedback collection and hygiene promotion activities. To maintain the gains achieved through previous interventions and expand coverage to high-burden and underserved communities, there is a need to mobilize and support approximately 350 trained volunteers across the target LGAs.

Additional gaps include limited availability of ORS, chlorine products, disinfection materials, cholera kits, hygiene supplies and IEC materials necessary to support ongoing prevention and response efforts. These shortages constrain the ability to rapidly respond to emerging hotspots and conduct effective community-level outbreak control activities.

Persistent misinformation, poor health-seeking behaviour, delayed reporting of suspected cases and population movement between affected communities continue to contribute to cholera transmission. Strengthening RCCE, community-based surveillance, CATI teams, ORP support and referral mechanisms remain critical to reducing transmission and cholera-related mortality.

Children, older persons, pregnant and lactating women, persons with disabilities, internally displaced persons (IDPs), returnees and households living in overcrowded communities with poor access to safe water and sanitation remain the most vulnerable groups. National surveillance data indicate that children aged 5–14 years account for the highest proportion of reported cases.

Recent surveillance data indicating a modest reduction in weekly 28/29 reported cases, this trend is likely influenced by the recent joint efforts from all partners and government but remain limited. The vaccination remains an essential preventive pillar. The Global Vaccine Alliance (GVA) has reported the approval of an additional 2,230,059 OCV doses for Nigeria to support a reactive vaccination campaign in Mafa, Konduga, Monguno, and Kukawa LGAs in Borno State, as well as Jos North and Mangu LGAs in Plateau State. These interventions would impact toward positive mitigation and further spread of the cholera outbreak. Therefore, subject to the timely arrival of these vaccines in-country and its subsequent distribution to the target states, the need for active social mobilisation and support to the vaccination micro-planning that will be in place will be one of the priorities. Nigerian Red Cross Society (NRCS) Risk Communication and Community Engagement (RCCE) team will actively support the campaign by driving community mobilization and demand creation activities across LGAs within its operational areas, with the aim of maximizing vaccine uptake and contributing to effective cholera outbreak control. Additional resource opportunities would be explored, if possible, to support the campaign if these activity does not fall within the DREF response period.

Water, Sanitation And Hygiene

Limited access to safe water, adequate sanitation facilities, and hygiene services remains one of the key drivers of cholera transmission in Borno State. Many communities, particularly in displacement-affected settlements and underserved areas, continue to rely on unsafe water sources and face inadequate sanitation and hygiene conditions. These vulnerabilities are further exacerbated by the ongoing rainy season, which increases contamination of water sources and creates favorable conditions for the spread of cholera and other waterborne diseases.

While NRCS and its partners have implemented hygiene promotion and household WASH interventions, the scale of support remains significantly below the current needs. Through Norwegian Red Cross support, approximately 400 hygiene kits were distributed to vulnerable households in affected communities, while a further 350 hygiene kits were mobilized from existing stocks at National Headquarters through ICRC support. Despite these efforts, the coverage achieved represents only a small proportion of the affected population in the outbreak hotspots, leaving substantial unmet WASH needs across affected and high-risk LGAs.

The Borno State Primary Health Care Development Board has identified critical gaps in community hygiene promotion, household water treatment, chlorination and disinfection activities, and community-based cholera prevention interventions, particularly in underserved LGAs where there are limited implementing partners despite ongoing transmission. Additional support is required to scale up Case Area Targeted Interventions (CATI), hygiene promotion, water treatment activities, environmental sanitation campaigns, and the distribution of essential WASH supplies to high-risk households and communities.

There is also a need to sustain and expand volunteer-led WASH activities through the mobilization of trained volunteers to conduct household visits, hygiene promotion, chlorination and disinfection activities, community sensitization, and CATI interventions around reported cases. Response efforts continue to be constrained by limited quantities of Aqua tabs, chlorine products, hygiene kits, disinfection materials, and other WASH consumables required to interrupt transmission and contain emerging hotspots.

To strengthen preparedness and response capacity, the operation will support the transportation of an additional 650 hygiene kits from NRCS National Headquarters to Borno State Branch, bringing the total number of mobilized hygiene kits from the National Society's response to 1,000 kits. In addition, the operation will support the procurement of 1,000 hygiene kits for immediate distribution, as well as the pre-positioning of 1,000 hygiene kits at branch level as contingency stock. This will facilitate the rapid deployment of assistance in the event of any increase in cholera cases, particularly following alerts from CATI teams (e.g., reports of suspected cases within clusters of 15–20 households) and other public health emergency response mechanisms. The intervention will reduce response lead times, strengthen

operational preparedness, and enhance NRCS's capacity to provide timely assistance to newly affected communities and neighboring high-risk LGAs.

The most vulnerable populations include internally displaced persons (IDPs), returnees, women-headed households, households with children under five years of age, pregnant and lactating women, persons with disabilities, and communities living in areas with poor access to safe water and sanitation services. Addressing these WASH gaps is critical to reducing transmission, preventing new infections, and supporting ongoing cholera containment efforts across Borno State.

Protection, Gender And Inclusion

The cholera outbreak is affecting populations already facing significant humanitarian vulnerabilities due to prolonged displacement, insecurity, limited access to basic services, and poverty. Internally displaced persons (IDPs), returnees, host communities, women-headed households, children, older persons, pregnant and lactating women, and persons with disabilities are among the groups most affected by the outbreak and the associated public health risks.

The affected communities, particularly those living in overcrowded settlements and displacement-affected areas, continue to face barriers in accessing safe water, sanitation facilities, health services, and timely health information. Long distances to water points, overcrowding, and inadequate sanitation facilities can expose women, girls, children, older persons, and persons with disabilities to increased safety and protection concerns while accessing essential services.

Women and girls often carry the primary responsibility for water collection, household hygiene management, and caring for sick family members, increasing their exposure to cholera infection. The additional caregiving burden can also limit their access to information, livelihoods, and essential services. Children remain particularly vulnerable as national surveillance data indicate that the highest proportion of reported cholera cases are among children aged 5–14 years.

Older persons and persons with disabilities face additional challenges in accessing health information, hygiene materials, ORP services, and referral pathways, particularly in hard-to-reach and overcrowded communities. Mobility limitations and dependence on caregivers may further reduce their ability to access timely assistance and adopt recommended cholera prevention measures.

Community consultations and previous response activities have also highlighted challenges related to misinformation, stigma associated with cholera, and limited access to inclusive health information. These factors may discourage timely reporting of cases and negatively affect care-seeking behaviour, particularly among vulnerable populations.

Additional gaps exist in ensuring that cholera prevention messaging, community feedback mechanisms, and response services are fully accessible and responsive to the needs of women, children, persons with disabilities, older persons, IDPs, and other vulnerable groups. The operation will therefore integrate Protection, Gender and Inclusion (PGI), Community Engagement and Accountability (CEA), Child Safeguarding, and Prevention of Sexual Exploitation and Abuse (PSEA) measures across all interventions to ensure safe, dignified, inclusive, and equitable access to assistance.

Community Engagement And Accountability

The cholera outbreak continues to expose gaps in access to timely, accurate, and trusted health information in affected communities. Previous NRCS interventions demonstrated that community engagement and house-to-house sensitization improved early reporting of suspected cases and adoption of preventive behaviours. However, misinformation, rumours, poor health-seeking behaviour, and misconceptions about cholera transmission and treatment remain prevalent in some communities, contributing to delayed reporting and ongoing transmission.
The end of NorCross-supported activities and the scale-down of existing interventions have created gaps in sustained community engagement, feedback collection, and accountability mechanisms, particularly in underserved LGAs. As a result, many communities have limited opportunities to access reliable information, raise concerns, and participate in decisions affecting the response.

Additional support is needed to strengthen community feedback mechanisms, volunteer capacity on CEA, and the collection and analysis of community feedback to ensure that response activities remain responsive to community needs and concerns. Special attention is required to ensure that vulnerable groups, including IDPs, persons with disabilities, older persons, women-headed households, and hard-to-reach communities, have equitable access to information and opportunities to participate in the response.
Strengthening CEA will improve trust, increase acceptance of response interventions, and support more effective cholera prevention and control efforts across affected communities.

Any identified gaps/limitations in the assessment

Despite ongoing efforts by government authorities and response partners, significant gaps remain in health and WASH interventions across cholera-affected LGAs. Several communities continue to have limited access to community-based surveillance, active case finding, referral services, ORP operations, hygiene promotion, and essential WASH support, increasing the risk of continued transmission.

The assessment identified shortages of trained volunteers, ORS, water treatment products, hygiene kits, disinfectants, and IEC materials needed to support community engagement and cholera prevention activities. Existing resources are insufficient to meet the growing needs across all affected LGAs.

Operational constraints, including limited transport and logistics capacity, continue to affect the timely deployment of volunteers and delivery of supplies to remote and underserved communities. While coordination mechanisms are operational, partner presence remains uneven, resulting in response gaps in several affected LGAs. Particularly vulnerable groups—including internally displaced persons (IDPs), returnees, children, pregnant and lactating women, older persons, persons with disabilities, and households living in overcrowded settlements with poor access to safe water and sanitation—remain at heightened risk and may not be adequately reached by current interventions. Additional resources and multisectoral support are required to expand coverage and address these gaps.

Assessment Report

Operational Strategy

Overall objective of the operation

The operation aims to contribute to reducing cholera-related morbidity and mortality and interrupting the chain of transmission in the five most affected LGAs of Borno State through community-based surveillance, active case finding, referral services, RCCE, hygiene promotion, and WASH interventions. The operation will target approximately 1 million people at risk in Maiduguri, Jere, Monguno, Konduga, and Mafa LGAs over a period of 5 months.

Operation strategy rationale

The operational strategy was developed based on rapid assessments conducted by the Nigerian Red Cross Society (NRCS), epidemiological data from the Nigeria Centre for Disease Control and Prevention (NCDC), requests from the Borno State Primary Health Care Development Board (BSPHCDB), and lessons learned from ongoing cholera response activities in Maiduguri Metropolitan Council (MMC) and Jere LGAs. The strategy is designed to support government efforts to contain the outbreak through community-based prevention, surveillance, Case Area Targeted Interventions (CATI), Oral Rehydration Point (ORP) services, and WASH interventions in the most affected and high-risk locations.
The response seeks to address critical gaps identified during assessments, including inadequate community awareness, poor hygiene practices, shortages of WASH supplies, insufficient volunteer coverage, limited community surveillance, and unequal response coverage across affected LGAs. The strategy focuses on the five most affected LGAs Maiduguri, Jere, Monguno, Konduga, and Mafa—which account for approximately 97 per cent of reported cholera cases, while maintaining the flexibility to support neighboring high-risk LGAs and states should the outbreak expand.

1. Risk Communication and Community Engagement (RCCE)

The operation will prioritize community-based prevention through Risk Communication and Community Engagement (RCCE). Trained Red Cross volunteers will conduct house-to-house visits, community dialogues and feedback, awareness campaigns, and dissemination of cholera prevention messages. Include any messages for the OCV campaign once micro-planning is made.
RCCE efforts will also be reinforced through radio jingles, interactive radio call-in programmes and focused group discussions (FGDs). Key messages will focus on handwashing, safe water handling, food hygiene, environmental sanitation, early recognition of cholera symptoms, prompt healthcare-seeking behaviour, and the benefits of cholera vaccination.
To maximize coverage based on population size, cholera burden, and response gaps, the 350 RCCE volunteers will be deployed across the five target LGAs as follows: 40% in MMC, 20% in Jere, 20% in Monguno, 10% in Konduga, and 10% in Mafa. Final deployment will be validated through coordination with government authorities and partners to address service gaps and avoid duplication within the LGAs. Particular attention will be given to overcrowded settlements, IDP camps, and communities with limited access to safe water and sanitation.

2. OCV Campaign support

Subject to the effective arrival of these vaccines in-country and related micro-planning to take place, Nigerian Red Cross Society (NRCS) Risk Communication and Community Engagement (RCCE) team will actively support the campaign by driving community mobilization and demand creation activities across LGAs within its operational areas, with the aim of maximizing vaccine uptake and contributing to effective cholera outbreak control. IEC materials will be adapted to that priority if within DREF active period and volunteers deployment for social monilisation will be prioritised as part of their daily activities. Depending on the scale of the campaign and the outbreak evolution, the current scope of the DREF could be revised. However, additional resource opportunities would be explored for possible to support the campaign if these activity does not fall within the DREF response period.

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

Given the rapid spread of cholera across multiple LGAs, strengthening community-based surveillance remains a key priority. The operation will deploy 150 CBS volunteers in selected high-risk IDP camps and vulnerable communities within cholera hotspot LGAs that remain at risk of transmission. Volunteers will be strategically concentrated in priority locations identified jointly with government authorities and partners based on vulnerability, population density, and proximity to affected areas.
Each volunteer will be assigned to a fixed catchment area covering 20–40 households and will conduct regular visits to the same households throughout the operation to support the early detection and reporting of suspected cholera cases, deaths, and other public health alerts. Volunteers will support event-based surveillance, active case finding, and timely alert reporting through established surveillance channels, while facilitating referrals to ORPs and health facilities.
The intervention will leverage the technical expertise of the Norwegian Red Cross (NorCross) in Community-Based Surveillance and strengthen community-level early warning systems, enabling rapid detection and response to be emerging cases and helping prevent the spread of cholera among vulnerable populations.

3. Oral Rehydration Point (ORP) Support

NRCS has established experience in ORP management through previous and ongoing cholera responses in Borno State. Building on this capacity, the operation will support the continuation and expansion of ORP services to ensure timely access to life-saving oral rehydration and referral services. The 25 ORPs (21 new and 4 existing) will operate 7 days per week for 8 hours per day and will be strategically located across the five target LGAs based on population size, case burden, identified gaps, and accessibility. Approximately 40% of the ORPs will be located in MMC, 20% in Jere, 20% in Monguno, and 10% each in Konduga and Mafa, with final placement validated through coordination with government authorities and response partners.
The operation will procure supplies (ORP Kits) for 21 new ORPs and replenish consumables for both new and existing ORPs - 25 ORPs. Each ORP will be staffed by four trained volunteers working in pairs on a rotational basis, with one pair covering 3 days per week and the second pair covering 4 days per week to ensure uninterrupted service delivery. ORP locations will be reviewed regularly and adjusted as the epidemiological situation evolves to maximize access to live saving services.
Additionally, one volunteer will be stationed each day at the OPRs to receive and provide feedback as well as a suggestion box at these OPRs to the community members coming to access ORP services. All feedback collected by these volunteers will be consolidated weekly and all relevant stakeholders will be given responses to their concerns.

4. Case Area Targeted Interventions (CATI)

Given the current widespread transmission and full-scale response phase of the outbreak, the operation will focus on strengthening preparedness for future cholera outbreaks for implementing CATI interventions. The operation will support the training and orientation of LGA-level CATI teams on CATI protocols, rapid response procedures, surveillance linkages, and outbreak containment measures. This will strengthen local capacity for the timely activation and implementation of CATI in response to future cholera outbreaks, emerging hotspots, and other public health emergencies. The NRCS will immediately deploy these trained CATI teams to new Cholera hotspots arising from new areas (wards) in the same hotspot areas targeting 5 CATI teams LGA comprising of 6 members per team.

5. WASH Support

Poor access to safe water, sanitation and hygiene services remains one of the main drivers of cholera transmission in Borno State. The operation will therefore support targeted WASH interventions aimed at reducing community exposure to contaminated water sources and promoting improved hygiene behaviours.
Activities will include hygiene promotion, household water treatment education, support for environmental sanitation campaigns, targeted distribution of hygiene materials, and reinforcement of preventive practices through community outreach. The operation will support 2,000 hygiene kits and 1,000 Aquatabs. Of these, 1,000 hygiene kits and 1,000 Aquatabs will be distributed to vulnerable households in cholera-affected communities. The remaining 1,000 hygiene kits to be replenishment of supplies mobilized during early response. Transport will be supported for the deployment of kits in intervention areas.
Regular Free Residual Chlorine test will be conducted across hotspot communities and households to help verify that treated water maintains the required chlorine levels and is within recommended standards. This approach will enhance water safety, reduce the risk of

cholera transmission, and strengthen accountability in water quality management throughout the response.

6. Volunteer Capacity Strengthening

Volunteers are central to the response strategy. The operation will strengthen the capacity of existing volunteers through refresher training and orientation on cholera prevention and control, RCCE, Community-Based Surveillance (CBS), CATI implementation, ORP management, referral mechanisms, community feedback collection, and data reporting.
Strengthening volunteer capacity will improve the quality, consistency, and reach of community-based interventions while ensuring that volunteers remain capable of supporting both current response efforts and future public health emergencies.

7. Coordination and Partnerships

NRCS will continue to work closely with NCDC, BSPHCDB, the Borno State Ministry of Health, Norwegian Red Cross, ICRC, IFRC, UN agencies, and other humanitarian partners through existing government-led coordination structures. This will ensure complementarity of interventions, avoid duplication of efforts, and facilitate effective information sharing.
The operation will complement ongoing government and partner interventions by focusing on identified service gaps, underserved communities, and high-risk transmission areas. Close coordination with health authorities will also ensure that response activities remain aligned with national cholera control strategies and epidemiological priorities.
Through this integrated approach, the operation aims to reduce cholera-related morbidity and mortality, interrupt transmission, strengthen community resilience, and support government-led efforts to contain the outbreak among population at risk in the most affected LGAs of Borno State.

Targeting Strategy

Who will be targeted through this operation?

The operation will target the five LGAs with the highest cholera burden in Borno State: Maiduguri Metropolitan Council (MMC), Jere, Monguno, Konduga, and Mafa, which account for approximately 92 per cent of reported cholera cases in the state. These LGAs have a combined estimated population of 2,151,990 people, the operation aims to target approximately 1 million of the estimated affected population who will be reached through community-based surveillance, different channels of Risk Communication and Community Engagement (RCCE), Oral Rehydration Point (ORP) services, Case Area Targeted Interventions (CATI), hygiene promotion and other cholera prevention activities.
In addition to the primary target LGAs, the operation will maintain flexibility to support high-risk neighboring LGAs and surrounding states through CATI interventions where surveillance data indicate active transmission, emerging hotspots, or elevated risk of spread. This approach recognizes the dynamic nature of cholera outbreaks and the potential for transmission through population movement, trade routes, displacement patterns, and social interactions between affected and neighboring communities.

The outbreak trend shows that cholera transmission affects a broad cross-section of the population. Therefore, community awareness and prevention activities will be designed to reach the wider population in the targeted LGAs. Particular attention will be given to communities living in overcrowded urban settlements, displacement-affected locations, hard-to-reach communities, and areas with poor access to safe water, sanitation and health services, as these conditions increase vulnerability to cholera transmission.

Special consideration will be given to vulnerable groups including children, pregnant and lactating women, older persons, persons with disabilities, internally displaced persons (IDPs), returnees, and female-headed households, particularly during CATI activities and hygiene kit distributions. National surveillance data indicate that children aged 5–14 years account for the highest proportion of reported cases, while women represent a slightly higher proportion of infections, highlighting the importance of targeted community engagement and prevention messaging.
The operation will use epidemiological data from NCDC, State Ministry of Health surveillance reports, community-based surveillance information, and vulnerability assessments conducted by NRCS and health authorities to identify priority communities and populations. Through trained volunteers and existing community structures, the operation will aim to reach vulnerable populations with timely information, referral services, hygiene promotion, and cholera prevention measures, while ensuring that hard-to-reach and underserved communities are not left behind.

Explain the selection criteria for the targeted population

The selection of the target population is based on epidemiological data from the Nigeria Centre for Disease Control and Prevention (NCDC), surveillance reports from the Borno State Ministry of Health and Primary Health Care Development Board, and assessments

conducted by the Nigerian Red Cross Society (NRCS). The operation prioritizes Maiduguri Metropolitan Council (MMC), Jere, Monguno, Konduga and Mafa LGAs, which collectively account for approximately 92 per cent of reported cholera cases in Borno State and are therefore considered the highest-risk areas for ongoing transmission.

The primary criterion for targeting is the risk of cholera transmission and exposure to conditions that facilitate outbreaks, including overcrowding, inadequate access to safe water and sanitation facilities, poor hygiene conditions, population displacement, and limited access to health services. In addition to communities with ongoing outbreaks, the operation will support neighboring high-risk LGAs and, where necessary, neighboring states through Case Area Targeted Interventions (CATI) to rapidly contain emerging hotspots and prevent further spread.
While cholera affects all population groups, particular attention will be given to vulnerable groups who face higher exposure risks and barriers in accessing health and WASH services. These include internally displaced persons (IDPs), returnees, children, pregnant and lactating women, older persons, persons with disabilities, and female-headed households living in overcrowded settlements and communities with poor access to safe water and sanitation. National surveillance data indicate that children aged 5–14 years account for the highest proportion of reported cases, highlighting their increased vulnerability during the current outbreak.

Given the continued risk of transmission across affected and high-risk communities, the operation will adopt a broad community-based approach for awareness, surveillance, and prevention activities while prioritizing the most vulnerable households for hygiene kit distribution and targeted WASH support. This approach will ensure that those most at risk are reached while contributing to wider community protection and outbreak control

Total Targeted Population

Women	**255,000**	Rural	**30%**
Girls (under 18)	**270,000**	Urban	**70%**
Men	**245,000**	People with disabilities (estimated)	**1%**
Boys (under 18)	**230,000**		
Total targeted population	1,000,000		

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
Increased infection through cross boarder movement affecting other at-risk and possibly low risk communities and LGAs apart from the five worse affected LGAs.	Inter-Community coordination and intensification of messages across such areas.
Staff and volunteers' exposure leading to possible infection.	Promote good general and hand hygiene practices as well as use of PPEs provided. Also, staff and volunteers will be briefed on IPC essentials.
Considering Borno has been identified among the hotspot flash flooding states. The Flash flooding and rising rainfall occurrence would likely lead to increased Cholera spread beyond the current intervention resources and NS capacity.	NRCS will ensure continuous interdepartmental coordination with DM department and necessary Government agencies for close monitoring of the situation in floods affected areas and flood prone areas for referrals, sensitization and other mitigation strategies.
Access may be restricted to affected communities/LGAs due to security challenges or other seasonal factors (heavy rains) for areas with poor road network affecting deployment of supplies and other project commodities.	NS to work closely with community informants, local and government security focal points for clearance and access. NS will also ensure engagement of local volunteers to enhance uninterrupted community-based support.
Delayed procurement processes may be experienced, approvals, or supplier lead times.	Initiate procurement early based on preparedness plans, possibly adopt emergency procurement procedures where applicable and pre-position supplies in high-risk areas.

Please indicate any security and safety concerns for this operation:

The operation will be implemented in Borno State, where security challenges remain in some locations and may occasionally affect access to affected communities. In addition, seasonal rains and poor road conditions may cause movement constraints and delays in the delivery of supplies and implementation of activities.

To mitigate these risks, NRCS will primarily utilize community-based volunteers residing within the target communities, reducing the need for extensive movements and ensuring continuity of activities. The operation will also leverage the established presence and acceptance of the ICRC in Borno State and maintain close coordination with local authorities and partners. Staff and volunteers will receive regular security briefings and refresher orientations on Infection Prevention and Control (IPC), and appropriate PPE will be provided throughout the operation.

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

Planned Intervention

Health

Budget: CHF 187,015
Targeted Persons: 1,000,000

Indicators

Title	Target
Number of volunteers trained/refreshed on cholera response, RCCE, CBS, ORP, and CATI,	600
Number of RCCE volunteers deployed	350
Number of CBS volunteers deployed	150
Number of ORPs supported	25
Number of people reached through RCCE	1,000,000
Number of Supportive supervisions conducted	3
Number of Coordination meeting supported	3
Average Number of people seen per day per ORP	20
% of referrals of severe cases from ORP to CTC	100
% alerts responded to in 24h by CBS team	90
% of CBS volunteers reporting on time	90

Priority Actions

*Activity 1: Conduct training for 600 volunteers (350 RCCE, 150 CBS and 100 ORP volunteers) on cholera prevention and control, Community-Based Surveillance (CBS), Risk Communication and Community Engagement (RCCE), Case Area Targeted Interventions (CATI), water testing and treatment, referral pathways and reporting procedures.

* Activity 2: Deploy 350 RCCE volunteers to conduct RCCE. include
- House-to-house sensitization, community dialogues, rumour management, and dissemination of cholera prevention messages in affected and high-risk communities as well as receiving and responding to nonsensitive community feedback. Volunteers will work in pairs (175 pairs), 3 days per week, per month, reaching at least 25 households per day over 3 months. Deployment will be based on population size, case burden, and identified gaps: MMC 40%, Jere 20%, Monguno 20%, Konduga 10%, and Mafa 10%, with adjustments made as the situation evolves.
- OCV demand creation during campaigns,
- Media use for RCCE: Radio jingles, interactive radio programmes, campaigns and focused group discussions.

* Activity 3: Deploy 150 CBS volunteers in selected high-risk IDP camps and at-risk communities within cholera hotspot LGAs. Each volunteer will be assigned to a fixed catchment area covering 20–40 households and will conduct regular visits to the same households to support active case finding, event-based surveillance, early alert reporting, and referral of suspected cholera cases.

* Activity 4: Establish and operationalize 21 new ORPs and sustain 4 existing ORPs, bringing the total to 25 ORPs across the five target LGAs. A total of 100 trained volunteers (4 per ORP) will work in pairs on a rotational schedule (3–4 days per week per pair) to ensure ORPs operate 7 days per week, 8 hours per day. The operation will procure equipment for the new ORPs and replenish consumables for all 25 ORPs to support timely rehydration and referral of suspected cholera cases.

* Activity 5: Conduct Monthly supervision, monitoring and review meetings with volunteers, health authorities and response partners to ensure quality implementation and timely adaptation of interventions.

* Activity 6: Support Monthly coordination and information sharing with the Borno State Primary Health Care Development Board, State Ministry of Health, NCDC and other partners involved in the cholera response.

• Activity 7: OCV campaign planning monitoring and adjustment of RCCE activities to support social mobilization.

Water, Sanitation And Hygiene

Budget: CHF 61,226
Targeted Persons: 1,000,000

Indicators

Title	Target
Number of people reached with hygiene promotion activities	1,000,000
Number of households who received hygiene kits	2,000
Number of hygiene kits replenished to NRCS National Headquarters stock.	1,000
Number of radio programmes/jingles on WASH and cholera prevention aired	180
Number of IEC material distributed	30,000
Number of Supportive supervisions conducted	3
Number of CATI teams Trained	5
Number of CATI volunteers trained	30
Number of households receiving Aqua tabs	1,000
Number of weekly sanitation activities/campaigns conducted	25
Number of water points monitored for Free Residual Chlorine each month	12
Number of household water samples tested for Free Residual Chlorine each month	750
Percentage of tested water points with Free Residual Chlorine levels within the recommended operational range	80

Priority Actions

* Activity 1: Conduct community-based hygiene promotion activities to 1,000,000 people in affected and high-risk communities focusing on handwashing, safe water handling, safe food preparation and cholera prevention practices.

* Activity 2: Train and orient LGA-level CATI teams (a team per target LGA comprising of 6 team members) on CATI protocols and rapid outbreak containment measures to strengthen preparedness for future cholera outbreaks and other public health emergencies.

* Activity 3: An average of 25 Weekly environmental sanitation activities will be activated at hotspots communities to promote environmental hygiene and limit breading areas of disease carrying vectors.

* Activity 4: Procure 2,000 hygiene kits. of these 1,000 kits are replenishing stocks already mobilised and deployed from emergency stocks

of NRCS National Headquarters for the current response.

* Activity 5: Procure 1,000 Aqua tabs for distribution to vulnerable households in cholera-affected communities

* Activity 6: Transport additional 650 hygiene kit components from NRCS National Headquarters to Borno State Branch to complete the initial mobilization of 1,000 hygiene kits for outbreak response activities.

* Activity 7: Support radio 180 jingles on cholera prevention, safe water handling, sanitation and hygiene practices.

* Activity 8: Print and distribute 30,000 WASH-related IEC materials, including posters, banners and flyers, to support hygiene promotion and community awareness activities.

* Activity 9: Conduct Monthly monitoring and supervision visits to ensure quality implementation of WASH interventions and appropriate use of distributed supplies.

* Activity 10: Conduct routine monthly Free Residual Chlorine testing at least 4 communal water points and within an average of 250 households within the 3 months of implementation.

Protection, Gender And Inclusion

Budget: CHF 3,089
Targeted Persons: 600

Indicators

Title	Target
Number of volunteers oriented on PGI, Child Safeguarding, PSEA and safe identification and referral pathways	600
Number of volunteers oriented on PGI, Child Safeguarding, PSEA and safe identification and referral pathways	5

Priority Actions

*Activity 1: Orient 600 volunteers on Protection, Gender and Inclusion (PGI), Child Safeguarding, Prevention of Sexual Exploitation and Abuse (PSEA), Community Engagement and Accountability (CEA), and safe referral pathways.

* Activity 2: Integrate PGI considerations across all cholera response activities, including RCCE, CBS, CATI, ORP operations, hygiene promotion and hygiene kit distribution.

* Activity 3: Ensure that cholera prevention messages, community engagement activities and IEC materials are accessible to women, children, older persons, persons with disabilities, internally displaced persons (IDPs), returnees and other vulnerable groups.

Community Engagement And Accountability

Budget: CHF 5,559
Targeted Persons: 500

Indicators

Title	Target

Number of community meetings conducted in affected communities	25
Number of focused group discussions conducted	10
Number of one-on-one interviews (KII) conducted	15
Percentage of community feedback addressed through the operation	80
Number of community stakeholders reached during community engagement visits	500

Priority Actions

* Activity 1: Conduct 25 community meetings in the affected community with at least 15 stakeholders per session.

* Activity 2: Strengthen safe and accessible community feedback mechanisms to enable affected populations through dissemination of NRCS toll free line and encouraged utilization to raise concerns, provide feedback and participate in decision-making processes.

*Activity 3: Conduct 10 focused group discussions (FGDs) and 15 one-on-one interviews (Key Informant Interviews) targeting key stakeholders across target LGAs. These sessions will guide the programme team in understanding the perceptions on the cholera epidemic within affected communities, challenges faced during such outbreaks and general feedback regarding the response interventions.

Coordination And Partnerships

Budget: CHF 29,032
Targeted Persons: -

Indicators

Title	Target
Number of Monthly Coordination meeting held with Branch and Division	5

Priority Actions

Engagement in health sector, WASH, and RCCE cluster meetings to enhance information sharing, partner alignment, joint planning, and harmonized implementation of response activities among government authorities and humanitarian partners.

*Activity 1: Participate in National, state and LGA-level cholera coordination meetings led by NCDC, BSPHCDB and the State Ministry of Health.

*Activity 2: Participate in monthly IPC/WASH-AWD coordination platforms and technical working groups to support information sharing, joint planning and identification of response gaps.

*Activity 3: Engage with the Country Support Platform (CSP) of the Global Task Force on Cholera Control (GTFCC) to strengthen coordination, preparedness planning, technical exchange and alignment with national cholera control priorities.

*Activity 4: Conduct monthly coordination meetings with divisional and branch structures to ensure effective implementation, monitoring and reporting of response activities.

Secretariat Services

Budget: CHF 30,391
Targeted Persons: -

Indicators

Title	Target
% planned DREF response activities implemented according to approved technical standards, operational plans, and timelines	100
% of required coordination meetings, monitoring reports, operational updates, and DREF reporting milestones completed on time and in compliance with IFRC requirements	100

Priority Actions

• Support efforts on communications, Visibility, Resource mobilisation and Advocacy.
• Handle, manage and implement Logistics, Procurement, and Supply Chain arrangements for this DREF.
• Ensure monitoring, timely reporting, and DREF Compliance.
• Support stakeholder coordination and engagement at national and state-level cholera coordination platforms to ensure complementarity and avoid duplication.
• Provide Technical Leadership and Quality Assurance on the key response pillars in accordance with relevant humanitarian standards.

National Society Strengthening

Budget: CHF 58,676
Targeted Persons: 600

Indicators

Title	Target
Number of NDRT deployed	2
Number of volunteers insured	600
Number of PPE materials procured and distributed to volunteers	600
Number of monitoring visist conducted	3
Number of LLW workshops conducted	1

Priority Actions

* Activity 1: The Operational capacity of the Nigerian Red Cross Society will support volunteer welfare, volunteer insurance coverage.

*Activity 2 Deployment of 3 National Disaster Response Team (NDRT) members.

*Activity 3: Provide visibility materials and personal protective equipment (PPE) for volunteers engaged in the operation.

*Activity 4: Conduct monthly field supervision, monitoring visits and supportive mentoring for staff and volunteers to ensure quality implementation and accountability.

* Activity 5. Conduct 1 lessons learnt workshop

About Support Services

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

• A total of 600 volunteers will be engaged in the operation, comprising 350 RCCE volunteers, 150 Community-Based Surveillance (CBS) volunteers, and 100 Oral Rehydration Point (ORP) volunteers. The volunteers will support house-to-house sensitization, Risk Communication and Community Engagement (RCCE), active case finding, community-based surveillance, Case Area Targeted Interventions (CATI), operation of ORPs, community feedback collection, hygiene promotion, and referral of suspected cholera cases in the targeted LGAs. All volunteers and staff involved in the operation will be covered by volunteer insurance and provided with the necessary personal protective equipment (PPE), visibility materials, and infection prevention and control (IPC) guidance to ensure their safety while conducting response activities.

• At divisional level, Divisional Secretaries and volunteer team leaders will support the day-to-day implementation of activities, including volunteer supervision, access facilitation, community engagement, security monitoring, and reporting from the field. Their proximity to the communities will help ensure timely implementation and rapid response to emerging hotspots.

. At Branch level, the operation will be coordinated by the Branch Secretary, with technical support from the Health Officer, WASH Officer, PMER Officer, Logistics Officer, Finance Officer, Communications Officer, and CEA/PGI focal persons, who will provide oversight, technical guidance, monitoring, reporting, and quality assurance throughout the operation. These staff will supervise field activities and ensure effective coordination with health authorities and partners. They will also be responsible for consolidating reports for HQ

• At National Headquarters level, the operation will be managed through the Health and Care Department, with support from Health, WASH, PMER, Logistics, and Finance staff. These technical staff will provide overall supervision, technical support, monitoring, reporting, financial oversight, and coordination with IFRC and Movement partners. The Director of Health and Care will provide overall strategic oversight of the operation.

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 NRCS volunteer network in Borno State largely reflects the gender, age and cultural diversity of the affected communities. The operation will primarily utilize community-based volunteers who speak local languages and are familiar with the cultural and social context of the target LGAs, helping to promote trust, acceptance and effective community engagement. Volunteers will include both men and women to ensure appropriate access to different population groups, particularly women, children and caregivers.

While the volunteer base is diverse, gaps remain in specialized PGI capacity and the representation of persons with disabilities. These gaps will be addressed through refresher training on Protection, Gender and Inclusion (PGI), Child Safeguarding, Prevention of Sexual Exploitation and Abuse (PSEA), and Community Engagement and Accountability (CEA). The operation will also ensure targeted outreach and inclusive participation of vulnerable groups, including internally displaced persons (IDPs), older persons, persons with disabilities, pregnant and lactating women, and female-headed households throughout the response

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

All procurement related to this operation will follow the IFRC's standard procurement procedures, National Society financial SOPs, and Sphere Standards for household item purchases. The National Society has the capacity in the procurement processes through the logistics department at headquarters to buy the necessary supplies for the operation in a centralized manner to regulate the items

needed to respond to this emergency. The NS will be responsible for all the procurements with support and guidance from IFRC and IFRC will do direct payment for all the procurements.

How will this operation be monitored?

The Branch officers at the state level will undertake the biggest part of daily monitoring and ensure weekly updates are provided to the HQ by sectors. Tracking will be done on the intervention key output and reports will be timely submitted. A two-way communication will be put in place between HQ, branches, and divisions, and consolidated monthly reports will be shared with the IFRC. The NS has an existing partnership with the relevant government departments for technical support. The Ministry's local representation will support training programs and provide supportive supervision to volunteers. The presence of ICRC in the states is an asset to the technical and operational efficiency of this intervention. Information sharing and monitoring will be combined and coordinated with ICRC. The IFRC will support NRCS implementation through monthly monitoring visits of this operation at different levels and in collaboration with the NRCS team, to project sites.

Please briefly explain the National Societies communication strategy for this operation

The IFRC and NRCS communications team will provide technical support for the communication of this operation. The NS comms person will cover the operation through social media presence on different platforms, interviews, and target population stories.

The IFRC Communications team will work closely with the National society to adapt key messages, collate success stories, and ensure visibility of the operation through documentaries, fact sheets, and newsletters.
The communication department will also support the resource mobilisation for the operation.

Budget Overview

DREF OPERATION

Code - Nigerian Red Cross Society
2026 Cholera Response

Operating Budget by Output Codes

		Total
Planned Operations		**256,889**
Shelter and Basic Household Items		**0**
AP005	Shelter assistance to households	0
Livelihoods		**0**
AP007	Improvement of income sources	0
Multi-purpose Cash		**0**
AP081	Multipurpose cash grants	0
Health		**187,015**
AP107	NS health capacity	0
AP108	Health services	0
AP109	Health services in emergencies	187,015
Water, Sanitation & Hygiene		**61,226**
AP110	WASH	0
AP111	WASH in emergencies	61,226
Protection, Gender and Inclusion		**3,089**
AP114	Humanitarian values and principles	0
AP116	Protection/gender/inclusion services	3,089
AP117	Protection/gender/inclusion capacity	0
Education		**0**
AP115	Access to education	0
Migration		**0**
AP112	Support to migrants and displaced	0
AP113	NS Migration & Displacement Capacity	0
Risk Red., Climate Adapt. and Recovery		**0**
AP101	Climate change adaptation	0
AP103	Comm. risk reduction and resilience	0
AP104	Assistance to people affected	0
AP105	NS DM Capacity	0
AP106	Disaster Law	0
Community Engage. and Accountability		**5,559**
AP129	Community engagement/accountability	5,559
Environmental Sustainability		**0**
AP102	Climate change mitigation&greening	0
Enabling Approaches		**118,098**
Coordination and Partnerships		**29,032**
AP049	IFRC coord. in humanitarian system	0
AP118	Engagement w. stakeholders	17,913
AP119	Influencing and hum. diplomacy	6,795
AP120	Innovation	0
AP121	Digital Transformation	0
AP127	Membership Coordination	0
AP128	Movement Cooperation	4,324
Secretariat Services		**30,391**
AP122	Secretariat services strengthening	30,391
National Society Strengthening		**58,676**
AP124	National Society Development	50,496
AP125	Volunteering development	8,180
AP126	Leadership development	0
TOTAL BUDGET		**374,988**

all amounts in Swiss Francs (CHF)

[Click here to download the budget file]

Contact Information

For further information, specifically related to this operation please contact:

National Society contact: Aminu Abdullahi, Coordinator Health and Care, aminu.abdullahi@redcrossnigeria.org, +234 8060763302

IFRC Appeal Manager: Ghulam Muhammad Awan, Head of Delegation, ghulam.awan@ifrc.org

IFRC Project Manager: Sandra Zi, Senior Health and care Officer, sandra.zi@ifrc.org

IFRC focal point for the emergency: Sandra Zi, Senior Health and care Officer, sandra.zi@ifrc.org, +234 7033514532

Media Contact: Susan Nzisa Mbalu, Communications Manager, susan.mbalu@ifrc.org

National Societies' Integrity Focal Point:
Amina Mustapha, Coordinator, Internal Audit, amina.mustapha@redcrossnigeria.org, +2348036429570

National Society Hotline: +2342013430601

Click here for the reference