Tackling deadly diseases in Africa

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TACKLING DEADLY DISEASES IN AFRICA: KEY CONSIDERATIONS FOR EPIDEMIC RESPONSE AND PREPAREDNESS IN CHAD

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EXECUTIVE SUMMARY AND KEY IMPLICATIONS

The lack of capacity in state provided health services, including poor governance, is a severe limitation on the country's ability to fight disease. There is a high burden of communicable disease and an increasing burden of non-communicable disease. Health data is not shared between health and humanitarian actors and indicators produced by state authorities are sometimes unreliable.

o There is a need to improve accountability mechanisms, coordination and data sharing between the health system, and across sectors, especially between health and humanitarian actors.

o Support is needed in the production of quality and reliable social science and medical and epidemiological intelligence.

■ **The lack of physical and economic access and low quality of care in government-provided clinics** means that only those in rural areas or the poorest in urban areas seek care there. This is compounded by the fact that state-provided health care is not free, so if cheaper non-profit NGO or religious clinics are available, poor people will attend those instead. Those who can afford to do so, bypass state-provided medicine to attend private clinics or alternative health providers. Health workers' capacities, infrastructure and funding are insufficient.

o state-provided health systems should be strengthened, by expanding health worker capacity, ensuring their livelihoods and providing recognition

o To improve trust, health service provision should be adapted to local customs and needs, and staff and health volunteers should be recruited locally whenever possible to improve local ownership and intercultural relations in the clinic.

- **Targeting of vulnerable groups has to occur at a local level**, as vulnerability is highly determined by context, but the following groups should be considered as potentially requiring support:
  - o People with inadequate WASH infrastructure, nomadic pastoralists, the urban poor, people in displacement camps, fisherfolk, street children, and women.
- **Many drivers of disease in Chad are related to a lack of basic services (e.g. water and sanitation) and safety nets rather than 'risky behaviours'.** In turn access to health services in Chad is shaped by gendered relations, both in terms of household decision-making and in patient-staff relations in the clinic.
  - o Structural causes of vulnerability to epidemic disease can be addressed by liaising with other sectors (WASH, Social Protection, Gender and Development, etc.).
- **People rely on a diversity of health providers** (private, state-provided and non-profit biomedical clinics, faith healing *marabouts, tradipraticiens*, drug sellers, diviners, etc.).
  - o Alternative health providers should be engaged for surveillance, risk communication, certain delivery of treatments and referral to biomedical services.
  - o A systematic survey of local etymologies and understandings of disease is necessary to facilitate intercultural understandings in the clinic and to tailor risk communication to specific populations.
- **There are significant parts of the population that feel disenfranchised and do not trust the government.**
  - o Involving trusted actors (health staff, civil society organisations and local authorities) in epidemic response can lessen resistance from certain communities and bring new and valuable perspectives into the response. We explore the role of these actors in detail in the report.
- **Previous epidemic responses have engaged communities in successful ways, but impact could be improved by tailoring response activities and communications to the local context.**
  - o feedback loops can be used to modify response activities and respond to queries by communities.
  - o Communication must be adapted to local idioms and languages, and ensure targeting and messages do not use blame and generate stigma.
  - o Holistic health interventions building on community expertise should be prioritised over disease-specific ones.

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INTRODUCTION

Figure 1. Source:
http://ontheworldmap.com/uganda/uganda-political-map.html

Despite an increase in government revenue from oil for almost two decades, the health system of Chad remains underfunded and has limited capacity in terms of infrastructure and human resources. This hampers its ability to respond effectively to epidemic and other health challenges. Disease outbreaks occur against a backdrop of complex and interlinked humanitarian crisis including conflict, forced displacement, environmental disasters (drought, floods, etc.) and food insecurity which epidemic and preparedness activities must take into account. Chad has made significant progress in terms of planning and policy development for epidemic response, immunisation and the fight against zoonotic diseases. There are positive experiences from past epidemics when coordination between state and non-state actors was enhanced, multiple stakeholders (e.g. alternative health providers, civil society and religious authorities) and communities were engaged.

The brief is structured as follows: 1) an overview of the country's health system, including both the public and private health sectors; and 2) key issues related to infectious disease outbreaks, response, and preparedness and 3) a list of key actors with which early responders may want to engage in response activities. The brief closes with implications and recommendations for future epidemic preparedness and response in Chad.

This brief offers a contextual overview of the Chad's health system, highlighting key factors and their implications for disease outbreak preparedness and response. It draws on a literature review of both academic and grey literature, as well as informal interviews with social scientists and others with expertise on the Chadian context. An appendix provides more in-depth presentation of basic context, history and political economy, and social groups and organisation. This technical brief was prepared by the Institute of Development Studies to support the embedding of social science and anthropological
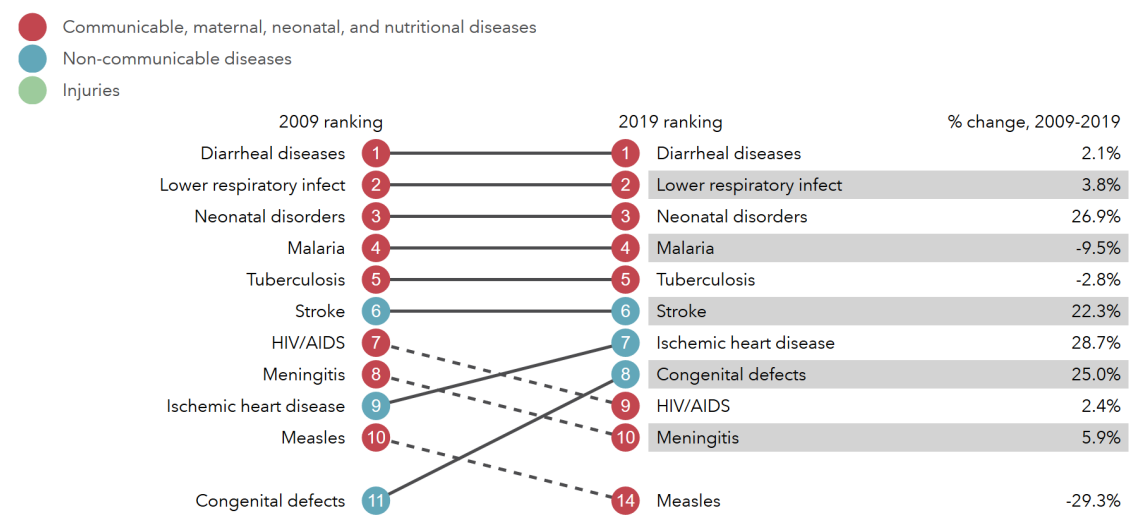
perspectives in UK AID-supported Tackling Deadly Diseases in Africa (TDDA) programme technical assistance as well as its Early Response Mechanism.

HEALTH SYSTEM

BURDEN OF DISEASE

Chad's life expectancy at birth is 53 years for men and 55 for women[1]. The under-five mortality rate is 113.8 per 1,000 live births. Chad has one of the highest maternal mortality rates in the world, 6.7%, meaning 1 in 15 women will die in childbirth[2]. Diarrheal disease, lower respiratory infections, neonatal disorders, malaria, and TB are the major causes of mortality amongst Chadians (see figure[3]). HIV/AIDS prevalence is 1.3%, as 120,000 people are living with HIV[4]. Chad's response to HIV/AIDS has successfully brought down prevalence by 12% since 2010. Women are disproportionally affected by HIV/AIDS in Chad (60%), yet they are also more likely to be in treatment (67%) [4]. Notably, national statistics[5] are not always trustworthy and triangulation with independent surveys is recommended.

What causes the most deaths?

- 🔴 Communicable, maternal, neonatal, and nutritional diseases
- 🔵 Non-communicable diseases
- 🟢 Injuries

2009 ranking			2019 ranking	% change, 2009-2019
Diarrheal diseases	1	1	Diarrheal diseases	2.1%
Lower respiratory infect	2	2	Lower respiratory infect	3.8%
Neonatal disorders	3	3	Neonatal disorders	26.9%
Malaria	4	4	Malaria	-9.5%
Tuberculosis	5	5	Tuberculosis	-2.8%
Stroke	6	6	Stroke	22.3%
HIV/AIDS	7	7	Ischemic heart disease	28.7%
Meningitis	8	8	Congenital defects	25.0%
Ischemic heart disease	9	9	HIV/AIDS	2.4%
Measles	10	10	Meningitis	5.9%
Congenital defects	11	14	Measles	-29.3%

Top 10 causes of total number of deaths in 2019 and percent change 2009–2019, all ages combined
See related publication: https://doi.org/10.1016/S0140-6736(20)30925-9

Figure 2. Burden of disease Chad (source: IHME 2019)

Non-communicable disease is increasing in importance, with 10% of deaths attributed to cardiovascular diseases, 3% to cancers, 2% to chronic respiratory illness and 1% to diabetes[6]. There is a double burden of malnutrition in Chad: 39.8% of children under 5

years old are stunted, and 8.9% of women and 3.1% of men are obese[7]. Obesity is linked to high income, urban (especially in N'Djamena) demographics[8].

PUBLIC HEALTH SYSTEM

Governance of the contemporary health infrastructure has its roots in the top-down, centralised French colonial model. This has implications for the management of large-scale natural disasters and pandemics where centralised decision-making power creates bottlenecks. Successive decentralisation reforms implemented since the 1990s have not radically altered the system. Additional challenges related to lack of public funding and qualified staff within the state health system. The health system is sorely underfunded and has very limited number of qualified staff. There are only 3.7 physicians and 2.1 nurses and midwives per 100,000 population, concentrated primarily in the N'Djamena region[9]. There are 40 hospital beds per 100,000 population[1]. Some development and humanitarian projects by external agencies such as MSF and UNICEF have involved embedding foreign physicians in state-provided hospitals and clinics to enhance capacity and carry out on-the-job training[10]. Chad spends 3.62% of its GDP in medical expenditures. Doubts have been raised about the handling of resources managed through the state health system - equipment, drugs, funds - with accusations of nepotism and corruption[11].

Focusing on the National Health Policy, the Ministry of Public Health is implementing the National Health Plan (PNS) 2016-2030, defined by technicians from the Ministry of Public Health, with the support of national and international actors. International actors can support health provision vertically through improvements of government-led health system, both in term of improving policy, financing health facilities and infrastructures, and providing logistical support for improved health delivery by state clinics and hospitals. These actors include UN agencies or bilateral aid donors. Alternatively, external actors also support health systems through the provision of complementary biomedical services (clinics, vaccination, etc.), such as international NGOs like MSF, International Medical Corps, etc (see list of international organisations in Annex 1). There is limited coordination between donors and different health providers, both national and foreign aid-financed , which has led to "fragmentation of health systems and duplication of services and monitoring mechanisms"[12]
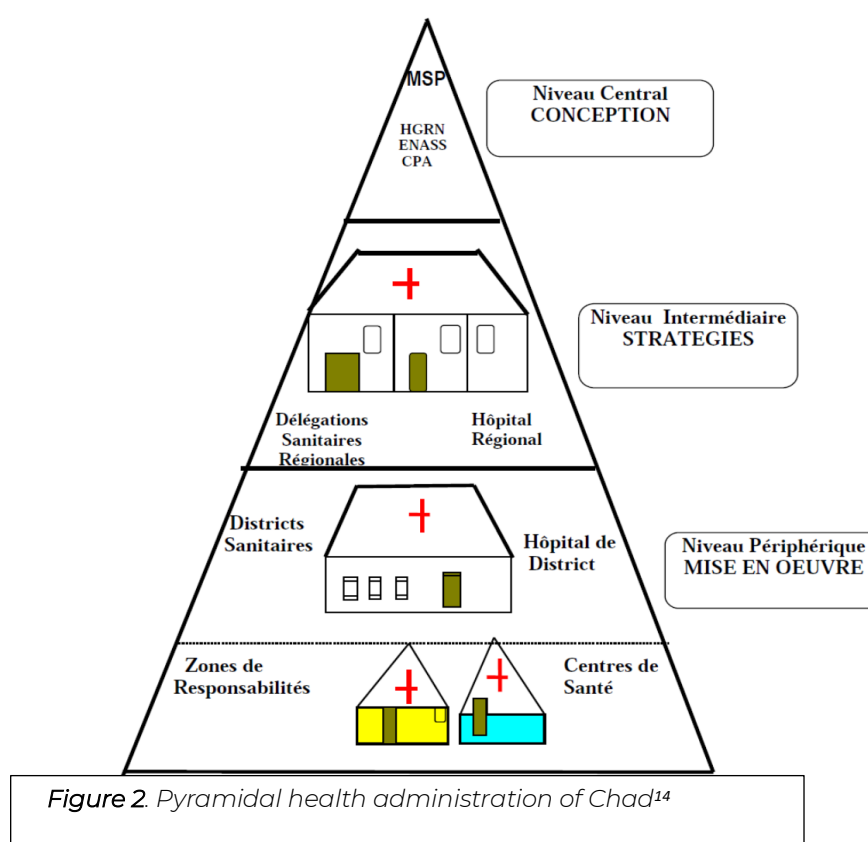
Public health system structure
The Chadian health system is conceptualised as a pyramid structure, organised into four levels[13]:

1. A top-central level, including the National Health Council, the central services of the MOH, the general National Reference Hospital (HGRN), The National School for Health

and Social Agents (ENASS) and the Central Agency for Purchase of Pharmaceuticals (CPA). At a political level, key actors are the MOH, the Ministry of National Defence, which together with the general secretariat of the presidency and the civil cabinet of the president play an important role in decision-making.

2. A central level comprising the central services and national institutions. At this level, there are 5 national hospitals;

3. The intermediate level subdivided into 23 Provincial Health Delegations, provincial reference hospitals, regional supply pharmacies and regional health training schools;

4. Finally, the peripheral level groups together 138 health districts, of which only 107 are actually functional. In addition, there are health centres and the relatively small private health sector.

Figure 2. Pyramidal health administration of Chad[14]

In general, very few people have access to the health system in Chad. The supply of biomedical care remains very limited and there is no free access to all state health services. In a 2019 Gallup poll, 63% of Chadians reported being dissatisfied with the access to quality healthcare[15]. Free care was introduced by law for maternal care services, support to children under 5, emergencies and treatment for TB and HIV/AIDS. However, due to a lack of adequate funding many of these services still require payments[16]. As in other African countries, there is a problem with the circulation of counterfeit drugs, with 33% reporting having been sold fake drugs[17].

The rate of attendance at health centres in rural areas is among the lowest in the world. Income inequality and the high cost of health care and transport means that in urban areas only wealthy people can bypass low quality government-provided clinics. Poorer households in urban areas and people in rural areas are locked into low quality health provision[18]. Aiming to address the lack of availability and unaffordability of primary health clinics, NGOs and religious organisations have also set up some non-profit clinics in Chad which are cheaper, and on occasions, if linked to a foreign aid funded development project, free.

Level of income is generally low and only 6.28% of the population can afford to spend more than 10% of their income on their health. According to the World Bank, between 4 and 10% of the population suffer catastrophic health expenditures every year, a fact compounded by the lack of social safety net mechanisms or livelihood support[19].

Chadians have a clear sense of quality of biomedical health care and are willing to travel further afield or pay more for it, if they are wealthy enough. People are aware in what circumstances modern medicine is effective and what it should deliver, and in many occasions, for example in Abéché city, they do "not trust the local hospital to have the capacities to deliver what modern medicine is supposed to be"[20].

ALTERNATIVE HEALTH PROVIDERS

As in other African countries, health services in Chad are largely dependent on providers outside of biomedical health facilities.

People choose between providers based on their community and religious affiliations. Muslim patients are more likely to use the treatment provided by the *marabout*, a spiritual leader also in charge of basic health treatment in rural communities, while patients who are Christian or follow traditional religions tend to use traditional healers, whose name and function change depending on the specific local community. It is estimated that traditional medicine is used by 60-79% of the population[21], particularly so by people in rural and periurban areas. Traditional healers are generally called *tradipraticiens* and use a range of local plants to treat different diseases. They recently created their own confederation, the "National Confederation of Traditional Practitioners of Chad".

A more recent phenomenon among the Pentecostalists is that of the "healer-pastors", who claim to cure diseases through prayer, while there are also the *tchoukou* doctors" or *djim* doctors, young people in urban centres who sell street biomedical drugs and even provide first aid; and the "fortune-tellers", women who use cowrie shells or other divination methods to predict the future but also to cure certain diseases.

HEALTH SEEKING AND LOCAL EXPLANATIONS OF DISEASE

Ill people seek advice simultaneously and/or successively from different care providers. The first care pathway is the one that focuses on traditional practitioners. When the illness persists or worsens, people turn to formal biomedical care providers, if they have enough resources to access it. Seeking treatment though dispensaries or drug sellers is also common (even though the market is poorly regulated and low quality or counterfeit drugs circulate)[22].

The initial preference for alternative health providers is compounded by the unaffordability of and lack of confidence in the government-provided clinics. When available in their area, poor people prefer help from NGOs or religious clinics in comparison to the state-provided healthcare as they provide cheaper treatment, and wealthier Chadians in urban areas bypass state-provided care and attend higher quality private clinics[18]. Sometimes wealthy Chadians travel outside the national territory in search of higher quality healthcare. Cameroon, Sudan, Egypt and Tunisia are the preferred destinations for medical evacuations.

Within the household, men tend to decide when to seek help, and choose what health provider to resort to. Men are expected to pay for treatment and women in the household are expected to provide care and support to the patient.

Understandings of illness and health

People link diseases to various causes in Chad. People identify immediate and ultimate causes of disease, sometimes attributing an anthropic origin (caused by another person through witchcraft or magic) or a divine or supernatural origin. People often invoke the magical-sorcerer dimension of the cause of disease to treat certain pathologies, such as epilepsy, autism or genetic malformation. As far as the divine cause is concerned, patients attribute all illness to "the will of God". These popular beliefs are widespread and guide the choice of health care providers to consult. African traditional disease models which have been applied by some Anthropologists to Chad stipulate that when people fall ill, there is a need to identify four things: what the disease is (an illness assigned to a constellation of symptoms), what the instrumental cause is (how it happened), the agent (what or who caused it), and the origin (why me and why now)[23]. These models may gloss over local particularities. In practice, people would seek help addressing the symptoms, and if the treatment did not provide immediate relief, alternative explanations seeking to address ultimate causes will be sought[24].

There is a dearth of literature coming from Chadian (or other) universities on local terminologies and understandings of infectious disease and how they relate to health seeking practices. The majority of the relevant medical anthropology work available is on pastoralist communities[25–28]. For example the Fulani speak of: *ouirde* (rainy season fever),

and seek malaria treatment from the market, *sabib* (diarrhoea), *kalara/kolera* (cholera diarrhoea), *ouarama* (illness complex associated with heat and swelling), *fuli/ sondarow* (tuberculosis symptoms), and so on. The symptoms and the gender relations determine what treatment is sought from which provider[28]. In terms of the generic word "epidemic" it does not exist in all languages spoken in Chad, but it does in some, for example in the regions of Ere, Djoumane and Kim, people use the term *mbôgôm* to speak of outbreaks of different diseases like measles or smallpox[29]. A systematic survey of these terminologies and understandings is necessary for effective surveillance of emerging diseases, effective communication of risk mitigation activities and appropriate inter-cultural relationships in the medical clinic.

SERVICE DELIVERY, EXPERIENCE OF CARE AND EXCLUSIONARY PRACTICES

A former Minister of Public Health acknowledged in 2016 that the health system was struggling to meet the needs of poor, indigent and rural people. Since colonial times, the state concentrated the infrastructure in the main cities, neglecting rural areas. As a result, public health provision does not reach remote areas. Pregnant women face several difficulties in attending health facilities, both in terms of physical access but also due to the need for a male member to be present[30]. A survey conducted in 2012 showed that 9.4% of respondents felt they had experienced discrimination in their access to health services, either because of their ethnic or religious background, or their socio-economic status[57].

This discrimination is even more patent in the relationship between nomadic pastoralists and health clinics. Health services adapted for settled communities are ill-adapted for the livelihood needs of nomadic pastoralist communities. There are also socio-linguistic barriers between nomadic groups and health workers, and pastoralists have been treated with disrespect or faced discrimination in the provision of drugs[26]. Mistrust of health providers is a key driver of vaccine hesitancy. Solutions have included the provision of mobile clinics for pastoralists, lists and descriptions in the local language of the nomadic pastoralists (e.g. Fulani) and capacity building for service providers about the needs and constraints of nomads. In turn, the recruitment of nomadic community health workers and midwives is a way of increasing access and improving clinic-patient relations[27] as tested in the polio vaccination campaigns of 2011-12[31]. The importance of appropriate intercultural skills was also evident in the hospital treatment in Abéché town during the Darfur crises, in which patients were attended to by health workers from different ethnicities and nationalities who did not explain in culturally appropriate ways the medical practices they were carrying out, and thus patients left the hospital against medical advice.[59]

INFECTIOUS DISEASE OUTBREAKS, RESPONSE AND PREPAREDNESS

DISEASE RISK AND VULNERABILITY

Endemic disease and seasonal emergence

In Chad, epidemics of other diseases such as cholera and malaria are frequent. Cholera is endemic in the country, with outbreaks often occurring in regions bordering Cameroon, Niger and Nigeria, and initial outbreaks often occurring in the period from March to May. Emergence is linked to bodies of water such as the regions of Lake Chad and River Logone[32]. Transmission is enabled by poor water and sanitation systems, including poor WASH conditions in refugee camps[33]. Only 56% percent of Chadians have access to an improved water source, with access skewed towards urban areas, and more so in the capital. Only 51% nationally have access to improved sanitation, yet mostly biased towards cities, as 85% of rural households do not have toilets[34].

Malaria is endemic in the region, being one of the main causes of morbidity and mortality in the country. As with other interventions, conflict in the past has impeded the distribution of preventative or curative medicines or bed nets. The short rainy season (June-September) is peak malaria season, and seasonal malaria chemoprophylaxis has proven very useful in mitigating outbreaks. Proximity to the lake Chad region in the summer season means higher incidence due to increased humidity and vector transmission.

Measles and other vaccine-preventable diseases are rife in the country. Despite progress in its vaccination programme, only 1 in 4 Chadian children are fully vaccinated, and only 57% of children are vaccinated against measles. Emergency vaccination has proven to contain measles outbreaks in the past before they reached epidemic proportions[35], yet until herd immunity is achieved (95% rather than the current rate) epidemics are likely to remerge periodically. A measles epidemic is ongoing, with 67% of health districts affected at the time of writing[36]. Limited access to health services drives low immunisation coverage. Whilst figures will vary across groups and regions, a Wellcome trust survey conducted in 2018 showed that people in Chad value vaccines, with 85% responding they are important for children to have, and 81 % agreeing or somewhat agreeing to the statement that vaccines are safe[37]. Nomadic pastoralists have a lower rate of vaccination, derived from lack of physical access to health services and information, as well as discriminatory attitudes by vaccinators (not due to fears towards the vaccine itself)[38].

Livestock farming is central to Chad's economy. Over 40% of the population depends on livestock herding, and there are over 94 million heads of cattle. Nomadic pastoralism

makes 90% of livestock herding[39]. Hence, zoonotic diseases are common and have an impact on the economic security of herders and their health outcomes. Rift Valley Fever is of common occurrence in the country, as is Q fever (linked to camel herding)[40], Brucellosis, and Trypanosomiasis[41].

Table 1. *Notable outbreaks of infectious disease in Chad, 2000-2020*

Meningitis	2001, 2004, 2010, 2011	Largest outbreaks involve Neisseria meningitidis serogroup A (NmA), but often several serogroups and other bacteria (Streptococcus pneumoniae and Haemophilus influenza type b (Hib)) can occur simultaneously[42]. Common in refugee camps, due to crowding and rapid turnover of dwellers, and response has involved emergency vaccination.[43]
Cholera	2001, 2004, 2006, 2010, 2011 (>16,000 cases), 2017	Cholera emerges endemically linked to rains and water bodies, yet small outbreaks can become epidemics when transmitted due to poor water and sanitation infrastructure- particularly so in camps.
Polio	2005, 2007, 2019, 2020	Risk mostly in the Lake Chad regions. Very small-scale vaccine-derived poliovirus outbreaks, not necessarily linked to a local history of vaccination e.g. Cameroon border. Linked to poor sanitation, lack of immunity and population movements.
Chikungunya	2016, 2020 (>16,000 cases)	Currently affecting the Abéché district in the East. Mosquito-borne, linked to rains and water bodies and availability of bed nets.
Hepatitis E	2004, 2016, 2017	Linked to poor WASH infrastructure, and consumption of surface water. Latest outbreak confined to South Eastern region of Salamat.

VULNERABLE POPULATIONS

Vulnerable populations vary depending on the epidemic disease, but those with potential co-morbidities which are highly prevalent in the country such as HIV/AIDS, parasitosis, malnutrition and high malaria rates are more likely to be impacted. Vulnerable populations include people with inadequate WASH infrastructure, rural populations, nomadic pastoralists, the urban poor, people in displacement camps, fisherfolk, street children, and women.

Response efforts should acknowledge that constraints are more likely to be structural (e.g. lack of WASH infrastructure in the case of cholera) than behavioural. Further, note that some people may be vulnerable to the response itself. Communication on cholera

infection may cause stigma as it is associated with insalubrity, and this has deterred patients from attending Cholera Treatment Units[44]. Targeting and risk communication messaging must be sensitive to the potential for stigma when explaining the root causes of disease. Other response measures have impacted on people's livelihoods, making them less likely to trust the response or be able comply with guidance (e.g. COVID-19-related bans on gathering in markets and movement across borders has affected pastoralists livelihoods severely) [45].

The importance of population movements

The porous and arbitrary (due to its colonial history) nature of Chad's borders means that ethnic, kinship, and economic ties exist on both sides of the border, and cross-border movement is frequent, due to international labour migration, seasonal mobility of livestock, visiting relatives for festivities, and so on. Other factors influencing mobility are conflicts and extreme events: in the last 10 years, turmoil in Sudan (e.g. Darfur conflict) and its spillover into the Eastern Border has generated both cross-border and internal displacement in the East of the Country. In turn, conflicts in Central African Republic (CAR) and Nigeria displaced hundreds of thousands of people mainly in the lake region and the south-eastern borders, returnees from Libya, in addition to those internally displaced by flooding or other disasters. UNHCR in 2019 estimates there to be over 730,000 'people of concern' in Chad, including refugees, asylum-seeking or internally displaced people [46], which constitute a significant vulnerable group in times of pandemic and epidemics. These population movements can impact on the spread of any infection, as they cross-cut almost every Chadian region, and involve the use of very crowded means of transport. For example, cholera outbreaks have been linked to movement along the Nigeria, Cameroon and Niger borders[32].

EPIDEMIC AND OUTBREAK RESPONSE GOVERNANCE

In terms of epidemic preparedness Chad has followed global trends. It incorporated the International Health Regulations (IHR) (2005) into national legislation in 2012 to prevent and react to global epidemics, and developed the National Health Security Plan. In 2009 Chad implemented influenza surveillance as a result of the Avian Flu epizootic, and now carries out sentinel surveillance and has a reference laboratory with PCR diagnostic capacity that has proved useful for the COVID-19 response.

Disease surveillance

Pre-COVID-19, disease surveillance was carried out by the National Committee of Epidemic Prevention. This was grounded on the National Health Security Plan and the National Directives on Integrated Surveillance and Response to Disease (Surveillance Intégrée des Maladies et Riposte, SIMR). The Service for Integrated Epidemiological

Surveillance (SEEIS) carries out surveillance of communicable diseases by supporting the delegations and health districts to collect health data, and informing the National Committee for Disease prevention in case of an outbreak. The National Technical Committee for Epidemic Control (CTNLE) and the SEEIS meet on a weekly basis to address any ongoing epidemics e.g. cholera, rubeola or meningitis.

Formal response architecture

In order to respond to the COVID-19 pandemic a National Plan[47] was developed, covering activities such as surveillance, communication, quarantine and isolation facilities, and the use of mobile laboratories and rapid response teams. Coordination is led by the Health Crisis Management Committee (CGCS), chaired by President Déby, and five specialised subcommittees: awareness raising, finance and orders, assistance to the poor, resource mobilization, and defence and security[48].

COVID-19 in Chad

The pandemic has had relatively low impact at the time of writing, over 100 deaths reports and over 1,600 cases, however, Chad has one of the highest Case Fatality Rates in the world, due to limited intensive care capacity and low rates of presentation at hospital of milder cases44. In line with other African countries, the government imposed measures to prevent transmission such as border crossings, limited inter-city movements, closure of businesses and bans on gatherings. This has had a massive impact on livelihoods. Particularly affected were the poor and informal workers who depend on daily wages, small-scale businesses, and pastoralists who suffered from market bans and movement restrictions, etc. Childhood vaccination campaigns were put on pause and health services interrupted[46].

In terms of humanitarian coordination, Chad coordinates their response with UN agencies, Red Cross and INGOs through the humanitarian cluster structure. This mechanism has been successful in coordinating key humanitarian actors at a Central level in Chad[49]. However, coordination with state authorities and humanitarian actors is much poorer on the ground. There is a Directorate of Non- Governmental Organisations and Humanitarian Affairs (DONGAH), and the National Commission for the Reception and Reintegration of Refugees and Returnees (CNARR) to coordinate with foreign agencies. However, humanitarian actors roll out epidemic response activities (or stop them) without communicating with local public authorities. The government has set up Local, Departmental and Provincial committees to liaise with humanitarian agencies on the ground but these bodies have very limited funding. Public authorities report they

should be better informed about humanitarian activities and argue that they have contextual insights which are necessary for the good running of humanitarian projects[50].

Box 1. Political economy

To understand how different groups of people respond to and trust the governments' epidemic response it is important to understand the politics and history of Chad. See more detail in Annex 2.

■ Since independence from France in 1960, several military conflicts have arisen between elites claiming to represent southern Christian farmers and northern Muslim herders. However, framing the conflict along farmer-herder/Northern-Southern rhetorical divides, hides that military action in Chad has been the only route to power, and that "tactical alliances or personal rivalries and sometimes purely materialistic motives" go a long way in explaining why conflicts in Chad arise (Hansen 2020).

■ Instability decreased after the military takeover by current President Idriss Déby Itno in 1990, who established a formal multi-party democracy. Multi-party politics of the country have been dominated by current President Déby's Patriotic Movement of Salvation (MPS) party, in power since 1990. There has been a progressive centralisation of power in the hands of the presidency, which has become increasingly authoritarian. The opposition has been repressed and has been unable to coalesce into a coalition that threatens that continuity.

■ The MPS party is dominated by the Zaghawa and other ethnic groups from Northern Chad, creating resentment from over 120 other ethnic groups. Political and economic elites in the opposition have created NGOs and civil society organisations to increase their influence beyond politics. For this reason, civil society partners may be subject to harassment and repression by the government.

■ While the inhabitants of cities can directly elect their mayors, there are not elected authorities at the rural level, where a rural *sous-prefect* appointed by the government oversees the customary authorities (*sultan, chef de canton, chef de village*).

COMMUNICATION AND TRANSPORT

Chad had very few paved roads until 2003, after which the government began to build road infrastructure using funding from oil exploitation. To date, 3,200 kilometres of roads have been asphalted[51], linking N'Djamena to the cities of Moundou and Sarh, in the South; and the city of Abéché, in the East. However, parts of these have deteriorated and require 4x4 drive. There are no other major paved roads. Two national companies, the *Société Tchadienne d'Eau* and the *Société Nationale d'Electricité* (SNE), provide water and electricity. There are no national networks for electricity or water, and each city has its own facilities supplying neighbourhoods in different ways.

Airtel and Tigo are the two main mobile phone network companies, but neither can cover the whole national territory and the price to access internet is among the highest in Africa[52]. Only 11% of people had access to internet in 2019[53]. Social media usage has increased in the last decade, and now local associations and NGOs have started having their own Facebook pages. Facebook Is the most popular platform, particularly amongst urban youth. Social media is used by the diaspora as a means for political mobilization. The government sees social media as a "threat to national security" and blocked it (WhatsApp, Twitter, Instagram, YouTube, and Facebook, as well as media websites like bbc.com) for 16 months from March 2018 to July 2019, effectively reducing the organisation of anti-government protests[53] .

Communication

For the design of public communication campaigns, radio is a trusted medium for communication. There is only one radio with nationwide reach, the government-radio *Radiodiffusion Nationale du Tchad (RNT)*[54]. The Chadian media landscape includes about 60 private community, associative, confessional and commercial radio stations, most of them rooted in rural areas and diffusing information in the various local languages. Televisions are not commonly owned and are restricted to people with electricity supplies mostly in major cities, therefore as a communication medium it has limited reach. TéléTchad is the Chadian state-run TV station. Mobile phones have become a crucial form of communication: in 2019, there were 48 mobile cellular subscriptions per 100 inhabitants[55], although coverage is patchy in rural areas, and poor rural people are unlikely to have a phone.

There are over 100 languages spoken in Chad. French and Modern Standard Arabic are the official languages of Chad. French is the working and communication language in public administration, while in daily life Chadian Arabic is the main "lingua franca", widely used for commercial transactions. Sixty percent of the population can speak and understand Chadian Arabic[54], but it is spoken as a mother tongue only by a few groups [54]. Literacy is gendered: In 2016, 31.3% of men over 15 years old could read and write, whereas only 14% of women could.[56]

GOVERNANCE AND KEY ACTORS

State authorities

The Déby government under the Patriotic Movement for Salvation (MPS) finds support across the country, and the opposition has been unable to coalesce into a viable alternative. There has not been a change in power since 1990. There has been a progressive concentration of authority in the figure of the President and repression of opposition parties. For this reason, there is a decrease in trust democratic politics (see

context box above). Only 18% of Chadians interviewed by a 2014 Gallup poll reported having confidence in the honesty of elections. State political and military power is dominated by elites from Northern Chad, and prominent business and political positions dominated by the Zaghawa ethnic group and the Presidents family networks. This makes other ethnic groups and Christians from the South of the country feel disenfranchised. This may play a role in people mistrusting government health advice. In 2018, 47% reported they trusted (fully or somewhat) health advice from the government, but 35% did not trust it (at all or not much)[37]. See Annex 2 for further information on the political economy of Chad.

This political situation accounts for the fact that in the event of a pandemic or epidemic, public health recommendations issued by the government authorities may not be trusted by many Chadians. Thirty-nine percent of respondents in a Wellcome Trust survey said they did not trust the national government much or at all, as opposed to 24% who trust the government and 27% who have some trust in the government. This is particularly so when recommendations clash with local cultural practices or religious beliefs. In the same Wellcome trust survey 70% of respondents in Chad reported that they would choose religion when science disagreed with religious precepts. However, as shown below, there have been many positive experiences in enrolling religious leaders in outbreak response to avoid this potential conflict.

Customary leadership

Customary and traditional authorities (*sultan, chef de canton, chef de village*) are often used as community interlocutors by both the Chadian government and International agencies in development and humanitarian projects, including in epidemic response. These authorities need to be ratified by the Ministry of Internal Affairs and are supervised by the politically-appointed *sous-prefect* of the region.

In the case of nomadic pastoralists, engagement can be achieved through the camp elder (*boulama*), who heads the dispersed and mobile nomadic camps.

The traditional and customary authorities are very important in the implementation of any development project as they are the only authority on the ground, particularly so in remote rural communities. However, there is variation in terms of inclusivity and how much they are trusted by communities. Vulnerable and marginalised members of their communities can be excluded from decision making, such as young people, women or ethnic minorities.

Religious leaders

Religious leaders maintain good relations with the government, which sees them as leaders who can help implement policies. The Directorate of Religious and Traditional Affairs of the government has organised interfaith prayer and forums since the early

2000s, involving leaders of the main faiths represented in Chad. Religious leaders are more likely to be trusted by citizens than state authorities. Religious leaders are often consulted by international organisations to help them convey messages about epidemics. They have previously been recruited successfully to communicate health and hygiene messages in cholera responses[29] and, in tandem with traditional authorities, to convey messages around the prevention and vaccination of Polio[57].

Health professionals

Health recommendations conveyed by doctors and nurses are trusted by a majority of the population. According to the 2018 Wellcome trust survey, 51% of respondents in Chad trusted health messages by these health workers, as opposed to 35% who do not. Doctors and nurses are the most trusted actors in the country (as opposed to government or NGOs), with 75% of respondents saying they trust doctors and nurses in the country. There are a number of customary positions occupied by women and who are able to play a role in community engagement and risk communication. Traditional midwives (locally called *matrons*) assist pregnant women by monitoring the progress of the pregnancy and assisting them during labour and in facilitating access to care. Nurses raise awareness and treat illness in the community. Both midwives and nurses are well known and respected in rural areas, and for this reason, often NGOs recruit them to carry on sensitization about women on development projects.

Civil society

There are a wide range of civil society organisations and social movements in Chad[58–61],

made up of religious associations, women's and youth groups, development groups and trade unions. They are often led by elites (mostly urban) in the South, as a response to their political disenfranchisement. This means civil society organisations are harder to find in the North, and that civil society partners may be subject to harassment and repression by the government[62,63]. As for the trade unions, they are gradually beginning to free themselves from the tutelage of politicians to truly play their role as social movements.

Although national media are controlled by central government, there are independent media associations such as the Independent Union of Journalists of Chad (UJT) and the Association of Private Press Publishers in Chad (AEPT). Since 2009 the *Maison de Médias du Tchad* – managed by civil society - played a very important role in the training of journalists and the organisation of community events, although the state has increasingly taken control in the past two years.

Within the framework of the humanitarian response, Chadian NGOs work alongside international humanitarian agencies in the management of humanitarian emergencies. Most of these civil society organisations belong to national networks focused on particular issues, such as networks for women rights, for food security, for youth issues, etc.[64]

Women and youth are especially well organised and there are at least eight major youth and women's associations at the national level and a multitude of associations at the local level (See list of civil society organisations in Annex 1).

The Chadian diaspora is not as active as in other African countries, but it has played a role in highlighting human rights abuses and corruption by the government through social media.

COMMUNITY ENGAGEMENT, EXPERIENCES AND RESPONSES

Generally, in the event of an epidemic, health authorities rely on a range of actors such as traditional chiefs, youth and women's associations, comedians, storytellers (*troubadours or griots*) and journalists to pass on information effectively. These actors are trusted more than doctors and nurses in rural areas as people are less likely to interact with health professionals, and are more familiar with those civil society actors and customary authorities. Combining several interlocutors in the same interventions has been successful in people complying with public health guidance in the past.

As mentioned above, Chad's response to HIV/AIDS has successfully brought down prevalence and improved compliance by communities of risk mitigation measures and treatment uptake by infected individuals [4]. Chad's response to HIV/AIDS is a good example of community mobilisation for surveillance and treatment of stigma. With the support of UNICEF, local organisations carried out community dialogue and participatory theatre to encourage women to attend antenatal care and be tested for HIV and other STDs. They also mobilised youth and community leaders, including religious and traditional leaders. This was coupled with a mass communication campaign "Free to Shine "using radio, TV and print media, including a nation-wide launch by the First Lady. UNICEF also mobilised their network of youth activists through the U-Report platform, which uses SMS to convey Sexual and Reproductive Health messaging[65].

Holistic community interventions rather than those focused on a single disease have proven to be more effective. For example, successful promotion of vaccination has been achieved by engaging Community Health Workers in case-finding in rural districts[68], and advocating for vaccination as part of a broader package of community interventions including immunisation, hygiene and sexual and reproductive health[67]. This works well when a disease has limited impact on a community and is not perceived as important, but can be addressed as part of a broader package of interventions which are perceived as relevant and useful as a whole.

Communicating effectively
As in other countries, is not uncommon for alternative explanations of a pandemic to emerge. For example, at the onset of the COVID-19 pandemic in Chad, some people

denied the existence of the virus or claimed it only killed white people, or that the virus would die in Chad because of the heat. In order to guide risk communication and community engagement activities, it is necessary to systematically track rumours and misinformation within communities in terms of the epidemic disease and the response, as well as gather people's questions and potential suggestions for improvement. .

Combining a variety of communication channels has been successful in Chadian epidemic response. For example, challenges to address malaria include lack of consistent medication, late presentation at the clinic or dispensary and lack of bed nets. Successful campaigns have included messages dispelling myths or rumours about the benefits and safety of sleeping under bed nets. These campaigns have relied on a variety of communication channels, from town criers and theatre, to mobilising SMS and radio spots[68].

Adapting the response activities to the specific needs of the target population is also crucial. For example, successful polio campaigns have involved joining animal and human vaccinations and exploring new channels of communication between vaccinators and pastoralists, involving the community through local social mobilisation teams and health volunteers as interlocutors and maintenance of contact networks through the year e.g. using mobile phones with camp leaders[38].

ONGOING CHALLENGES AND RECOMMENDATIONS

In 2018 the think-tank Prevent Epidemics conducted a global assessment of the readiness of different countries to face pandemics, measuring 20 indicators, from legislation and financing, laboratory capacity, surveillance, capacity of the workforce, to risk communication and deployment. Chad received a score of 29/100, one of the lowest in the region. It concluded that Chad was 'not ready' for an epidemic, and if one occurred it could be expected to cause loss of life and political and economic disruption[69]. Prevent Epidemics found there was political willingness for preparation, for example by finishing the preparedness plan, and that some advances had been made in the prevention of zoonoses and childhood immunisation. The main gaps identified were lack of biosafety and biosecurity measures, low capacity to roll out emergency response operations and a lack of coordination between public health and security authorities[69]. According to the Global Health Security Index in 2019, Chad has a score of 28.8 percent, and had done relatively well in adhering to International Norms and devising plans on paper, but failed in terms of the actual capacity within the health system and epidemic surveillance.

Epidemic preparedness and response is also hampered by complex humanitarian emergencies in different parts of the country, in which health emergencies, food security crises, environmental emergencies and conflict overlap with multiplier effects. For

example, during the current COVID-19 pandemic, the state and humanitarian actors have also had to respond to a malaria and chikungunya epidemic, catastrophic floods, crop losses and ensuing food security problems, as well as localised conflict. This puts a great strain in the allocation of resources and the coordination of different actors to address different emergencies happening simultaneously.

KEY IMPLICATIONS FOR OUTBREAK RESPONSE

Supporting health system coordination and accountability: Lack of capacity in state provided health services, including poor governance, is a severe limitation on the country's ability to fight/address disease. There is a need to improve accountability mechanisms, coordination and data sharing between the health system, and across sectors, especially between health and humanitarian actors. There is a need to improve quality and reliability of social science and medical and epidemiological intelligence produced.

- Support civil servants in MOH in development of capacities and advocate for funding of MOH activities. Advocate for systems of good governance and accountability in the use of government and international resources managed by the state system to ensure non-salary resources reach primary health care centres.

- Support coordination and information-sharing between Ministry of Health, donors, international organisations providing health care, state clinics, NGO clinics and religious clinics, to avoid duplication and to expand coverage. Support coordination between actors not only at a centralised level (e.g. humanitarian clusters) but also at a local level.

- Support public health institutions and non-profit organisations in the production of reliable and actionable health statistics and epidemic surveillance, incorporating social science intelligence as well as medical and epidemiological indicators.

- A cross-country coordinated surveillance and response is often necessary as kinship, ethnic, inter-ethnic, political and trade networks in Central Africa often cross borders. This is exacerbated by refugee movements because of conflict in neighbouring countries.

Addressing structural causes of vulnerability: many drivers of disease (generating co-morbidities and exposure to infection) are related to the lack of provision of basic services and safety nets rather than behavioural patterns. Access to health services in Chad are shaped by gendered relations, both in terms of household decision-making and in patient-staff relations in the clinic.

- Liaise with other humanitarian and development sectors to address structural factors that drive vulnerability to disease:

- WASH infrastructure to facilitate handwashing and curtail oro-faecal transmission
- Social protection mechanisms to avoid catastrophic health expenditures
- Food security and livelihood support to reduce vulnerability to illness due to immunosuppression
- Gender and health projects promoting greater autonomy and decision-making by women and young girls to access health care and gendered aspects in delivery of health care.

Identifying vulnerable populations: targeting of vulnerable groups has to occur at a local level, but the following groups should be considered as potentially requiring support:

- people with inadequate WASH infrastructure, nomadic pastoralists, the urban poor, people in displacement camps, fisherfolk, street children, and women.

- When preparing response plans, take into consideration the vulnerability of particular populations to the response activities themselves, and promote equity and proportionality (e.g. transport restrictions or bans on gatherings impact on pastoralists or urban poor)

Working with different health providers in a pluralistic health system: people rely on a diversity of health providers. Alternative health providers should be engaged for surveillance, risk communication, certain delivery of treatments and referral to biomedical services. A systematic survey of local etymologies and understandings of disease is necessary to facilitate intercultural understandings in the clinic and to tailor risk communication to specific populations.

- Work with alternative health providers: faith healers such as *marabouts*, *tradipraticiens*, *tchoukou* doctors and other drug sellers, diviners and others. Provide basic epidemiological and risk communication training and enlist them in disease surveillance, the provision of health information, delivery of particular treatments (e.g. Oral rehydration solutions in the case of diarrhoea, mosquito nets, etc.) and to identify particular diseases and how make referrals of their patients to biomedical clinics when relevant.

- Support country efforts to ensure drugs that are sold meet minimum quality standards.

- As the literature on people's trust in different health providers and their health seeking pathways is very limited in Chad, local Knowledge Attitudes and Practices (KAP) surveys on health-seeking behaviours, and local terminologies are necessary. This should be complemented with long term support to universities to carry out systematic anthropological review of local etymologies of illness and treatments in the

country. In turn, health staff and response workers should be aware of local language of illness and categories of symptoms, and peoples' challenges to accessing care.

Strengthening state-provided health systems: the lack of physical access and low quality of care in government-provided clinics means that only those in rural areas or the poorest in urban areas seek care there. This is compounded by the fact that state-provided health care is not free, if cheaper non-profit NGO or religious clinics are available, poor people will attend those instead. Those who can afford to do so, bypass state-provided medicine to attend private clinics or alternative health providers. To improve trust, health service provision should be adapted to local customs and needs, health workers capacity expanded, and staff and health volunteers should be recruited locally whenever possible to improve local ownership and intercultural relations in the clinic.

- Health service provision in epidemic emergencies will need to be adapted to different kinds of demographics in the country, in terms of their cultural and livelihood preferences. For example, nomadic communities in Chad have required mobile clinic provision and human linked to animal vaccination programmes. Communities themselves must be involved in the design of these services.

- Support health workers in state-provided and non-profit clinics, building their capacity, ensuring their livelihoods and recognizing their work, particularly those in remote areas. Build skills for interpersonal communication and socio-cultural understanding to curtail discrimination in the health system.

- Recruit health workers locally whenever possible. Ensure translation is available if necessary. Introduce accountability and complaint mechanisms to curtail discrimination. Recruit and support health volunteers locally to deliver services or alternatively mediate and translate between health clinics and communities.

Engaging with trusted interlocutors: There are significant parts of the population that feel disenfranchised and do not trust the government. Involving trusted actors in epidemic response can lessen resistance from certain communities, and bring new and valuable perspectives into the response. The most trusted actors (relatively to others like the government or NGOs) in Chad are doctors and nurses when discussing health concerns. Collaboration with civil society is necessary although made difficult by government repression. Collaboration with local authorities (customary and administrative) and religious leaders is crucial in the design and implementation of epidemic preparedness and response.

- Doctors and nurses are the most trusted interlocutors in the country. Enrolling them in the response and in community engagement activities, listening to peoples' feedback and answering their questions (e.g. through local radio programmes).

- The state has a limited reach, particularly so in remote areas, therefore work with civil society organisations is necessary. It is easier to find civil society organisations in the South. Beware that civil society organisations are under scrutiny by the government and have been repressed when they have voiced criticism. Trade Unions and certain journalist associations have achieved a degree of independence. NGOs, religious groups, trade unions, youth and women's groups, artists and journalist associations (see list attached) have experience in health responses in the country.

- Collaborate with local authorities, both customary (*sultan, chef de canton, chef de village)* and administrative (Local, Departmental and Provincial committees), yet do not take for granted their trust by local communities. Roll-out light surveys at a local level to identify people and positions that are most trusted. Ensure participatory activity design includes the voices of traditionally marginalised groups (e.g. youth, women, or social groups subject to discrimination like the Haddad (See annex 2)

- Work with religious authorities is crucial both at a central and local level. They can be found in remote areas, they are respected by the communities, and some engage in forms of healings (*e.g. marabouts*). When public health recommendations clash with religious precepts people tend to prioritise fulfilling religious commitments, and when responses in Chad have engaged religious leaders in community engagement people's uptake of public health recommendations and trust in the response.

Engaging communities and establishing dialogue effectively: engagement with communities should take a form of dialogue. Community feedback loops can be used to modify response activities and respond to queries by communities. With over 100 local languages and different levels of comprehension of French and Chadian Arabic, communication must be adapted to local idioms and languages. Prioritise holistic health interventions building on community expertise over disease-specific ones and ensure targeting and messages do not use blame and generate stigma.

- Communication and messaging should be conveyed in culturally appropriate ways, using local languages, local terminologies and frameworks of disease, in order to enhance treatment seeking behaviour. Any epidemic response in a Chadian locality should require a language assessment including comprehension and communication preferences. Local radio is the most used avenue, but other mechanisms (SMS programmes, enlisting town criers, etc.) should be explored.

- Adapt messaging, both in terms of content and interlocutors to specific social groups, as who they trust and the logics and idioms that resonate vary. Successful interventions have included involvement by different actors using very different channels.

- Generate closed loop community feedback mechanisms between communities and preparedness and response efforts: monitoring peoples' perceptions of epidemic response activities, tracking mis- and dis-information, taking suggestions and gathering queries or questions about the response, and in turn using this intelligence to adapt/modify activities.

- Ensure targeting and messaging does not generate stigma, as in the case of cholera targeting, avoiding shaming messaging around lack of hygiene and insalubrity. Design interventions with community participation and engagement with trusted leaders, and adapt service delivery.

- Prioritise holistic community interventions instead of disease-specific packages. Work with experienced community health workers and health activities to use their existing networks and expertise across diseases and health issues.

KEY ACTORS

This section presents a list of key actors identified in the process of researching for this brief with whom early responders may want to engage with.

LOCAL RESEARCHERS

Dr Hoinathy Remadji, anthropologist

Dr Djimer Seli, anthropologist

Dr Eugène Neleyota, politist,

Mr Allah-Kauis Neneck, sociologist/anthropologist

Mr Abdelbanat Oumar, anthropologist

Mrs Maimouna Bah, anthropologist

Mr Lewa Elie Doksala, anthropologist

CHADIAN RESEARCH ORGANISATIONS

CRASH- Centre de Recherches en Anthropologie et Sciences Humaines (*CRASH*), is a think-tank and a network of Chadian researchers. https://www.facebook.com/crash.tchad/ Hosts with N'Djamena the influential social science interdisciplinary journal *caTchas*. Cahiers Tchadiens des Sciences Humaines https://catchas.mmsh.univ-aix.fr/Pages/default.aspx

Faculté des Sciences Humaines et Sociales, Université de N'Djamena, which trains future anthropologists, sociologists and political scientists as well as conducting research on the

Chadian context https://www.universite-ndjamena.td/formation/facultes/faculte-des-sciences-humaines-et-sociales/

Université Populaire (UP). Popular/People's University, carrying out professional development but also involved in promoting good governance, civil society and citizenship. https://www.peaceinsight.org/en/organisations/universite-populaire-up/?location=chad&theme

ASSOCIATIONS/NETWORKS

Cellule de Liaison des Associations Féminines (CELIAF). CELIAF, includes over 700 women's associations and advocates for the inclusion of women in civil society, politics and then economy and promotes civic education and the participation of women and young people in public decision-making processes. https://www.peaceinsight.org/en/organisations/cellule-de-liaison-et-dinformation-des-associations-feminines-celiaf/?location=chad&theme

Union des Syndicats du Tchad (UST). The Union of Trade Unions in Chad, a strong and independent civil society actor. http://www.ituc-africa.org/Union-des-Syndicats-du-Tchad-UST.html

Union des Associations des Femmes Arabophones du Tchad (UAFAT). Umbrellla Union for Arabic speaking associations. https://www.facebook.com/pages/category/Community-Organization/Union-des-associations-f%C3%A9minines-arabophones-du-Tchad-UAFAT-1872343512794867/

Réseau des Femmes Ministres et Parlementaires du Tchad (REFEMPT), a network of female Members of Parliament and Ministers working towards gender equality. https://www.genreenaction.net/Reseau-des-Femmes-africaines-ministres-et.html

Association des Autorités Coutumières et Traditionnelles du Tchad (AACTT). Association of Customary authorities, involved in development activities and advocacy (e.g. child marriage) and in local mediation of conflict https://www.peaceinsight.org/en/organisations/association-des-autorites-coutumieres-et-traditionnelles-du-tchad-actt/?location=chad&theme

Union des Journalistes du Tchad (UJT). Union of journalists in Chad, influential and vocal civil society organisation advocating for media freedom which has suffered arrests by the government.

Coordination des Associations et Mouvements des Jeunes du Tchad (CAMOJET), an apolitical platform of youth associations advocating for human rights and citizenship and promoting the social and professional development of young Chadians.

https://www.peaceinsight.org/en/organisations/collectif-des-associations-et-mouvements-de-jeunes-du-tchad-camojet/?location=chad&theme

Conseil Supérieur des Affaires Islamiques (CSAI), the highest council for Muslim affairs in Chad.

Conférence Episcopale des Évêques du Tchad (CET), the highest council for Catholic affairs in Chad.

Entente de Eglises et Missions Evangéliques du Tchad (EEMET). The umbrella organisation representing Evangelical churches in the country.

Confédération Nationale des Tradipraticiens du Tchad. It is the national confederation of traditional practitioners of Chad.

CHADIAN DEVELOPMENT AND HUMANITARIAN NGOS

Association Help Tchad pour le developpement. General development activities. https://tadamon.community/organisations/association-help-tchad-pour-le-developpement-atdh-/overview

Action Rurale pour un Développement équitable et endogène (ARDEE). Rural Development Programmes, cash transfers and poverty alleviation. No website.

Organisation Humanitaire pour la Promotion des Initiatives de Développement Local. Local support to COVID-19 response. No website.

Afri'competence. Support to health and sanitation displaced populations. https://www.facebook.com/africomptence/

Association Humaniste d'Entraide et d'Action Sociale. Support to refugees. Housing. Camp management. https://www.peaceinsight.org/en/organisations/aheas/?location=chad&theme

Organisation Humanitaire pour l'Urgence et le Développement. Development and Humanitarian programmes, support to displaced populations. No website.

Mission Parole de Vie du Tchad. Food security and malnutrition interventions.

Action pour le Développement Social et Humanitaire (ADSH). General development and humanitarian interventions. Youth and health. https://www.facebook.com/pages/category/Non-Governmental-Organization--NGO-/ONG-Action-Pour-le-D%C3%A9veloppement-Social-et-Humanitaire-ADSH-103276374376366/

Vision pour le Développement Durable au Tchad, General development interventions. Support to refugees. No website.

Association pour l'Action Humanitaire et le Développement Durable. General sustainable development and humanitarian activities. http://www.achdr.org/index.php

Association pour le Développement Economique et Social du Lac. Sustainable Development activities: income generating activities, health, youth, education. Mostly focused on the South. https://www.adesaf.fr/

Association pour la Protection de la Santé, de l'Environnement et la Lutte contre la Pénurie Alimentaire (APSELPA). Health, sustainable development and food security programmes. https://www.facebook.com/pages/category/Community/ONG-Apselpa-1398553736856701/

For a complete list of humanitarian contacts in Tchad (last updated in August 2020) see UN OCHA's public directory: https://www.humanitarianresponse.info/en/op%C3%A9rations/chad/document/tchad-liste-des-contacts-humanitaires-ao%C3%BBt-2020

ACKNOWLEDGEMENTS

Suggested citation: Remadji, H., Neneck, A.K., Colosio, V. and Ripoll, S. (2020) Tackling Deadly Diseases in Africa: Key Considerations for Epidemic Response and Preparedness in Chad, *Briefing*

Published December 2020

ANNEXE: ADDITIONAL HISTORY AND CONTEXT

This annexe provides additional contextual information on aspects presented in the brief, as well as additional issues which responders may want to know about.

GEOGRAPHY

Chad is a landlocked country located in central Africa, covering 1,284,000 km^2 at the crossroads between the Sahara Desert and the more fertile savannas. The UNDP's Human Development Report 2019 ranks Chad 173rd out of a total of 174 countries[70]. In 2012, FAO estimated arable land to be 19 million ha whereas the total area under cultivation was only about 3.63 million ha[71].

There are several permanent and seasonal rivers in Chad. The two main rivers are the Chari and the Logone, that supply fresh water to Lake Chad. Chad has 8 other important lakes in terms of surface area and in fishing and other natural resources.

Chad is divided into three climate zones: a Saharan zone, a Sahelian zone and a Sudanese zone. The rainy season runs from June to September and the dry season from October to May. According to FAO data[71], the Saharan zone receives an average of only 300 mm of rain per year and occupies more than half of the country. Rainfall in the Sahelian zone is between 300 and 600 mm yearly. This makes this zone an area par excellence for livestock herding. Finally, the Sudanese (*soudanien*) zone is the wettest. It receives annually more than 600 mm, even 1200 mm in some places.

POPULATION

The latest World Bank projection estimated Chad's population in 2019 to be around 15.94 million[72]. The density was 12.292 inhabitants per square kilometre in 2018. The spatial distribution of this population is uneven and follows the scale of socio-economic activities and climate zones: very scarce in the Sahara, where people are mainly involved in nomadic herding and some farming in the oasis; quite scarce in the Sahel strip, where there is subsistence-oriented farming and semi-nomadic herding near lakes, mountains or in the flooding areas of the rivers; and more densely populated in the South, where the main cities (apart from the capital N'Djamena), the oil reserve and most of the farming are situated. The number of people living in urban areas (officially the 23.279 %) tends to grow faster than the number of people living in rural areas.

LIVELIHOODS

In Chad, about 80% of the population is engaged in agriculture, livestock farming and fishing[71]. Small-scale farmers mainly inhabit the Sudanese and Sahelian areas of the country and cultivate millet, sorghum, peanuts, sesame and some vegetables such as tomatoes, aubergine, peppers and okra. Millet and sorghum are the staple foods, while peanuts and sesame are used both as protein sources and as a cash crop. Cotton is farmed exclusively in the South and is the main Chadian cash crop. Herders are both nomadic and semi-nomadic people and inhabit mainly the Sahelian and Sahara parts of the country. Arabs and Tubu/Gorane-speakers generally herd camels and cows, while Fulani herd cows. Since the 1980s, herders tend to move more toward the South because of climate change, amongst other reasons.

POLITICS, GOVERNMENT AND ADMINISTRATION

History

Chad was part of French Equatorial Africa (FEA) and gained its independence on 11 August 1960 under Ngarta François Tombalbaye, a Christian former teacher from the South of the country. During colonial times, the South progressively increased its dominance thanks to cotton farming and the more positive approach towards French language and institutions than in the North, where dominant Muslim elites – which used to control trans-Saharan trade routes before colonization and had a century-old tradition of centralised statehood– resisted colonial power.

Three years after independence in 1963, Muslim politicians with strong ties to Sudan created the Front de Liberation National (FROLINAT), that started an armed rebellion against the central government. In response, President Tombalbaye abolished political opposition parties and exacerbated the tensions between the North and South of the country before being overthrown by a military coup d'état in 1975, led by Felix Malloum, also a Southern Christian.

The resentment from the Muslim North continued, and FROLINAT succeeded in entering the fragile Transitional Government of Unity Power in 1979, which quickly broke apart triggering a civil war. Following intense clashes between different factions of the FROLINAT, Hissene Habré, leader of one of those factions, took power in 1982 with the support of France and the United States and instituted a one-party state rule. Habré was recently found guilty of crimes against humanity due to the repression of political opponents, Hadjerai and Zaghawa ethnic groups, and the people of southern Chad[73].

Habré was ousted by a military coup led by his former army General Idriss Déby, whose troops invaded N'Djamena in 1990. As shown below, the political landscape in Chad has been defined by Deby and his party the Patriotic Movement of Salvation (MPS) since then.

Political parties

The party in power today is the Patriotic Movement of Salvation, the political party of the current President Idriss Déby Itno. The MPS was born out of an anti-Habré alliance of military leaders mainly from the North. The MPS has been ruling the country since 1990. In 1996, Déby formally allowed a multiparty system. Since then, as the Presidential candidate for the MPS, Déby has won 5 presidential elections (the latest in 2016), and the MPS has dominated the National Assembly elections including the latest assembly election in 2011. The National Assembly elections were due in 2015, but the Presidency has postponed them ever since, avowedly due to lack of government funds and to the threat of Boko Haram attacks.

After almost three decades in power, in May 2018 President Déby declared the 4th republic and changed the constitution. The new constitution restored the limit on Presidential mandates to two terms (a restriction that was abolished in 2005 when Déby decided to run again for Presidency), and increased terms from 5 to 6 years. Yet this limit was not retroactive, therefore the new constitution enabled Déby to run for two further mandates, hence being able to rule until 2033. The vote was boycotted by the opposition parties, who demanded a referendum. This is a recent example of a progressive centralisation of power in the hands of the presidency, which has become increasingly authoritarian. The new resources guaranteed by oil exploitation since 2003 have further strengthened the President's grip on power[74], as well as support from the French army. Since 2014, oil revenues have declined due to lower oil prices, but the government has sustained Itself through aligning Chad with the Interests of the EU and US In the global fight against Jihadism, and funds emerging from telecommunications and renewable energies (e.g. solar)[63]. The government has a tight control over media, with limited freedom of speech, has clamped down on opposition groups and has undermined the independence of the courts. For example, the new constitution abolished the High Court of Justice, a body that would handle cases of treason involving members of the government. Transparency International ranked Chad 162nd out of 183 countries in its 2019 Corruption Perceptions Index, with a score of 20/100.

Despite the Zaghawa being a minority ethnic group, at less than 2% of the total population, important parts of the state apparatus such as the military and the secret police are dominated by this ethnic group that is mainly concentrated in eastern Chad and in the Sudanese state of North Darfur. Several members of President Déby's family and Bideyat family group within the Zaghawa enjoy prominent positions in government

and business, with relative immunity from the law[54]. As a result of this domination of politics by Muslim political élites and in particular the Zaghawa, other ethnic groups feel disenfranchised, particularly those belonging to the Christian South.

Chad's opposition is very fragmented, with a multitude of parties that have been unable to unseat the MPS in either the Presidential or the National Assembly elections. For example, in the latest Assembly elections In 2011, the MPS coalition won 134 seats out of 188. There are three key opposition parties. The National Union for Development and Renovation (*l'Union Nationale pour le Développement et le Renouveau* - UNDR*)* which won 10 seats, led by Saleh Kebzabo, the current *de facto* main leader of the democratic opposition. Despite being under constant attack by the government, the party has succeeded in retaining its key leaders. The Union for Renovation and Democracy (*l'Union pour le Renouveau et la Démocratie*- URD) has 8 seats in the National Assembly, and was founded by General Wadal Abdelkader Kamougué, a charismatic leader who was close to winning the Presidency in 1996. His death in 2011 has left a gap in leadership, with one of his sons in charge of the party today. The Federation Action for the Republic/Federalist Party (FAR) won 4 seats. Due to organisational problems, many of its leaders joined other parties. Its popular appeal is its goal to transform the country into a federation.

The political opposition is legally recognised, but harassment and arrests occur when they voice dissent. Opposition leaders have disappeared after entering state custody, and since 2018 the state has forbidden political rallies and meetings between opposition officials[75]. Another strategy by the Déby government has been to bring opposition leaders into the MPS fold, by offering them positions within the party or the cabinet[76].

Conflict

Since independence, Chad has experienced a cycle of interminable politico-military conflicts and periods of relative calm defined by Marielle Debos as "interwar"[77], as there was never a full transition toward a peaceful management of power. There are three intertwined conflict dynamics in place in Chad: the politicisation of the Muslim North-Christian South divide, herder-farmer conflicts and spillover from neighbouring countries. Note that this North-South/Herder-Farmer divide Is often more of a rhetorical account rather than an accurate explanation of conflict, as often rebellion and conflict have been the main access to power In the country[77], and often "tactical alliances or personal rivalries and sometimes purely materialistic motives are more important"[63] than these grand narratives.

The third political dynamic is the spillover from conflicts beyond Chad's borders. The conflict in Darfur generated a mass influx of refugees from Sudan, and also Sudanese militants have crossed the border and supported rebel groups fighting MPS rule in N'Djamena. In turn, Déby has funded ethnic Zaghawa fighters in Darfur. Chad is also

positioning itself as a 'western' ally against jihadism and has sent troops to fight Al Qaida in Mali and Boko Haram in Nigeria, whose activities have created an influx of refugees. As a result of this foreign intervention, Chad has improved its standing in the African Union, yet in retaliation, Boko Haram has carried out several terrorist attacks in the lake region since 2015.[78] Recently, there have also been attacks by rebel forces based In Libya.

Administrative structure

Colonial institutions shape contemporary Chad in many ways. The French organised the cities in a pattern almost identical to all their African colonies: a district for the whites (the colonial administrators, their collaborators and their relatives), a so-called 'evolved' district grouping together the 'evolved natives', in other words those who went to school; an indigenous neighbourhood where the rest of the population of diverse origins settled. Today the upmarket neighbourhoods are inhabited by those close to the authorities, while the underprivileged neighbourhoods are inhabited by people on average incomes.

Chad's administrative structure replicates that of the colonial system, with a centralized administration and a variety of local authorities – the governors for the 23 provinces and the *prefects* for the 107 *prefectures* - appointed by the central government. The central government also appoints and oversees the "customary authorities" (*sultan, chef de canton, chef de village*), recognized by the organic Law n°10-013/PR of 25 August 2010 as "collaborators of the administration" and placed under the authority and control of the heads of the administrative units of their jurisdiction. In the last twenty years, the Chadian government increased significantly their numbers through new appointments, which led to frequent tensions, often resulting in the removal of some leaders and its replacement by rivals, as in the recent example of the Ouaddaï sultanate[79]. Customary authorities are appointed first within the communities according to their customary practices (in many cases the elders choose the best candidate in the ruling family, but the system is flexible and this may change), and following this, the government through the Ministry of Internal Affairs confirms the decision and officially appoints the authority.

While the inhabitants of cities can directly elect their mayors through formally democratic elections, there are no elected authorities at the rural level, where a rural *sous-prefect* appointed by the government oversees the customary authorities. Hence, they represent the only forms of rural grassroots authorities and have a crucial role in connecting rural communities with state authorities.
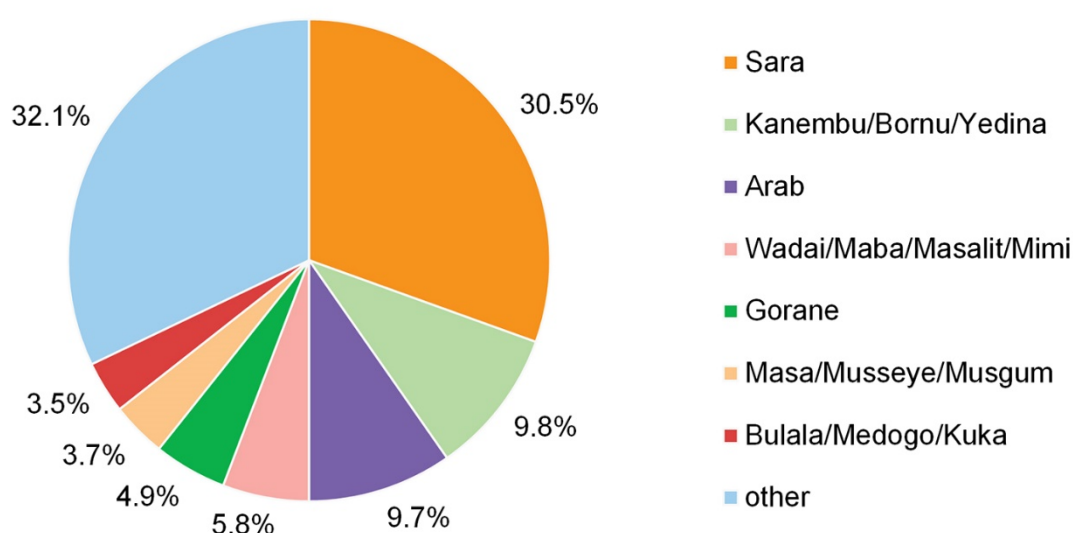
SOCIAL ORGANISATION

Ethnicity

Chad has over 100 ethnic groups[80] and 150 different languages[81] spread across the national territory[a]. The most important ethnic groups in terms of population are: the Sara

(30.5 %), who live mainly in the central parts of the Chari and Logone river basins ; the Kanembu/Bornu/Yedina (9.8 %) typically inhabiting the Lake Chad and Kanem regions; the Arabs, that are found widely in the country, including areas surrounding the Sara ; and nomadic herders in the East and South-centre of the country, and the Masalit peoples (Wadai/Maba/Masalit/Mimi) (7%) in the Eastern regions including Ouaddaï province[a].

The state was mainly controlled by the Sara during the Tombalbaye regime and the Tubu/Gorane ethnic group under Habré, while today it is dominated by the Zaghawa, the ethnic group of the president of the Republic, which is over-represented in the army and among the appointed local authorities[84].

Chad ethnolinguistic composition (2014–15)

- 30.5% — Sara
- 9.8% — Kanembu/Bornu/Yedina
- 9.7% — Arab
- 5.8% — Wadai/Maba/Masalit/Mimi
- 4.9% — Gorane
- 3.7% — Masa/Musseye/Musgum
- 3.5% — Bulala/Medogo/Kuka
- 32.1% — other

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Figure 3. Chad ethnolinguistic composition (2014-15)[82]

It is worth mentioning the wide discrimination in the country of groups such as the blacksmiths, called Haddad in Chadian Arabic - in the Sahelian and Saharan parts of the country[85], who live in the outskirts of settlements and carry out menial work (historically blacksmithing). Other disenfranchised groups include the Yalnas, the Kamaya (in the Saharan belt) and other smaller groups who are sometimes stigmatized. These prejudices are based on precolonial hierarchies, where descendants of professional groups considered of a lower status like the blacksmith or of slaves had limited rights in comparison to other groups. Labels related to these groups, such as Haddad meaning "blacksmith", or Yalnas and Kamaya, connected to slavery, are used to limit access to land or political representation, not fully recognizing the legitimacy of their customary authorities[86].

Chadian languages are divided in three main families: the Afro-Asian (in particular Chadian Arabic and languages such as Massa, Kabalaye, or Bidijo), Niger-Congo (with the languages of the Adamawa group, such as Moundang, Toupouri, Day or Boua) and the Nilo-Saharan family (with the Sara-Baguirmian language groups, and the desert and eastern groups such as Tedaga, Zaghawa, Massalit or Tama).

French and Modern Standard Arabic are the official languages of Chad. French is the working and communication language in public administration, while in daily life Chadian Arabic is the main "lingua franca", widely used for commercial transactions. 60% of the population can speak and understand Chadian Arabic[54], but it is spoken as mother tongue only by a few groups. Sara is spoken by 20% of Chadian, around the city of Sarh (named after the Sara ethnic group) in the South of the country. Other languages include Kanembou, spoken by 5% of the population, mostly in the South-West of the country bordering Cameroon, and Dazaga (3.8%) and Maba (3.4%), spoken in the Sahelian areas and Sahara in the North[54]

Religion

Islam and Christianity are the main religions in Chad. Alongside these, there are indigenous religions whose number of followers tended to decrease since colonization. As indicated above, Muslims live mostly in the North and Eastern parts of the country, and Christians and those following traditional religions populate mostly southern Chad and Guéra. However please note that It Is not so clear cut, there are also significant Muslim populations also in Guéra, Mayo Kebi and the South in general. Figures on the number of followers vary according to the statistical data available. According to the DHS 2014-15 survey 34, Islam is the most widely practiced religion in Chad, with about 51.8% of the population. Christianity is the second major religion with 44.1%, including 20% Catholic and 23.9% Protestant (Baptist, Evangelist and Anglicans). As in other countries, indigenous or traditional religions are sometimes folded into the statistics of monotheistic religions, depending on survey design. In the 2009 census, 8 percent of respondents followed traditional religion. Despite comprising 44% percent of the population, Christians in the South have been excluded from political power: there is some representation in government, but their voice is limited75. However, Deby has succeeded in finding support from Southerners as well and Northerners. Those who declare themselves to be non-religious are very few and often marginalised.

Kinship, gender and youth

Most Chadian societies are patrilineal. The members of a family recognise each other around a male common ancestor, which is considered to be the basis of the family lineage. Both in the North and in the South, kinship group are linked to their clans, although clans are decreasing in importance, particularly so in towns. Family and clan ties

shape social and cultural allegiances, but political affiliation is shaped by ethnic group, religion and the regional identities, a dynamic reinforced by the armed conflicts of the past[87].

In terms of property, women are considered as the usufructuary of her husband's or family's property; similarly, inheritance and succession tend to be patrilineal. These practices of ownership and inheritance are quite similar in both the various "traditional" institutions and Muslim institutions across the country and contributes to the marginalization of women and young people from decision making in the family[88].

Women are often involved in the informal sector, although their main tasks are domestic ones and they often have the obligation to participate in field work in rural areas. They have weaker access to health-care (due to their lack of resources and, in some regions, limits to independent movements) education, employment, training, inheritance and property rights, while some forms of violence to educate them is often considered acceptable[89]. Social roles are intimately linked to gender. Generally farming of main staple crops is a men's task, while women oversee household activities, petty trade and may help men in some specific tasks in the fields.

Young people have also limited access to family resources that are in the hands of the male household head (e.g. farmland). Hence young people in Chad are mainly involved

in the informal sectors, such as driving motorised taxis or doing petty trading in the urban areas; and brick construction and growing vegetables in the rural areas. Although in the last two decades more young people are graduating from school thanks to the relative economic and political stability, youth unemployment is very high as there not many job opportunities[90].

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