DREF Operation

Chad_Cholera outbreak

Engagement with communities during epidemic cholera 2025 @CRC

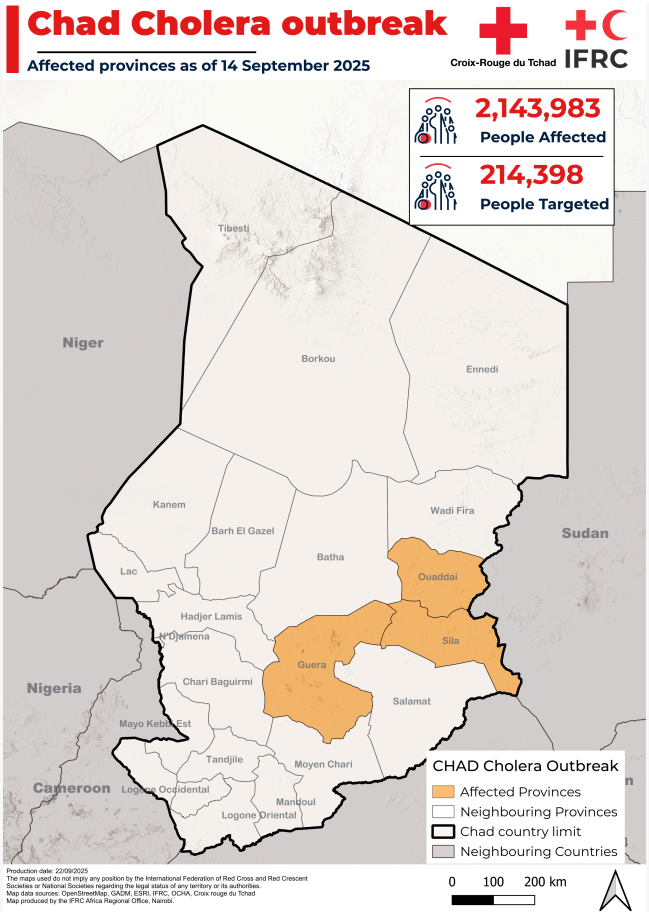
Appeal: **MDRTD025**	Hazard: **Epidemic**	Country: **Chad**	Type of DREF: **Response**
Crisis Category: Yellow	Event Onset: **Slow**	DREF Allocation: **CHF 468,269**	
Glide Number: -	People Affected: **2,143,983 people**	People Targeted: **214,398 people**	
Operation Start Date: **23-09-2025**	Operation Timeframe: **6 months**	Operation End Date: **31-03-2026**	DREF Published: **13-10-2025**

Targeted Regions: **Ouaddai, Sila**

Description of the Event

Date when the trigger was met

15-09-2025



What happened, where and when?

Since the start of the cholera outbreak declared on 24 July 2025 in Chad, National society has been monitoring the situation which has now escalated as of mid-September 2025.

Initially confined to the eastern provinces of Ouaddaï and Sila, the outbreak keeps escalating in numbers, mortality and geographical spread. From 1891 cases on 9 September to 2,165 cases by 17.09.2025 and a constant high fatality rate, especially at community level. Furthermore, initially confined to the eastern provinces of Ouaddaï and Sila, the outbreak expanded by mid-September to include Guéra province, specifically Bitkine district.

As of 14 September 2025, the outbreak is active in 3 provinces and 8 districts: five in Ouaddaï (Chokoyane, Hadjer Hadid, Adré, Farchana, Amleyouna), two in Sila (Abdi, Goz Beïda), and one in Guéra (Bitkine). As per the National response plan, the Government has called for partner support and prepositioning, urging for NS contribution to mitigate the geographical expansion of the situation and the increasing mortality rate at community level.

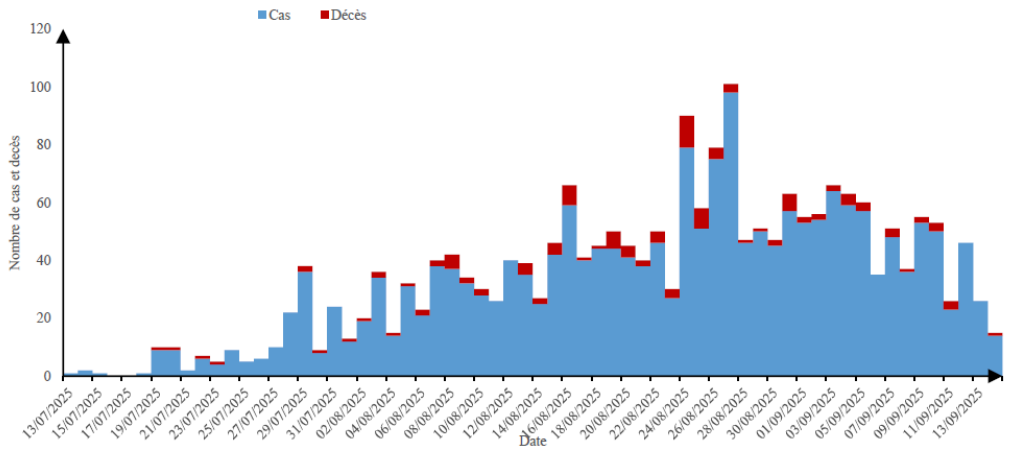


Figure 2 : *Courbe évolutive des cas et des décès de choléra (**N=2081**)*

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

@SITREP of 15 July MoH

Scope and Scale

The cholera outbreak began with a suspected case reported on 13 July 2025 in Chokoyane Health District, Ouaddaï Province. Laboratory confirmation of Vibrio cholerae O1 Ogawa followed on 24 July, and the Ministry of Health officially declared the outbreak on 25 July. The source is believed to be cross-border transmission from Darfur, Sudan, where cholera remains widespread.

- 25 July, following the declaration of the outbreak, the Red Cross Provincial Committee of Ouaddaï took part on a joint evaluation mission with Health authorities in the Dougui camp but also surrounding villages revealing ongoing 216 cases and 10 deaths in Chokoyane, 15 cases and 2 deaths in Hadjer Hadid (Treguine camp), and 3 gastroenteritis cases in Adré. The assessment also shows that the rainy season has hindered access to clean water and mobility. This expansion was later confirmed by MoH SITREP.
- On 12 August, the outbreak had expanded to three active districts—Chokoyane, Hadjer Hadid, and Adré—with 16 affected health areas. These include Dougui, Kaoukaou, Kouchaguine, Malabat, Amdokone, Magrane, Treguine, Hadjer Hadid Urban, Bredjeing, Amchalob, Gourgoudji, Site du Lycée, Arkoum, Mermek, Yagom, and Adré Urban. A total of 487 suspected cases were recorded, including 157 RDT positives out of 227 tested, 30 deaths for a CRF of 6.2% (9 death in the community). 31 samples analyzed in the laboratory out of which 25 cases are confirmed by culture (80.6%). Chokoyane were registering 372 cases and 19 deaths, Hadjer Hadjid 108 cases and 11 deaths and Adre has got 07 cases and 0 deaths.
- Mid-September: Initially confined to the eastern provinces of Ouaddaï and Sila, the outbreak expanded by mid-September to include Guéra province, specifically Bitkine district.
- As of 18 September 2025, the outbreak is now active in 3 provinces and 8 districts: five in Ouaddaï (Chokoyane, Hadjer Hadid, Adré, Farchana, Amleyouna), two in Sila (Abdi, Goz Beïda), and one in Guéra (Bitkine). Cumulatively, 2,165 cases and 137 deaths have been reported, with a case fatality rate (CFR) of 6.3%.

* Top-burden districts (as of 18 Sept SITREP table) include: Chokoyane (Ouaddaï) with 1,145 cumulative cases; attack rate 949/100,000; CFR 4.5%. Hadjer Hadid (Ouaddaï) 697 cases; attack rate 277/100,000; CFR 7.2%. Abdi (Sila) 113 cases; CFR 15.9%. Farchana (Ouaddaï) shows 50% CFR on a very small denominator (2 death out of 4 cases).
* The majority of cases (~91%) present with moderate to severe dehydration, contributing to high mortality.
* A significant proportion of deaths (63) have occurred in the community, indicating delayed care-seeking and limited access to health services.
* The most affected districts are Chokoyane (1,145) cases, CFR 4.4%) and Hadjer Hadid (697 cases, CFR 7.3%). Adré, the most recently affected district, has reported 45 cases with no deaths. Attack rates vary widely, with Chokoyane reaching 949 per 100,000 population.
* Vulnerable populations include residents of refugee camps near the Sudan border, where overcrowding and poor sanitation heighten transmission risks. Women and individuals aged 15–44, 45–59, and over 60 are disproportionately affected by mortality.

Cross-Border and Regional Concerns:
The refugee population in Ouaddai affected districts are at very high risk of getting infected as they are crowded and there are some degrees of promiscuity and some water challenges. The population of the 3 affected health districts is: 120,527 people for Chokoyane, 250,761 people in Hadjer Hadjid and 526,525 people in Adre. The crowded situation of the refugee camps in the area is at risk of getting infected with cholera if some measures to control and to prevent the spread of the cholera are not strengthened in the area.

Moreover, with a lot of internal Chadian population movements (transhuman movement of livestock farmers, movements of ordinary populations from one town to another including the capital Ndjamena as well as the provincial capital Abeche which are much more

crowded), the risk is more higher of spreading all over the country with a high risk reaching the capital faster as its population flux is higher.

Wider Impact Scenarios:
If not urgently contained, the outbreak could lead to:
- Increased morbidity and mortality, particularly among vulnerable groups such as children, the elderly, persons with disabilities, returnees and the refugees, and mobile populations.
- Overburdened health facilities, straining available resources, beds, and medical staff in an overstretched situation of refugees almost beyond the number of the host population for the available health services in the area.
-Heightened vulnerability for marginalized communities such as those living in the slumps of the cities of the targeted health districts.
-Misinformation and panic, creating stigma and undermining of risk communication and community cooperation.

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

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	No
Did it affect the same population group?	No
Did the National Society respond?	No
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:

Community Engagement Drives Success
In Chad, meaningful community participation has consistently underpinned effective emergency response. Community management committees in the 2017 food crisis strengthened local ownership and streamlined coordination, while the 2012 flood response showed that when affected people help design and deliver interventions, they adopt and sustain protective practices—improving outcomes. Building on this pattern, the operation will embed local knowledge, inclusive committees, and clear feedback channels to tailor assistance, boost accountability, and increase uptake.

Sustainable Strategies for Slow-Onset and Recurrent Crises rely on adaptable and context specific solutions that can be integrated to communities' systems.

Sustained, community-led approaches are essential where risks stem from chronic vulnerabilities and seasonal shocks. This DREF will prioritize community capacity, understanding, and ownership of core pillars (safe water, sanitation and hygiene, early care-seeking, SDB, RCCE), leveraging existing structures—committees, volunteers, local services—to amplify impact during the emergency and maintain continuity beyond the DREF period. Because transmission is compounded by population movement and protracted crises,

solutions will be adaptive, low-cost, and replicable at community level, with simple solution, practices and behavior change at the center. Rapid monitoring and feedback loops will guide course-corrections and keep the response aligned with evolving needs.	
Did you complete the Child Safeguarding Risk Analysis in previous operations, what was risk level?	**No**

Current National Society Actions

Start date of National Society actions

31-07-2025

Health	In this cholera epidemic outbreak, the CRC(CRT) has once again taken the lead in preparedness and is tackling the response to the epidemic head. It is working closely with national and local authorities and other components of the movement (IFRC, ICRC and the French Red Cross, Luxembourg Red Cross (CRL), British Red Cross (BRC)). It has already taken the following steps: - Alert local branches, - Mobilising committees and volunteers with local authorities for mass awareness and sanitation activities in public places in the three districts affected by cholera, regardless of the province or locality, we have volunteers available - Participating in the inter-NGO meeting in Abéché - Making around 400 volunteers available to the regional health delegation for awareness-raising - Participating in the visit on 24 July 2025 by the Minister of Public Health and representatives of other partners in the province of Ouaddai, specifically the health districts DS of Chokoyane, where the SN was represented by the National President. Strengthen Risk Communication and Community Engagement (RCCE) in the affected health districts and their camps as well as the hyper high risk health districts in eastern Chad: Embedded across all pillars of response to promote behaviour change, drive surveillance, and enable early action, isolation, orientation/referral to treatment centres/health centers. -Sensitize the population and orient them to psychological support points for bereaved families in the affected areas. Support will also be provided in critical districts to help set up oral rehydration points. IIn addition, a vaccination campaign was launched with the support of partners. The first phase, using the available vaccines, covered five of the eight planned health districts (see attached situation report). The SN mobilised a few volunteers to support vaccination activities in these districts, but their contribution was insignificant. A small project to support vaccination was submitted and approved for funding by the CDC through the FICR health team in Geneva, in the amount of USD 25,000. This project will support the second phase of vaccination, which began on Monday 22 September 2025 in Abdi and will also cover the districts of Abéché and Goz Béida, the three districts that were awaiting vaccines. The national society plans to mobilise around 250 volunteers across these three health districts. The DREF request will therefore not cover these costs, which will be reimbursed by the vaccination support project for which the volunteers will be mobilised. However, the DREF will only cover the health actions formulated as part of the response, taking into account the dynamics of the epidemic.
Coordination	The national society participated at all the coordination meetings on the cholera epidemic outbreak at the national, provincial, district and health area levels of the health system in Chad in the affected and hyper high-risk areas. The national society participated in all coordination meetings on the cholera epidemic at the national, provincial, regional and local levels of the health system in Chad, in affected and very high-risk areas.

	In order to ensure better operational coordination, the national society will deploy supervisors in each targeted district. A total of 16 supervisors will be deployed in the field, with two supervisors per locality. This team will be coordinated by the incident manager of the health department, supported by an assistant. The supervisors, the assistant incident manager and the incident manager will work at their respective levels with the health officials of the coordination bodies that have been set up.
Assessment	The local branches and the headquarters have done initial quick evaluation mission with local health authorities on 25 July as a direct observation on the situation and gaps. Since, there is a continuous context and risk monitoring that have been in place through the EOC and HQ covering the all the six health districts. The resources mobilised to achieve that has been restricted and ICRC and UNICEF support so far has helped mobilize 20 volunteers on a 10-day period.
Resource Mobilization	The National Society has activated support from partners to mobilize additional resources for the cholera response as part of the NS contribution to the response plan. In parallel to the DREF resources, CRT has submitted proposals for the cholera response. A proposal for USD 25,000 (≈ XAF 13.97M), targeting 75,415 people (direct: ~10%) is ongoing. It will help extend the response team for RCCE/OCV social mobilization. That funding will be primary focusing on Mass & proximity sensitization, radio spots, megaphone outreach; acceptance of OCV; community feedback loops for the OCV efforts. It will also support the ORP set-up and management in Abdi, Abéché and Goz-Béida.
National Society EOC	The National Society has activated its emergency operations centre at the national level and ordered the branches in the 6 targeted health districts to start activities related to risk communication and community engagement as well as referral of cases to treatment centres. Volunteers have been in the community sensitizing as well as in markets.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC CAR & Chad Cluster Delegation maintains an office in Chad with staff based at CRT headquarters. In 2025, the IFRC is increasingly called upon to support the National Society's strategic and programmatic engagement in epidemic response. This includes: - Supporting the National Society to mobilise resources through this DREF and the Federation's Country Plan. - Providing technical expertise and guidance in epidemic response under DREF. - Actively participating in the Cholera Partners Task Force to strengthen coordination and ensure complementarity of actions and resources. IFRC enables Movement coherence by providing technical leadership, ensuring complementarity of interventions, mobilising resources, and acting as a platform for coordination both internally (with PNS/ICRC) and externally (with the Cholera Task Force and government/UN actors). IFRC Operations and funding coordination: Currently, the IFRC supports the CRT in implementing six projects across the country. Most of these are located outside Ouaddaï, Sila, and Ennedi East. The only ongoing Emergency Appeal (MDR022 – Population Movement) is due to end on 31 December 2025 and covers WASH, Migration, and Health. However, epidemic prevention is not funded under this Appeal; initial awareness activities were discontinued due to resource gaps. This DREF will therefore fill the critical gap in epidemic response, while the Appeal continues to address migration-related needs, including humanitarian service points (HSPs). Volunteers at the HSPs in Adré will also be mobilised to deliver cholera prevention messages to people on the move and newly arrived, with these points serving as priorities for community-based surveillance and early alert.

	Technical support and quality oversight: For ongoing projects, the IFRC applies a close monitoring and technical support system, with an operational base in Bongor (Mayo-Kebbi East) hosting dedicated staff. However, no such structure exists in Ouaddaï and Sila. Monitoring there relies primarily on remote support, complemented by short, targeted missions or temporary staff reassignments. Under this DREF, this approach will be strengthened through a minimum surge presence in Ouaddaï These deployments will be progressive and adaptive to the evolving situation, while also ensuring skills transfer to CRT branches engaged in the response.
Participating National Societies	Partners National Societies present in country or supporting the CRT in country includes French Red Cross; Luxemburg Red Cross and the British Red Cross. All PNS Participate in the Red Cross and Red Crescent Movement meeting where information and positioning are being discussed and agreed for effective resource management. FRC is actively involve in the cholera response coordination across the health intervention ongoing in their provinces of priority. They also - Participates in coordination meetings with external structures and the Government - Pre-positioning of kits - Organized the community-based surveillance training of trainers at the national level - Supported the drafting of the response strategy with the CRT Luxemburg Red Cross and the British Red Cross are also beside then CRT to give their technical and material support to CRT(CRC) in the response to this outbreak to the available resources that they could release in country.

ICRC Actions Related To The Current Event

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

Other Actors Actions Related To The Current Event

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

Are there major coordination mechanism in place?

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

strategic supervision is provided by the management teams of the health delegations.

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

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

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

Needs (Gaps) Identified

Health

Since the begining of the outbreak on mid-July, the outbreak has intensified but remained concentrated in Eastern Chad, adding Guéra (Bitkine) in mid-September. The caseload rose from 1,891 → 2,1651 between 9–18 Sept, while the CFR hovered at ~6.5–6.3% on 18 september 2025.

1) Ongoing widespread transmission both within the province and cross border require surveillance, and prevention.

The ongoing outbreak within the overcrowded camps with limited WASH facilities also present an important factor for the widespread of the disease. Furthermore, the outbreak is rapidly spreading within Ouaddaï Province. Initially confined to Chokoyane, it has now reached Hadjer Hadid and Adré. These districts host between 50,000 and 300,000 refugees or returnees each and are located near the Sudanese border, where cholera transmission in Darfur remains critical. On 8 August 2025, Darfur reported over 4,300 cholera cases and 113 deaths (ReliefWeb, UN OCHA). As the cases are more in Sudan and formal and informal movements continues, there is a need to improve preparedness at the points of entry so as to be able to reduce the spread.

2) Reduction of community mortality rate

High community deaths and late, severe presentations are the key mortality drivers at this stage.
From epi-data evolution, it is observed that majority of patients arrive with moderate or severe dehydration, indicating delayed care-seeking. in the first half of September for instance, between 84% to ~91% of cases arrive at health centers with moderate to severe dehydration, contributing to high mortality.

In addition, significant proportion of deaths (61 out of 135 s of 14.09.2025) have occurred in the community. That indicates a late presentation for treatment which could underline need for engagement, fears among the communities or lack of information on the symptoms of cholera or existing health supports for care.

3) Health facilities capacity and gaps

With the parallel crisis in the provinces, the long-standing refugee's situation and the ongoing cholera, health services are strained, with response efforts coordinated across multiple facilities including Adré Urbain, Hadjer Hadid Urbain, and MSF-supported clinics.

Laboratory testing has confirmed 25 cases by culture out of 31 samples analyzed (80.6% positivity), and 157 cases by rapid diagnostic test (RDT) out of 227 tested. Health services are strained, with response efforts coordinated across multiple facilities including Adré Urbain, Hadjer Hadid Urbain, and MSF-supported clinics.

4) Case Management scaled up and engagement

- Health services require immediate reinforcement to safely isolate and manage patients and to push lifesaving support closer to households. Based on MoH summary of constraints and gaps (SITREP), isolation capacity is insufficient; tents and basic infrastructure are

needed to expand CTC/UTC space and to house surge staff, with installations already underway in Amleyouna but still inadequate elsewhere. The CTC/UTC present gaps on material for proper installation of the units. there is a continued need for tents/space at isolation sites (capacity gap).
- Facility and pre-hospital IPC must be strengthened through team briefings, supervision and supplies, including systematic decontamination of high-contact transport/attendant items (e.g., moto-taxis, linens).
- Given severe dehydration at presentation and community deaths, establishing and supplying community level ORS/ORP points with clear referral pathways is urgent to initiate rehydration early and reduce fatality.

5) Testing and Vaccination planning

- The vaccination is being organised. Micro-plans/chronograms for Abéché, Abdi, Goz-Beïda is finalised and there is a plan to conduct catch-up vaccination in areas with gaps (e.g., Hadjer-Hadid) for end of september. Social mobilisation is necessary and will be provided on a case-by-case basis depending on the evolution of the situation and the mobilisation of additional external resources.
- Diagnostics are constrained by ruptures of RDTs and near-rupture of culture reagents, limiting rapid confirmation and timely triage; maintaining sampling and surveillance logistics is therefore essential. This is under the MoH and WHO lead.

Water, Sanitation And Hygiene

These health districts have population over 100,000 people each among whom there are a lot of refugees who have been arriving since 2023 to the point that in some areas the refugees are more than the host population. These refugees live in crowded camps while in some areas of the host population there are slumps and also very vulnerable populations who do not even have toilettes and access to enough good water to use and also to drink which are conditions that favour the spread of the disease. The refugees are continuing to come from Sudan where the cholera was imported and is still very active. From time to time the refugees leave the camps and go back to Sudan before returning with a high risk of introducing more importation cases and spreading the disease to other new areas.

Addressing the WASH gap such as the access of water, low hygiene and sanitation experienced by the communities in the camps and overall communities is a critical need to stop the transmission and support the prevention. There is a need to strengthen hygiene and sanitation of the communities where the cases are from and could occur in clouding public places.

The gaps of toilettes in some public places and some overcrowded areas like refugee camps and slumps in big cities like Adre, Abeche as well as in some households with limited resources.

25 July, following the declaration, Red Cross Provincial Committee of Ouaddaï conducts a field mission in Dougui camp and surrounding villages with local health autorities revealing 216 cases and 10 deaths in Chokoyane, 15 cases and 2 deaths in Hadjer Hadid (Treguine camp), and 3 gastroenteritis cases in Adré. The observation from that mission also shows that the rainy season has hindered access to clean water and mobility which contributed to the expansion for the outbreak.

Protection, Gender And Inclusion

Eastern Chad has received a massive influx of refugees and returnees since April 2023—over a million to Ouaddaï alone—amid pre-existing fragilities, exposing children to separation, violence, exploitation, and psychosocial distress.

The overall complex humanitarian context in Eastern Chad makes the existing vulnerable groups more exposed to protection and gender-based challenges. In the cholera spike being witnesses, it is important to maintain the safeguarding and protection priorities to ensure they are maintained, updated and considered in the design of the other sectors of intervention but also as part of the main awareness to be maintained.

there is a need to have sensitization of the beneficiaries to as to avoid occurrence during the relief of PSEA and for them to know how and where to report eventual abuses.

Community Engagement And Accountability

The late presentation at health centers and community mortality rate indicates either a fear or non-acceptance of the care or the lack of knowledge on the disease is still very low with gaps on early identification of the symptom to alert.

In both cases, the community engagement plays a vital role on the prevention efforts, especially on a complex setting such as the

displacement areas in the East regions of the country. Knowledge of the disease symptoms need to be increased. First gap on the sensitization on the alert for early detection of the disease is an essential part of it. Sensitisation, porevention and early detection can be leverage if community can support the teaching of the symptoms and the risks factors to their communities, helping in the active search of cases, teaching them what to do should they have a case, teaching the community the correct way of treating water, handling food, cleaning the environment and toilettes, using the toilettes. Tracking, understanding and addressing the perceptions, knowledge and gaps need also a two-way feedback system that ensure people's questions or concerns are addressed or used to serve CEA appraoch.

In addition to understanding of the communication channels and systems, there is also a need to know what is the understanding of the disease in the communities, if there are any perceptions or misperceptions but also gaps on the knowledges of the diseases which could explain the community drivers. In another hand, to effectively use that appraoch, the understanding of the context, community systems and communication channels is essential to make the CEA approach more effective and communication with affected populations more targeted.

Sensitize the population on the best attitute, practice and action to take to prevent having a lot of deaths from the disease, having people ill for long time, having a lot of community member affected and infected by the disease. Based on the MoH gaps expressed, the risk communications reauire a scale-up of teams deployed for the risk communication for prevention, OCV social mobilisation and diversifying communication material with audio, visual aids, flyers, and relevant languanges.

The various material and language adaptation is learnt to promote the understanding and acceptance. Therefore, the most local and languages adapted communication channels need to be identified and followed.

Any identified gaps/limitations in the assessment

The need for the response is enormous, and we will only use this DREF to fill part of it. To our observation on the ground, the most affected groups of people in this situation are the refugees and the returnees as well as the very poor's members of the host population.

Currently, the main challenges highlighted by the MoH through the EOC includes:
* Insufficient tents for isolation sites in health facilities and staff shelters.
* Open defecation (shortfall of 400 latrines).
* Persistent gatherings of people at funerals and food distribution sites.
* Insufficient supply of azithromycin tablets in the Dougui CTC.
* Food insecurity and insufficient means of subsistence (cash-for-food gap).
* Difficulty in implementing activities due to temporary watercourses making access difficult in affected areas.

Assessment Report

Operational Strategy

Overall objective of the operation

Over six months, this DREF will complement the ongoing National cholera response by closing community-level gaps that drive transmission and the high CFR in Ouaddaï and Sila provinces through key Health and WASH critical intervention, ensuring a string Risk communication and community engagement and protection gender inclusion approaches to the strategies. Intervention goal is to reach 214,398 people.

Operation strategy rationale

Chad Red Cross will work on: Health, Water & sanitation, Protection, Gender and Inclusion, Risk communication and community engagement (Community engagement & accountability). These pillars are prioritised based on National plan main priorities and the identified needs/gaps. Urgent intervention on these pillars will support controlling the spread and the community level mortality in health districts with ongoing outbreak while improving and acceleration preparedness and readiness of 4 the health districts that are on high risk of outbreak.

1) Health

SITREPs indicate rapid case growth across Ouaddaï/Sila (and Guéra), high CFR (~6.5%), many community deaths, and very late care-seeking. The strategy therefore prioritize the efforts at community level, the risk communicattion for early presentation and preventive measures acceptance while tightening early detection and referral to bend both deaths and new cases. Strategy begins with training

volunteers and community focal points on ECV, RCCE, SBC and ORP/ORS modules as per IFRC standards so they can recognize symptoms early, deliver key prevention messages, prepare ORS correctly, and navigate clear referral pathways. The skilled volunteers will then be deployed. Main intervention aareas being:

- Community- and event-based surveillance to be scaled up to generate rapid alerts from villages, markets, schools, and places of worship, with same-day notification to health authorities. NS volunteers will do a sensitization of the population and leaders on detecting cases early then referring them to the treatment sites. By activating and using the community systems, CRT ensure more effective approach to the surveillance and early referral or presentation to the health centers/ORP/CTU.
- In very high-incidence areas, the operation will establish Oral Rehydration Points and a community ORS distribution scheme to start rehydration at once and safely link patients to CTC/CTU.
- In parallel to volunteers community surveillance, specific screening and referral will be strengthened at points of entry in high-risk health districts to detect suspected cases promptly and reduce onward spread.
- Psychosocial support will be available for people who are sick and for families who have lost relatives to cholera, with confidential, culturally sensitive assistance and referral to specialized services where needed.
- Each ORP or screening point will be run by a mixed-gender team of six trained volunteers (three women and three men) working on a rotation basis
- The SBC and screening team will be working in rotation to ensure continuous, safe, and accountable service delivery that reduces mortality and interrupts transmission.
- Support scaling-up the social mobilization for the OCV, complementing the resources deployed through other fundings.

2) RCCE

Community leaders /representative systems will be leverage for the effective risk communication. The CRT will engage with the key local leaders and local influencers to ensure they promote equally the key messages for cholera behavior changes, preventive measures and care seeking.

In addition, for all the WASH activities, an intensive community engagement and communication will be deployed. All the demonstration and awareness for water treatments, maintenance and sanitations will be language-appropriate dosing instructions; issue jerry cans to the most vulnerable households to store treated water safely.

During their visits, the awareness campaigns, or the wash demonstrations, volunteers will work with local leaders to promote Preventive measures; acceptance for OCV; early care-seeking; immediate referral to treatment sites and other good behavior. changes

2) WASH

The National Society will reduce immediate WASH-related vulnerability by ensuring people can access, use, and sustain safe water, sanitation, and hygiene practices in outbreak hotspots. Main priorities of the WASH intervention is as follows:
CRT will restore and expand safe water access by rehabilitating 8 water sources and by providing household water-treatment support to 1,000 high-risk families in camps, pairing every distribution with practical, language-appropriate training on boiling and chlorination so products are correctly used. To keep water safe to the point of consumption, CRT will run routine water-quality monitoring (free residual chlorine checks and sanitary inspections) at public points with household spot checks, using weekly results to retarget supplies and coaching where gaps persist. Sanitation will be reinforced in communities and high-traffic public facilities (water points, toilets, health centres), focusing on active districts and dense nodes—including Adré, Abéché, refugee camps, markets, transport hubs, schools, and places of worship—to rapidly interrupt fecal–oral transmission. In parallel, CRT will expand hygiene access and behavior change: install and maintain handwashing stations at priority public sites, and supply soap and bleach to 1,000 families to cover at least two months of basic hygiene, while demonstrations reinforce correct technique at critical moments (after toilet use, before food prep/eating, after caring for the sick). To sustain quality and coverage, CRT volunteers will be trained in water-treatment techniques, sanitation, and IPC, and will scale up community outreach on good hygiene, safe water handling, and environmental cleanliness, using monitoring feedback to adapt activities week by week.

4) PGI

Our PGI strategy ensures do-no-harm, inclusive, survivor-centered assistance by prioritizing the safety, dignity, and equal access of girls, boys, women, men, older persons, and people with disabilities. CRT delivery mechanisms and substance will be context-adapted and flexible—using mobile/outreach modalities, culturally appropriate messaging, and low-barrier entry points for refugees and host communities alike. In parallel to that ongoing support from other sources, this DREF will complement with Protection messages, ensuring continuous safeguarding is prioritized and reporting and referral systems are promoted.

Some resources will be invested in local human resources by mobilizing and training some community volunteers and leaders (with strong female and youth representation as relevant) on PGI, PSEAH, child safeguarding, confidentiality, and safe referrals, supported by supervision and staff wellbeing. Finally, CRT will formalize integrated referral pathways linking protection, education, and mental health services.

The above efforts will complement the PGI settings already in place under Population movement Emergency appeal. For instance, following the Sudan crisis, with UNICEF and local authorities, the Chad Red Cross set up an integrated protection programme in 2023 across eight camps/transit sites with some having cholera ongoing or are at risk (e.g., Ambelia, Arkoum 1–2, Farchana, Koufroune, Midjikilta, Mitché, Tongori, Adré, Assoungha). In these set-ups, CRT is supporting the child protection, restore family ties, provide MHPSS, and support education. Child-Friendly Spaces (CFS)—tents or fixed/mobile structures—are safe, inclusive, participatory hubs that combine child protection, psychosocial support, and non-formal education. For details consult https://pgi.ifrc.org/resources/case-study-chad-red-cross-cfs-refugee-settings#:~:text=The%20Chad%20Red%20Cross%20with,Download%20French%20version

5) CEA

CEA is integrated to health RCCE intervention. In addition to the RISK COMMUNICATION prioritized in this DREF, CRT will ensure feedback are collected and managed through existing channels. The channels being community systems and representatives, direct door to door, protection services points in place etc. CRT will mobilize communities through representative committees and feedback channels to co-design services, tackle harmful norms, and strengthen accountability.

Targeting Strategy

Who will be targeted through this operation?

Operation target focus is as follows:
1) Geographical focus:
- In Ouidai province: Abeché, Chokoyane, Hadjar Hadid, and Adré districts that have an ongoing outbreak targeted with the entire DREF activities.
- In Ouidai : , Abgoudam, Farchana, Abdi and Amelyona at high risk and targeted for preparedness and prevention

Targeting and geography: prioritize active districts and dense nodes where transmission and crowding coincide (e.g., Adré, Abéché, refugee camps, major markets, transport hubs, schools and places of worship); extend a light-touch prevention package to adjacent at-risk localities.

Furthermore, Camps have been the major hotspots but surrounding communities have seen a growth of the cases. And this is considered in the target of displaced communities, entry points, camps and surroundings.

The geographical targeting of districts will be readjusted according to the dynamics of the epidemic if necessary. But for now, eight health districts are being targeted, with intensified action in the three most affected districts.

2) Group prioritized for direct relief and intensification of activities.
- Refugees and population displaced or on the move that are both affected and at risk.
- Group currently the most affected: Women with higher death figures.
- People with most vulnerable age and based on affected disaggregated data as epidemic evolve.
- Common vulnerable groups for water borne diseases in the country. includes kids,
- (1) communities of case origin; (2) high-traffic public places; (3) vulnerable households with limited resources; and (4) health-district systems.

3) For the effectivity of the response and especially the prevention and promotion of preventive actions by the communities, NS will also put an accent on community leaders/representatives to promote and reinforce the surveillance messages, WASH/IPC, safe practices; acceptance of OCV etc

Explain the selection criteria for the targeted population

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

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

The criteria to select a given health district was the fact that it had a cholera epidemic outbreak or that it is at hyper-high risk of having one(bordering the Darfur region of Sudan with a lot of movement between the and Sudan, having a high number of Sudanese refugees moving between the 2 countries, overcrowded refugee camps, existence of slumps, the water scarcity in the area, the flux of population

movement between the health district and the already affected health districts) . The 8 health districts need strengthening of the preparedness of the health areas not yet affected.

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

- The risk and underlying factors or contextual vulnerabilities associated to specific groups. That's the case for refugee camps population prioritized due to underlying factors such as the Overcrowded conditions in Chokoyane, Hadjer Hadid, and Adré increase transmission risk.
- The scope and scale of the impact towards specific demographics. Communities identified as the most at impacted based on current attack rate, death and cases repartition, Demographics of fatalities. Therefore, explaining the target priority to Women, young people, kids and elderly which are the most vulnerable.

Total Targeted Population

Women	120,063	Rural	0.5%
Girls (under 18)	-	Urban	0.6%
Men	94,335	People with disabilities (estimated)	-
Boys (under 18)	-		
Total targeted population	214,398		

Risk and Security Considerations (including "management")

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

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

Risk	Mitigation action
The raining season will be a big challenge to the geographic access to some of their sites by rendering roads difficult to access with the mayos and Ouadis. In addition, access to some communities limited by seasonal waterways, reducing reach of sensitization.	To mitigate the situation, movements will be done in convoye of at list 2 vehicles when there are sun and the water level in the mayos have reduced. Community level volunteers
Insecurity in the area could at times limit movements in the area due to some movement of uncontrol arms with the population movement across the border with Sudan	Security check in the area will be done and movement done when the security analysis shows that they could use the road to deliver goods but will use the humanitarian flights to get to areas where it is possible to go by air.

Delay in the time of response which will lead to more people exposed to the disease and may result in reputation damage of the national society and the RCRCS movement	Will anticipate and put together the technical and logistic resources of the red cross movement (ICRC, IFRC, PNS, NS) to coordinate and support the NS in the implementation of this response to Cholera
Safeguarding risk: Risk of harm, exploitation, or abuse of participants, especially vulnerable groups, may result in reputation damage	We will co-develop safeguarding strategies with Ministry of Health and partners, adopt safeguarding tools and codes of conduct, implement referral/reporting mechanisms and conduct safeguarding self-assessments.
Reputational risk: Miscommunication or program failures could damage the organization's credibility and stakeholder trust.	We will: - Develop a tailored communication strategy. - Define approval structures and clear messaging guidelines. - Train staff on communications and stakeholder engagement. - Use CEA feedback mechanisms for risk monitoring.

Please indicate any security and safety concerns for this operation:

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

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

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

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

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

Planned Intervention

Health

Budget: CHF 176,697
Targeted Persons: 30,000

Indicators

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

Priority Actions

Support scaling-up the early detection, and referral of identified cases
• Train 240 volunteers on who will run the health intervention. Training covering Integrated modules for cholera response skills. Include EVC, IPC, SBC), 300 different volunteers identified and trained for the RCCE.
• Strengthen community surveillance and event-based surveillance with referral of cases to health services.
• Strengthen surveillance at entry points in key high-risk health districts to rapidly detect cases and refer them to health services.

Support to case management at community level
• Train volunteers and their supervisors on ORP management, ORS administration.
• Establish community rehydration points and refer cases to treatment sites where incidence is very high; 30 units/teams to support ORS at community level.
• Support Local health authorities on the distribution of ORS at community level, to households. As per ORS provision from Health services at districts level.
• Establish psychosocial support services to those affected by the disease (patients, family members of patients or those who have death cases from the disease in their families).

Health prevention scale-up through the RCCE
• Deploy 300 volunteers to raise awareness among the population of the best attitudes, practices and measures to adopt in order to avoid a high number of deaths from the disease, prolonged periods of illness and a high number of community members affected and infected by the disease.
• Engage and train community committees' representatives, leaders on the cholera prevention and key messages. engaging them on promotion of the key messages during group meetings, mass communication etc.

• Activate trusted channels and audio-visual messages through the CEA strategy to scale-up the prevention messages.
• Translate awareness messages developed or received from MoH and support effective dissemination to the most at-risk areas.
• Activate mass communication for prevention. Include direct reach through door-to-door sensitization, Awareness in public and common spaces in and out of the camps, local radio engagement and IEC material.
• Key messages to scale-up include Promoting the cholera vaccination; the hygiene & sanitation practices; ORS use; importance of health referral and key health centers with active CTU/ORP etc.
• Leverage the RCCE and social mobilization for OCV - deploying 540 volunteers.

Includes messages on prevention: early detection of the disease by teaching symptoms and risk factors to their communities, assisting in active case finding, teaching them what to do in case of a case, teaching the community the correct way to treat water, handle food, clean the environment and toilets, and use toilets. Awareness through door to door, local media and community representatives and community platforms as relevant.

Water, Sanitation And Hygiene

Budget: CHF 93,454
Targeted Persons: 5,000

Indicators

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

Priority Actions

* Strengthen hygiene and sanitation in communities where cases originate and where cases could occur, including in public places (markets, bus stations, schools, mosques, refugee camps, etc.).
* Provide support for the treatment of water for consumption and domestic use in different communities through community awareness/training and the provision of chlorinated products for water treatment.
* Monitor the quality of the water available for use by the community.
* Install handwashing stations in public places (markets, mosques, churches, schools, entry points to certain cities) and entry points to certain localities to limit the spread of the virus.
* Distribute soap to the most disadvantaged households.

WASH priorities include the
* Support in treating water for use and drinking water in the various communities.
* Ensure control the water quality for the available water the community is using.
* Provision of hand washing points at the public places (markets, mosques, churches, schools, points of entries into some cities) to limit propagation.
* Distribute Aqua tabs to reduce water-related contamination.
* Distribution of sachet pure to treat water
* Test the quality of water using <pool testers>
* Raise community awareness about hygiene and sanitation promotion.

Protection, Gender And Inclusion

Budget: CHF 15,970
Targeted Persons: 24,000

Indicators

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

Priority Actions

• Train 160 volunteers et supervisors CRT on PSEA, safeguarding, child protection, and PGI standards.
• Ensure understanding and use of the survivor-centered approaches for the PGI volunteers' focal points and response team for all sensitive feedback or reports.
• Ensure PGI standards are monitored and considered in the WASH and health intervention.
• Briefing of wider team on PGI minimum standards to help integrate PGI principles into the various sectoral intervention (CEA approach, WASH and health).
• Revision and adaptation of PGI tools and messages to context and languages.
• Ensure mechanisms to manage sensitive complaints from beneficiaries in place in some of the camps are active and used or established based on learnings from MDRS1001 Emergency appeal.
• Raise awareness among beneficiaries on GBV, safeguarding and child protection. Use visual printing to promote messages to prevent and report cases of sexual violence and exploitation during humanitarian aid and to ensure they know how and where to report any abuse.

Community Engagement And Accountability

Budget: CHF 24,953
Targeted Persons: 100,000

Indicators

Title	Target
Number of volunteers and supervisors trained on RCCE for the control of cholera in their community.	416
Number of communities leaders engaged and mobilised alongside volunteers for the risk communication/households messages	100
Number of schools sensitized on cholera	100
Number of public places(markets, mosques, churches, mariage places etc.....) sensitized on cholera	400
Number of interactive talks made on community radios on cholera	48

% of community suggestions and feedback addressed or otherwise acted upon	100

Priority Actions

• Train at least 300 volunteers and 30 to 40 CRT supervisors and equip them with visual aids, leaflets, and knowledge on RCCE and minimum standards of CEA.
• Engage community leaders and representative structures to co-deliver cholera behavior-change messages, promote preventive measures, and encourage early care-seeking and referral. Volunteers and leaders to raise awareness about the correct use of hygiene material, water treatments and sanitation products before use or consumption; preventive measures; cholera vaccination; disease symptoms and early detection and referrals.
• Integrate intensive community engagement into all WASH & health activities: language-appropriate demonstrations on water treatment, storage, and sanitation to the most vulnerable households for safe storage.
• Activate trusted communication channels (traditional, culturally accepted) and ensure use of relevant languages to expand the cholera key messages. Includes: community leaders/representatives; local radio; direct volunteers visits; audio-visual supports.
• Establish two-way feedback mechanisms within the community on the response provided. People's questions or concerns will be collected through volunteers' visits, community meetings and they will be addressed through same channels using a FAQs continuously updated with feedback collected.

Coordination And Partnerships

Budget: CHF 0
Targeted Persons: -

Indicators

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

Priority Actions

• Participation in coordination meetings with MoH and partners at field and National level.
• Cooperation on security and risk for context monitoring.
• Participation in evaluations, joint partners and movement partners initiatives.
• Ensure Launch of DREF with engagement with partners and related CRT branches.

Secretariat Services

Budget: CHF 116,378
Targeted Persons: 30

Indicators

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

Priority Actions

• Revitalise the branches in each of the six health districts to enable them to fulfil their role in supporting the fight against cholera at the branch level.
• Support for two surges (public health in Emergency and WASH) for three months.
• Technically run the response structure of the NS.
• Organize the response at the level of the national society (HQ and the local branches where the crisis is).

National Society Strengthening

Budget: CHF 40,817
Targeted Persons: -

Indicators

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

Priority Actions

Among the priority activities based on planned strategy, CRT will ensure:
• Training and mobilization of Volunteers. Ensuring minimum standards briefings and technical trainings are run before deployment.
• Duty of care for volunteers, include visibility, safety/security mitigation, Insurance of volunteers.
• Kick-off meeting and information sharing with all partners.
• Ensure monitoring and evaluation planning with branched. Development and bi-monthly progress check of the 6 branches implementation and monitoring plans (Chokoyane, Hadjar Hadid, Adré, Abeché, Abgoudam and Amelyona) to adequately response to the cholera epidemic outbreak.
• Design and share support needed from partners (PNSs and IFRC).
• Ensure constant information sharing and coordination with relevant partners.
• Lessons learned workshop.

About Support Services

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

A total of 700 volunteers and supervisors, team leaders and supervisors will be mobilised for all sectors.
- 300 for the overall RCCE and campaigns.
- 240 covering the CBS and ORP support.
- 160 mobilised for the PGI and for rotation to the main core RCCE team.

Technical support will be provided by branches staff and head quatres. For the health and WASH component, the specialists will be mobilised and deployed frequently to the field. In addition, the IFRC must mobilise an RDRT to support the CRT team in the effective implementation of the DREF operation.

The DREF allocation will cover insurance costs, travel expenses, daily allowances for volunteers and travel and accommodation costs for the RDRT.

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?

In this area of Chad with a lot of religious and cultural sensitivity we have made efforts that teams of volunteers working in the comunity be gender based. Effort will be made to see if among the sudanese refugees some were Red Cross Volunteers before so as to include them, train them and work together.

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

Yes
The delegation ensures close monitoring and technical support across all programmes. In the south, a sub-office with dedicated staff provides direct oversight, while in Ouaddaï and Sila, monitoring has relied on remote support, short, targeted missions, and temporary staff reassignments. For this DREF, the same approach is applied but strengthened with a key surge presence in the field which remains the most reliable and cost-efficient way of ensuring quality and accountability is maintained and translated in the reports. List of surges and their intended roles:

- A Public Health Emergency specialist surge will be deployed as the main technical referee for the operation, linking with IFRC delegation and NS. The Public Health Emergency specialist will support the head of the health department to customize to the Chadian context the various technical public health guidance for the control of cholera, support in the training of health personnel and volunteers on cholera management, psychosocial support, IPC and to some extend RCCE.
- The WASH surge will support the national society in establishing and strengthening the WASH intervention, transfer of competencies and strengthening/training of branches to deliver quality services.

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

The national society with the support of the procurement team of IFRC cluster CAR-Chad will do the procurements. Depending on the availability of identified items to be procured it will be done locally or internationally (if internationally then the IFRC takes over to facilitate the purchase to the NS). The purchase will be for distribution within the response.

Since most of the items needed for the response are on the local market, the tendering will be for less than a month period. Only for unavailable items that procurement will be supported by IFRC through their international Logistics and supply chain. All the contracting processes required for the activities planned in the DREF operation will be carried out in coordination with the RDRT deployed by the IFRC, and in accordance with the standard procurement procedures of the CRT/IFRC.

For the fleet mobilization and management, the Community Health Department and the Disaster Management Department of the CRT use vehicles to support the implementation of the DREF operation - to transport volunteers, the RDRT and staff during assessment and implementation. This is more necessary now with some access challenges linked to waterflow. Fleet security rules will be followed strictly during the intervention.

How will this operation be monitored?

Once the cholera response team is established, an inception process will be conducted with branches to develop detailed implementation plans. Units at both HQ and branch levels will be briefed on the DREF objectives, indicators, reporting requirements, and their respective roles. Joint field visits by the Chad Red Cross (CRT) and IFRC are planned at launch and during implementation, both to observe progress and to provide technical guidance, ensuring quality standards, accountability, and coordination with external partners.

Monitoring tools already in use for the Emergency Appeal will be adapted to capture daily activity data across all response sectors. Weekly and monthly internal CRT coordination meetings will be held, producing synthesis notes to inform regular progress updates on the response.

Oversight of the intervention's efficiency and quality will be ensured through the in-country cluster delegation team and surges. IFRC maintains a team in N'Djamena working with the Ministry of Health, complemented by a decentralized team in the Hadjer Hadjid IFRC office represented by the surges deployed. Together with CRT, these teams will support data collection, reporting, and field monitoring. Weekly cholera control coordination meetings will bring together all levels of CRT and IFRC teams to ensure coherence of the response.

To strengthen technical and financial quality, IFRC will deploy surge staff, with priority profiles in Public Health Emergency and WASH. Additional expertise from the Bangui Cluster will be mobilized on a rotational basis, including Community Engagement and Accountability (CEA), Finance, Logistics, Operations, and PMER.

- CEA support will guide and strengthen community feedback mechanisms, ensuring that community concerns and needs are integrated into the operational response.
- Finance monitoring will be organised with a strong support from IFRC by deploying an experimented IFRC finance staff for several round of missions with the objective to ensure proper inception and systems set-up; monitoring with adequate interim financial reports; financial closure of the operations. In parallel, that staff will strengthen the capacity of the tea; by ensuring transfer of competencies from HQ to the branches. The missions will be jointly coordinated with NS finance staff.
- Operations and PMER missions will be part of the inception phase to brief teams and establish systems for effective monitoring, reporting, and results-based management.

Please briefly explain the National Societies communication strategy for this operation

Chad Red Cross will with the support of the IFRC's communicate using multiples channels of communication: Report of activities, doing press releases, convening journalists to the launch of the DREF, posting some synthesis of the response on their webpage and that of IFRC GO, using the local radio and television to pass educative messages on cholera control and to inform on the activities carried out, use posters, banners, flyers to disseminate messages.

The response team and the communication team through the team members working on RCCE will make sure that they get the affected population who wish to speak out to have a platform to express themselves and also to use feedback mechanisms to send out their thoughts.

Once the cholera response team is well established, the communication team and them will work together to establish a proposal communication plan that is transparent and enables the beneficiaries to express themselves.

IFRC's cluster communication team will support CRC in preparing and improving the quality of the communication information that will be broadcasted, published or disseminated.

Contact Information

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

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Click here for the reference