DREF Operation

Congo Flood 2025

Flooded streets in Pointe-Noire

Appeal: **MDRCG026**	Hazard: **Flood**	Country: **Congo**	Type of DREF: **Response**
Crisis Category: Yellow	Event Onset: **Sudden**	DREF Allocation: **CHF 499,267**	
Glide Number: -	People Affected: **50,000 people**	People Targeted: **12,500 people**	
Operation Start Date: **25-11-2025**	Operation Timeframe: **4 months**	Operation End Date: **31-03-2026**	DREF Published: **02-12-2025**

Targeted Regions: **Brazzaville, Pointe-Noire**

Description of the Event

Date of event

19-11-2025

What happened, where and when?

Exceptionally heavy rainfall triggered flash floods and severe flooding in the departments of Brazzaville and Pointe-Noire, causing significant human and material damage: around 50,000 people affected, 22,842 evacuated and 55 injured, according to the Congolese Red Cross.

Thousands of homes were partially or completely destroyed, several road links were damaged, and thousands of families have been left without shelter or means of subsistence. Most affected families are being hosted by neighbours; others, having lost everything, have taken refuge with relatives in other neighbourhoods and are living in precarious conditions.

The Congolese Red Cross urgently deployed 60 volunteers (30 in Brazzaville and 30 in Pointe-Noire) for relief and rapid assessment.

Evaluation Rapide à Talangai /brazzaville

Scope and Scale

According to data from the Ministry of Humanitarian Action, cross-checked with information from the Congolese Red Cross (CRC) local branches, the rains of 18 and 19 November 2025 caused flooding, siltation and erosion processes that affected more than 61,500 people, or 12,500 households. In Brazzaville, 7,035 households are affected in the arrondissements of Talangaï, Mfilou and Madibou; in Pointe-Noire, 5,305 households are affected in the arrondissements of Lumumba, Mvoumvou, Tié-Tié and Loandjili. Five injuries have been recorded, one in Brazzaville and four in Pointe-Noire.

The impact on lives, livelihoods, well-being and infrastructure is severe. More than 9,874 houses have been partially or completely destroyed (6,784 in Brazzaville and over 3,090 in Pointe-Noire). Over half of households report having lost, in part or entirely, their dwelling, food stocks, tools and livelihood assets, various belongings and even their administrative documents, complicating access to services and assistance. More than 9,000 latrines have been damaged or destroyed (5,000 in Brazzaville and over 4,000 in Pointe-Noire), several roads have been damaged, and over 16 erosion sites have worsened in both cities. The drinking water supply system is disrupted

in the affected areas: several thousand families no longer have access to safe water, lack hygiene and sanitation facilities, and face reduced access to primary health services. These failures heighten the risks of waterborne diseases, diarrhoeal outbreaks and malaria linked to stagnant water, as well as protection risks, particularly for displaced households sheltering with relatives or neighbours.

At this stage, the aggregated figures above are not yet fully disaggregated. The forthcoming detailed assessment will include the collection and analysis of data disaggregated by sex and age (women/men; 0–4 years, 5–17 years, 18–59 years, 60+), as well as by disability, in order to document the specific impacts on women, men, girls, boys and persons with disabilities and to adjust targeting accordingly.

Reports indicate that schools in flooded areas have been affected (flooded classrooms, damage to latrines and water points), leading to temporary suspension of classes and the loss of school materials. A joint assessment with education authorities and education partners is under way to determine the number of schools affected, the duration of disruptions and priority needs (cleaning/disinfection, school WASH, pupil reintegration).

The displacement and hosting of households with relatives, damage to infrastructure, and pressure on services increase the risks of gender-based violence (GBV).

Identified risk factors include:

- Overcrowding in shelters and lack of privacy;
- Collapse or weakening of community protection mechanisms;
- Limited access to safe, appropriate WASH facilities, particularly for women and girls (latrines that are not segregated/not lit, lack of menstrual hygiene management facilities);
- Displacement and loss of livelihoods increasing exposure to abuse and exploitation.

The populations most likely to suffer these impacts live in low-lying, densely populated, often informal neighborhoods along ravines, thalwegs and inadequately drained runoff pathways in the aforementioned arrondissements.
Their vulnerability stems from a combination of precarious housing (non-durable materials), poor drainage, limited financial resources, and low capacity for rapid recovery after disasters. High-risk groups include children (especially those under five), older people, persons living with disabilities or chronic illnesses, as well as pregnant and breastfeeding women and female-headed households, due to mobility constraints, more difficult access to essential services, and increased exposure to health and protection risks. Households that have lost identity and administrative documents are particularly disadvantaged in accessing aid and services. Internally displaced persons (IDPs) or refugees residing in these same areas, if present, also face heightened vulnerabilities linked to insecure tenure and barriers to rights.

Historically, Brazzaville and Pointe-Noire experience recurrent flooding during the rainy season, with regular damage to housing, temporary displacement, contamination of water points and deterioration of latrines, especially in areas with rapid urbanisation and inadequate drainage networks. Siltation and erosion processes, common on unstable and poorly protected soils, exacerbate these impacts by damaging roads, homes and WASH facilities. The 18–19 November 2025 episode fits within this context of recurrent risk, but stands out for the cumulative scale of shelter and sanitation infrastructure destruction, the simultaneous disruption of essential services, and the geographical extent of the impact across the country's two main urban areas.

In response, the Congolese Red Cross urgently deployed 30 volunteers in Brazzaville and 20 in Pointe-Noire to assist those affected and conduct a rapid assessment, and plans to provide targeted assistance to reduce the adverse effects of the disaster, prioritizing the most vulnerable households in the most exposed neighborhoods. The rapid assessment will consolidate data disaggregation (sex/age/disability), document the impact on education, and refine the GBV risk analysis to adapt targeting and mitigation measures.

Source Name	Source Link
1. ReliefWeb – Republic of the Congo - Severe weather and floods	https://reliefweb.int/report/congo/republic-congo-severe-weather-and-floods-ifrc-noaa-cpc-echo-daily-flash-20-november-2025

Previous Operations

Has a similar event affected the same area(s) in the last 3 years?	**Yes**
Did it affect the same population group?	**Yes**
Did the National Society respond?	**Yes**

Did the National Society request funding form DREF for that event(s)	**Yes**
If yes, please specify which operation	MDRCG022

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:

n the face of exceptionally severe flooding on 18 and 19 November 2025 in Brazzaville and Pointe-Noire, it is necessary to launch an emergency response without delay. In less than forty-eight hours, exceptionally intense rainfall triggered flash floods and major damage, affecting around 50,000 people, leading to the evacuation of 22,842 people and injuring 55, according to the IFRC. Thousands of homes were partially or completely destroyed, several road corridors were damaged, and thousands of families were left without shelter or livelihoods.

Hydrologically, the Congo along the Brazzaville–Kinshasa corridor and several tributaries exceeded alert thresholds for prolonged periods (from several days to weeks, depending on the stations), at levels consistent with multi-decadal return periods. Flood radar mapping (Sentinel-1/Copernicus) shows an extent at least comparable, and locally greater, than in 2019/20 along the Congo, the Oubangui, the Likouala-aux-Herbes and the Alima, with widespread agricultural losses and severed road links.

In Brazzaville, the 18–19 November 2025 episode was particularly extreme: over 24–36 hours, the city received the equivalent of several weeks of seasonal rainfall, with 1–24-hour intensities in the 95th–99th percentiles since 1981 (IMERG/CHIRPS analyses). This concentration of precipitation caused flash flooding, overwhelmed the urban drainage system, and led to flooding in several districts. The combination of extreme rainfall intensity, sustained exceedance of hydrometric thresholds, and an unprecedented spatial extent provides a strong statistical basis to characterise the event as exceptional rather than a routine seasonal overflow.

This episode is not a simple seasonal recurrence: its intensity, temporal concentration, and geographical extent — simultaneously affecting the country's two main urban areas — exceed typical rainy-season patterns. Even in the temporary absence of consolidated rainfall measurements, its severity is evidenced by the scale of impacts, the overloading of municipal and community systems, and the volume of displacement.

The DREF is therefore required to finance a rapid, life-saving and targeted response, prevent a deterioration in health and protection risks, and bridge the critical gap until complementary funding is mobilised.

Lessons learned:

Lessons learned from previous operations converge on the following priorities:

Start critical functions (CEA) earlier; strengthen inclusion (PGI/PSEA, accessibility, alternative forms of evidence); secure the multi-sourced supply chain; professionalize voucher schemes (merchant-based); and decentralize resources across the two departments to improve responsiveness.

These lessons must be integrated into the SOPs, procurement plans, activity design, and the PMER framework for this operation.

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

20-11-2025

Coordination	The CRC also took part in the crisis meeting organized by the Ministry of Humanitarian Action alongside all other humanitarian partners.
Assessment	The Congolese Red Cross deployed 30 volunteers (15 in Brazzaville and 15 in Pointe-Noire) to conduct a rapid assessment.

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC, through its delegation in Kinshasa, will provide technical support to the Congolese Red Cross for the design, planning, implementation and PMER management related to this DREF. The delegation currently includes a head of delegation; an emergencies/operations lead serving as the DREF focal point; PMER and information management specialists; a health lead; a livelihoods lead; logistics, supply chain and procurement staff; finance/administration managers; a protection, gender and inclusion delegate; a communications lead; and a security focal point.
Participating National Societies	To date, no Partner National Society (PNS) is present in the country.

ICRC Actions Related To The Current Event

The ICRC has no presence/delegation in the Republic of the Congo and has provided no direct support to this emergency response. The Congolese Red Cross will maintain ongoing collaboration with the ICRC delegation based in Kinshasa (DRC).

Other Actors Actions Related To The Current Event

Government has requested international assistance	Yes
National authorities	Following the floods of 18 and 19 November 2025 that affected Brazzaville and Pointe-Noire, the national authorities undertook several actions: - Evacuation and emergency assistance: The authorities, in coordination with the Congolese Red Cross and other actors, organized the evacuation of more than 22,800 affected people, assisted the injured, and coordinated the immediate humanitarian response. - Damage assessment: The relevant services carried out assessments in the affected areas to document injuries, damage to property, and priority needs. - Mobilization of resources and partners.
UN or other actors	The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and other UN agencies are monitoring the situation and coordinating humanitarian follow-up, although, based on the information currently available for this emergency, the level of specific operational engagement remains limited. No direct operational action by UN agencies on the ground has been explicitly documented for the immediate response to these floods, but the IFRC is playing a central role in coordinating relief and assessing needs. International partners are also continuing to support the mobilization of assistance and to prepare for managing the health and humanitarian consequences in the days ahead.

Are there major coordination mechanism in place?

1)At national level:
- The Ministry of Social Affairs and Humanitarian Action leads the coordination of humanitarian responses at the national level.
- Crisis meetings are organized under the coordination of this ministry, bringing together humanitarian actors, including the CRC.
- In emergencies, national authorities set up crisis committees to steer the response and ensure cross-sectoral follow-up. The Congolese Red Cross actively takes part in these meetings, sharing field information and coordinating its actions with other partners.

2) At departmental level:
- Administrative and local authorities (prefects, sub-prefects, mayors, district heads) take over operational coordination.
- Local crisis committees are operational; these committees include the CRC, technical services and community representatives.

The CRC works in consultation with local and traditional authorities to ensure a response tailored to the specific needs of the affected areas.

Needs (Gaps) Identified

Shelter Housing And Settlements

Shelter, Housing and Settlements needs focus primarily on providing safe, temporary shelter (such as raised shelters), protecting existing homes from damage (with barriers or by elevating belongings), and ensuring durable, longer-term housing solutions that reduce future vulnerability (through more resilient construction and better management of high-risk areas).

In the immediate term, a significant proportion of households cannot return home. Based on initial estimates, 25–30% of affected households (approximately 2,500–3,000 households) require emergency shelter, comprising plastic sheeting (two per household), ropes/cordage and a basic tool kit to stabilise existing structures or erect temporary solutions. This equates to roughly 6,000 tarpaulins, 6,000 fastening kits and 3,000 tool kits for the first month.

In parallel, 40–50% of households (4,000–5,000) whose homes are partially damaged need rapid repair kits and technical assistance to make their dwellings watertight and weather-proof; indicatively, providing 5–6 roofing sheets per household would amount to 20,000–30,000 sheets in total. To reduce overcrowding in collective centres, between 1,500 and 2,000 vulnerable urban households require transitional rent support (1–2 months), complemented by a household starter kit (mats, blankets, kitchen set, bucket, solar lamp) to facilitate a more dignified, decentralised accommodation solution.

Essential household items are an indispensable complement to shelter solutions. For the most vulnerable households (around 6,000), distributing NFI kits comprising mats, blankets (at least 12,000 units), kitchen sets (6,000), buckets and basins, as well as insecticide-treated mosquito nets in coordination with the health sector, will help restore minimum living conditions.

Livelihoods And Basic Needs

Following the floods of 18 and 19 November 2025 in Brazzaville and Pointe-Noire, approximately 50,000 people were affected, nearly 22,800 of whom were evacuated. Assuming an average household size of five, this equates to around 10,000 affected households. In these urban areas, where many rely on daily earnings, the sudden interruption of work led to an immediate drop in income.

According to the Ministry of Social Affairs, 60–70% of affected households (6,000–7,000 households) have seen their incomes fall, particularly small traders, informal workers, porters/handlers and artisanal fishers in Pointe-Noire. Floodwaters also damaged or swept away stocks of goods, tools and small equipment (market stalls, freezers, cool boxes, fishing gear, craft tools). An OCHA estimate suggests that 30–40% of affected households (around 3,000–4,000 households) have lost productive assets, making it difficult to restart their livelihoods without support.
This loss of income is already pushing many families to take on distress debt and resort to negative coping strategies (reducing meals, withdrawing children from school, selling tools), with heightened risk for 2,000–3,000 female-headed households, older people living alone, and persons with disabilities.
Basic needs are immediate and multi-faceted. In terms of food security, the loss of food stored at home and the difficulty of accessing flooded kitchens expose a majority of households to a temporary shortfall in intake. Assuming that 60% of affected households need support to cover a minimum food basket for 2–4 weeks, 6,000 households (approximately 30,000 people) would require temporary food or cash assistance.

To support livelihood recovery, many households need a small cash injection to restock and replace basic tools. By prioritizing households that have lost productive assets (estimated at 3,000–4,000), tailored restart grants or kits (small trade, artisanal fishing, crafts) would enable a rapid resumption of income-generating activities.

Health

Following the recent floods in Brazzaville and Pointe-Noire, many families were affected and thousands of people had to be evacuated. Contamination of water sources, damage to housing and disruption of livelihoods require a rapid response to meet essential needs, prevent health risks and support safe recovery.

In this context, health needs are immediate and multiple. Overcrowding in shelters, contamination of water points and disruption to services expose the population to increased waterborne diseases, respiratory infections and malaria.

Given the country's history of cholera outbreaks, an early detection system is essential, including rapid cholera tests and the pre-positioning of case-management supplies (intravenous rehydration solutions, second-line antibiotics) sufficient to manage at least 100 severe cases should an outbreak occur.

Malaria risk typically rises after floods. Assuming that 15–20% of affected people develop a febrile episode in the following month (7,500–10,000 fevers), and that 60% of these are due to malaria, 4,500–6,000 positive diagnostic tests should be anticipated, and therefore an equivalent need for ACT treatments, plus a 20% safety buffer. In addition to mosquito nets already planned, targeted distribution of 5,500–7,000 RDTs and 5,500–7,000 ACT treatment courses, as well as antipyretics, is required, alongside messages promoting early care-seeking for children under five and pregnant women.

Trauma related to flooding and debris clearance is another need. Around 1–3% of affected people may require first-line care for injuries, infected wounds or sprains, i.e. 500–1,500 patients to be treated with dressings, first-line antibiotics when indicated, and tetanus booster vaccinations. Facilities serving the affected neighborhoods should be supplied with dressing kits and aseptic consumables (chlorine solution, gloves, sterile procedure sets), as well as at least 1,000–2,000 doses of dT vaccine for adults with tetanus-prone wounds.

Maternal, neonatal and child health requires specific attention. In a population of 50,000, there are an estimated 625 pregnant women at any given time, and around 140–160 births per month. It is therefore necessary to provide at least 300 clean delivery kits for two months, ensure referral pathways for obstetric emergencies, and pre-position essential medicines (oxytocin, post-partum antibiotic prophylaxis per protocol) and basic neonatal resuscitation equipment. For children under five (around 7,500), prevention and management of diarrhea, ARIs and malaria should be reinforced.

The risk of vaccine-preventable outbreaks, particularly measles, is heightened by overcrowding. A rapid assessment of Expanded Programme on Immunization (EPI) coverage in hosting sites is needed; for planning purposes, a catch-up campaign in the densest sites could be considered.

Mental health and psychosocial support are cross-cutting needs. It can be estimated that 15–20% of affected people (7,500–10,000) will experience acute distress requiring first-level support, and 3–5% (1,500–2,500) will need more targeted assistance. The establishment of listening points, psychological first aid by trained volunteers, and referral mechanisms to professionals should be planned, with particular attention to survivors of gender-based violence; a stock of PEP kits and emergency contraception sufficient for at least 50–100 anticipated cases should be available in referral facilities.

Continuity of care for non-communicable diseases is also critical. Among affected adults, an estimated 1,500–2,000 people live with hypertension and 400–600 with diabetes who need a rapid resumption of treatment. One- to two-month repeat prescriptions, consumables (glucometers, test strips) and support with transport to health facilities are required, particularly for older patients or those with limited mobility.

Finally, epidemiological surveillance must be strengthened. A weekly early warning system, anchored in health facilities and community volunteers, will enable rapid detection of signals (acute watery diarrhea, fevers, ARIs, bites/suspected leptospirosis).

Water, Sanitation And Hygiene

In the event of flooding, WASH (Water, Sanitation and Hygiene) needs focus on access to safe drinking water, protection against contamination, the provision of emergency sanitation facilities, and hygiene measures to prevent disease. This includes distributing hygiene kits, installing safe emergency latrines, ensuring the disinfection of water points, and raising community awareness.

Indeed, widespread contamination of water points, damaged latrines and overcrowding in hosting sites expose the population to a high risk of waterborne diseases and outbreaks, requiring a rapid response centred on access to safe water, emergency sanitation and hygiene promotion.

Hygiene promotion and the provision of consumables are key levers to reduce disease incidence. Based on the standard of 250 g of soap per person per month, approximately 12.5 tonnes of soap should be allocated for 50,000 people over one month (i.e. 1.25 kg per five-person household). Household handwashing can be supported with buckets fitted with taps and hygiene kits comprising soap, buckets, ladles and towels, prioritising 6,000 vulnerable households in the worst-affected areas. Menstrual hygiene management must be integrated: assuming around 25% of the affected population are women and girls aged 12–49 (nearly 12,500 people), distributing dignity kits to at least 8,000–10,000 beneficiaries initially — including sanitary materials (disposable or reusable), additional soap and underwear — and providing separate, well-lit washing/bathing spaces will significantly improve safety and dignity.

Protection, Gender And Inclusion

The floods and mass evacuations in Brazzaville and Pointe-Noire have created an environment in which protection risks have risen sharply, particularly in overcrowded collective sites and neighbourhoods that remain flooded. The sudden loss of income and overcrowding are altering power dynamics within households and between groups, increasing domestic violence, exploitation and abuse, while access to basic services and formal redress becomes more difficult. At the scale of 50,000 people affected, PGI (Protection, Gender and Inclusion) needs go beyond the mere provision of relief items and require targeted measures for safety, dignity and inclusion from the outset of the emergency phase.

Women and girls are particularly exposed. According to the Ministry, around 12,000–13,000 women and adolescent girls of reproductive age face a lack of privacy and appropriate facilities for menstrual hygiene, unsegregated or unlockable latrines, and poorly lit distribution areas. This context increases risks of gender-based violence, sexual exploitation and negative coping practices, especially when distributions are poorly regulated or aid passes through intermediaries. Survivors need discreet and rapid access to medical, psychosocial and legal services, but the mapping and availability of these services remain uneven, particularly in peripheral areas. Confidentiality, adequate lighting, separation of spaces and safe reporting mechanisms are immediate needs.

Children, who may represent nearly half of those affected, face combined risks of family separation during evacuations, economic exploitation during the recovery phase, and exposure to unhealthy environments. School interruptions and the absence of safe spaces foster idleness and trauma; very young children, already weakened by waterborne diseases and malaria, require specific attention. Needs include the identification and follow-up of unaccompanied children, family reunification, child-friendly and safe spaces, and clear referral pathways to child protection services.

Persons living with disabilities and older people—likely 10–12% and 5–7% respectively of the affected population—face major physical and informational barriers. Queues, stairs, muddy ground, distant water points and inaccessible latrines limit access to services. The loss of assistive devices (cane, glasses, wheelchair) is common and increases dependency. Needs include accessible adaptations of sites and distributions (priority lanes, adjusted hours), information in inclusive formats, the restoration of essential assistive devices, and support to carers.

Tenant households, families without documents, migrants and single heads of household (women alone, older people alone) are at high risk of exclusion from aid and of eviction. The absence of identity documents and SIM cards hinders access to cash transfers; insecure leases and post-disaster landlord–tenant tensions increase Housing, Land and Property (HLP) disputes. Needs include inclusive targeting measures, support for re-issuing documents, housing-related mediation mechanisms and options for rent support to prevent harmful coping strategies.

Community Engagement And Accountability

The emergency has created a severe deficit of reliable information and channels for expression for around 50,000 affected people (nearly 10,000 households), including 22,800 evacuees. In collective sites and still-flooded neighbourhoods, families primarily want to know who is eligible for which assistance, when and where distributions will take place, the targeting criteria and the value of support (notably cash), and what steps to follow for the re-issuance of identity documents and SIM cards. In the absence of prompt and consistent answers, rumours about distributions, health risks (e.g. cholera) or relocations spread rapidly and fuel tension and mistrust, particularly when official announcements do not reach all sites simultaneously.

Communities expect transparency on targeting choices and the value of assistance, as well as safe avenues for appeal when they believe they have been wrongly excluded. With a caseload of around 50,000 people, it is reasonable to anticipate that 5–10% will seek to ask questions or lodge complaints each month, i.e. 2,500–5,000 interactions to be handled via feedback mechanisms. The ability to provide factual responses within 48–72 hours for non-sensitive enquiries underpins trust and smooth operations; sensitive reports, particularly those related to protection from sexual exploitation and abuse (PSEA), require dedicated, confidential channels and prioritized handling within 24 hours with safe referrals. Without accessible, widely known mechanisms, the risk of perceived favoritism, confrontational queues and “capture” by certain local networks increases sharply.

Any identified gaps/limitations in the assessment

Despite the initial interventions, several needs remain insufficiently covered. In WASH, access to reliably safe drinking water and the availability of functional sanitation facilities remain incomplete in several sites and peripheral neighbourhoods; latrine emptying and maintenance fall short of needs, increasing epidemic risks.

In shelter/housing, rapid repairs and transitional rent support are still limited compared with the number of displaced households or those whose homes are uninhabitable.

Resource shortages: Constraints on resources are hindering coverage. There is a funding gap to extend assistance beyond the first emergency wave, and pre-positioned stocks of tarpaulins, repair kits, NFIs, chlorine/HTH, hygiene kits, malaria tests and treatments, ORS and IPC consumables are insufficient.

The CRC will conduct a detailed needs assessment at the start of the operation to supplement the data.

Operational Strategy

Overall objective of the operation

This DREF operation aims to provide urgent, multisectoral assistance to reduce immediate humanitarian impacts, prevent epidemic outbreaks, and enable the early, safe recovery of 2,500 of the most vulnerable households in Brazzaville and Pointe-Noire affected by the 18–19 November 2025 floods, over a four-month period.

This DREF will also provide multipurpose cash transfers via vouchers, emergency WASH support, and first aid (including epidemic prevention and psychosocial support), while ensuring protection, gender and inclusion, dignity, accountability, and community resilience.

Operation strategy rationale

To meet the needs of the target population, the National Society's (CRC) strategy will focus on the following areas, implemented through a locally embedded operational set-up, trained volunteers, and close coordination with health authorities and community committees in the two affected departments:
1)Cash transfer
The process will begin with training volunteers and supervisors on targeting, data protection, community engagement/accountability, prevention of sexual exploitation and abuse (PSEA), use of enrolment tools (Kobo/ODK) and distribution procedures.
In parallel, a rapid market assessment will enable the contracting of a merchant network and the choice of modality (e-vouchers with paper back-up where connectivity is weak). After public information on the criteria and areas, teams will carry out identification and pre-selection of affected households, followed by community validation.
Minimal enrolment (head of household, composition, contact if available) will include sex/age/disability disaggregation and anti-duplication checks, without excluding households lacking identity documents.
The 2,500 selected households will then receive a notification (paper token or public notice with lists posted in the community) stating the voucher value (50,000 CFA francs), the list of partner merchants, eligible goods/services and the validity period. Distributions will be staggered by locality, during daytime, with priority queues and mixed-gender teams to ensure safety and dignity, and an on-site and hotline complaints/feedback mechanism will be in place.
At delivery, identity is checked against the lists, the voucher (secure paper) is activated, and a brief orientation reiterates how to use it and the redress channels. Households can then redeem the voucher with accredited merchants, who are reimbursed promptly.
Real-time transaction monitoring and post-distribution monitoring (PDM) on at least a 10% sample will measure usage, coverage of priority needs, satisfaction and any incidents, with immediate corrective actions as needed.

2) Health
Support will aim to reduce post-flood morbidity and provide first aid. A total of 150 volunteers trained in first aid and Epic (Epidemic Control) will be deployed in mobile teams for pre-hospital assistance and referral to health facilities, backed by 100 first aid kits to replenish stocks and ensure continuity of activities.
Malaria prevention will be strengthened by distributing two long-lasting insecticidal nets (LLINs) to each of the 2,500 targeted households (5,000 LLINs in total), with demonstrations on correct use.
Three months of psychosocial support will be provided by volunteers trained in psychological first aid, integrated into community rounds, with structured referrals to specialist services when necessary.
In addition, a community-based surveillance system will be set up in the targeted areas: around 60 volunteers (within the 150 mobilised) will be trained to identify and rapidly report priority diseases (acute watery diarrhea/suspected cholera, febrile rash outbreaks, suspected malaria fevers, deaths or unusual events).
Alerts will be transmitted within 24 hours to the health zones using dedicated forms, with confirmation and immediate referral to case-management facilities, and feedback to communities. Weekly briefings with health zones and supervisors will analyse signals to guide prevention actions.

3)Water, Sanitation and Hygiene (WASH)
The immediate objective is to ensure temporary access to safe water and reduce water, sanitation and hygiene-related risks in affected

neighborhoods. Sixty volunteers will be deployed to run weekly community sanitation campaigns (targeted disinfection of priority locations, unblocking drains, waste management), with 30 sanitation kits provided to local committees and 150 personal protective equipment (PPE) kits for field teams. In parallel, 2,500 households will receive Aquatabs and jerrycans, accompanied by practical sessions on safe water treatment and storage and on handwashing at critical times, followed by post-distribution follow-up to verify uptake and correct use. Once floodwaters recede, water points and sources will be systematically disinfected with chlorine, in coordination with local operators, to secure communal water points—particularly in flooded areas with high contamination—and rapidly restore water quality to standards.

4) Community Engagement and Accountability (CEA)
To place communities at the heart of the response, reduce epidemic risks and guarantee transparency, around 30 CEA volunteers will be deployed across the two departments.
They will establish multiple channels to inform and listen to communities, including information and listening points during distributions, door-to-door and mass sensitization, a toll-free hotline, community meetings, and messages broadcast via community radio. Messages, delivered in Lingala and French, will focus on water, hygiene, prevention of cholera/diarrhea and malaria, early recognition of warning signs and prompt care-seeking.

In support of vaccination activities (routine catch-up, measles, polio, OCV where applicable), teams will carry out close-to-community social mobilization in coordination with health zones. Transparency will be ensured by posting targeting criteria, beneficiary lists and schedules, with community representatives participating in operational oversight.

A structured community feedback system will record, categorize and address questions and complaints within 48–72 hours, with confidential channels for sensitive reports (including PSEA) and active referral pathways. Weekly review of feedback and rumors will inform corrective messaging and programmatic adjustments, respecting data protection and the inclusion of vulnerable groups.

5) Protection, Gender and Inclusion (PGI)
Planning and design of the DREF will aim to assess and reduce risks of discrimination and violence and to promote meaningful participation of all people, regardless of age, sex, disability or background. The response will be designed and delivered to be safe, inclusive and gender-sensitive. Seven PGI volunteers per department (14 in total), supported by a provincial focal point, will train all teams on PGI minimum standards and PSEA, ensure site accessibility (priority queues, arrangements for people with reduced mobility, adapted hours) and maintain referral pathways for protection and GBV cases. Sex/age/disability data disaggregation and proactive identification of female-headed households, older people and persons living with disabilities will guide targeting and inclusion monitoring.
The response will emphasize protection and well-being through psychosocial support, safety in shelters, mapping of referral pathways, facilitation of safe referrals, information sessions on available services and distribution of hygiene kits. Community sensitization, dissemination of IEC materials on reporting mechanisms, the establishment of sensitive communication channels and regular staff briefings will ensure accountability and do-no-harm.

6) Organisation and coordination
A pool of multi-skilled volunteers (150 in total) and 15 supervisors will be mobilised and will work in pairs over three months, with cross-sector role overlap as needed. They will be supervised by CRC secretariat teams and a provincial supervisor. Supplies will rely on local suppliers, nearby warehouses and distribution points agreed with municipal authorities. Technical coordination will be ensured with the government (Ministry of Social Affairs/Humanitarian Action and Ministry of Health), health zones, municipal services and humanitarian partners to avoid duplication and fill gaps. Post-distribution and routine monitoring, informed by CEA feedback, will enable continuous adjustment of implementation and capture of lessons learned at the end of the operation.
The CRC will take part in all coordination meetings organized by the ministry and/or other actors in the context of this crisis.

Targeting Strategy

Who will be targeted through this operation?

The operation will target 2,500 households (around 12,500 people) among the most vulnerable affected by the floods, with an indicative split of 60% in Brazzaville (1,800 households) and 40% in Pointe-Noire (1,200 households). Initial geographic targeting will focus on the worst-affected arrondissements/localities reported: in Brazzaville, Talangaï, Ouenzé, Djiri, Mfilou and Madibou; in Pointe-Noire, Loandjili, Mvoumvou, Tié-tié, Lumumba and Tchamba-Nzassi. This target balances the scale of needs (around 50,000 people affected) with the resources available over four months (CRC capacity of 150 volunteers, stocks and initial funding) and complements the coverage by the authorities and partners (4W coordination). The main voucher modality (cash-voucher) has been retained as urban markets remain broadly functional; in-kind support is planned where market access or identification remain problematic.

Explain the selection criteria for the targeted population

Given the scale of needs and the resources available, assistance is designed to reach 2,500 households (12,500 people) most exposed to post-flood health, protection and poverty risks. The targeting logic aims to concentrate assistance on households combining severe damage with socio-economic vulnerabilities, in order to prevent negative coping strategies (debt, meal reduction, school withdrawal, sale of tools) and to reduce epidemic risk.

Geographic targeting Territorial prioritisation is based on the severity of damage, WASH disruptions and the density of the affected population.

Brazzaville: Talangaï, Ouenzé, Djiri, Mfilou, Madibou (around 60% of the target, i.e. 1,500 households).
Pointe-Noire: Loandjili, Mvoumou, Tié-tié, Lumumba, Tchamba-Nzassi (around 40%, i.e. 1,000 households).
This allocation will be adjusted based on rapid assessments and other actors' coverage (4W coordination).

Household-level vulnerability criteria are as follows:
- Dwelling destroyed or uninhabitable; displacement to a collective site/host family; recurrent exposure.
- Households with a child under five; pregnant/breastfeeding woman.
- Older person living alone; person living with a disability; chronic illness requiring ongoing treatment.
- Household experiencing interruption of daily income/informal activity (petty trade, fishing/port activities), loss of tools/stocks.
- Female-headed household; loss of documents; history of GBV/protection concerns (with confidential handling and referral).

Priority will be given to households with severe damage or displacement, combined with at least one demographic/health or protection vulnerability factor.

Total Targeted Population

Women	**3,250**	Rural	**5%**
Girls (under 18)	**3,000**	Urban	**95%**
Men	**3,250**	People with disabilities (estimated)	**15%**
Boys (under 18)	**3,000**		
Total targeted population	12,500		

Risk and Security Considerations (including "management")

Does your National Society have anti-fraud and corruption policy?	**No**
Does your National Society have prevention of sexual exploitation and abuse policy?	**No**
Does your National Society have child protection/child safeguarding policy?	**No**
Does your National Society have whistleblower protection policy?	**No**
Does your National Society have anti-sexual harassment policy?	**No**

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

Risk	**Mitigation action**

Continued rainfall, further flooding, landslides/erosion, recontamination of water points.	Decentralized pre-positioning (two hubs: Brazzaville/Pointe-Noire), stockpiles (tarpaulins, chlorine/HTH, non-food items), weather monitoring/early warnings, flexible phasing of distributions (time slots, rapid re-scheduling), household-level risk-reduction messaging.
Market disruptions and risks associated with cash/vouchers.	Weekly rapid market analyses; adjustment of the transfer value; contracts with multiple merchants and price ceilings; prompt payments to merchants; grievance/redress mechanisms for beneficiaries; switch to in-kind assistance if necessary..
Outbreaks of waterborne diseases (cholera), a surge in malaria, acute respiratory infections (ARIs); overburdening of health facilities, infections at mass gatherings.	WASH package (chlorination, Aquatabs, jerrycans, hygiene promotion); community-based surveillance (EpiC); pre-positioning of ORS, zinc, RDTs and ACTs; LLINs (two per household) with usage messages; IPC and PPE for teams and service points; targeted support for referrals to health facilities.
GBV/sexual exploitation and abuse (SEA); violations of dignity (lack of privacy/lighting); exclusion of groups (female-headed households, persons with disabilities, older people, migrants, refugees); child separation.	PGI/PSEA integration (training, SOPs, confidential channels); separate, well-lit, lockable latrines; lighting of sensitive areas; priority queues and accessibility adaptations; inclusive committees; SADD (sex- and age-disaggregated data) and inclusion thresholds; active referral pathways (GBV/child protection); multilingual information (French/Lingala/Kituba).
Rumors about eligibility criteria/amounts, unrealistic expectations, loss of trust, community tensions.	CEA mechanism: helpdesks, a freephone helpline, community radio, posting of criteria/schedules/lists, responses within 48–72 hours, rumor monitoring and corrective messaging, spokespeople aligned with the authorities.
Crowd movements, theft/assault, misappropriation of aid, threats against teams. Tensions linked to scarcity, rumors, and the visibility of high-value items.	Crowd management plan (tokens, scheduled time slots, crowd-control barriers); presence and coordination with local authorities; safe, accessible siting of distribution points; low-visibility distributions; no cash on site (vouchers/digital transfers); daily security briefings; adjusted routes and timings; insurance cover for volunteers.
Population displacement, overcrowding in informal shelters, lack of privacy, and insecurity around water points/latrines (no lighting, doors that cannot be locked), together with the breakdown of community protection mechanisms and loss of livelihoods, heighten the risks of gender-based violence (domestic/intimate partner violence, sexual exploitation and abuse, harassment, early/forced marriage, and resort to negative coping strategies).	Sex-segregated latrines with doors lockable from the inside; lighting (solar lamps/strategic positioning); clear access paths close to shelters; menstrual hygiene management (MHM) facilities and private washing areas; accessibility adaptations (grab rails, ramps) for persons with disabilities.

Please indicate any security and safety concerns for this operation:

Although there is no active armed conflict in the targeted areas, the dense urban context entails heightened post-disaster risks, including opportunistic crime (theft, pickpocketing), tensions during distributions, disrupted road traffic, weakened infrastructure, unstable terrain (gullies/riverbanks), and standing water and contamination.

Snatch theft, break-ins at warehouses, and intimidation of teams or beneficiaries around distribution points; the risk is heightened by the visibility of items (tarpaulins, vouchers) and by rumors.

Has the child safeguarding risk analysis assessment been completed?	No

Planned Intervention

Multi Purpose Cash

Budget: CHF 233,664
Targeted Persons: 12,500

Indicators

Title	Target
# of households that have received at least one round of vouchers.	2,500
% of households informed of the criteria, value and schedule.	90
% of households reporting that their essential needs have been met.	80
% Overall satisfaction rate with the assistance (access, quality, safety).	85
% of beneficiary households that include at least one older person and/or a person living with a disability.	15

Priority Actions

• Finalize the rapid market analysis in each targeted locality (availability, prices, competition, security, access) and update the Minimum Expenditure Basket (MEB) to set the voucher value.
• Targeting and registration of households (3,000) using a transparent vulnerability scoring tool; obtain informed consent.
• Multilingual communication (French, Lingala, Kituba), posting of criteria and schedule, distribution helpdesks and a freephone helpline; rumor management.
• Organize voucher distributions: site/flow plans, tokens/time slots for crowd management, priority queues/accessibility measures, and a home-delivery option for people with reduced mobility.
• Post-distribution monitoring (PDM): voucher use, coverage of essential needs, quality/pricing, safety, satisfaction and complaints; rapid surveys and focus group discussions.

Health

Budget: CHF 37,309
Targeted Persons: 10,000

Indicators

Title	Target
# of households that received insecticide-treated mosquito nets and a demonstration session: 3,000 households (6,000 LLINs), with at least 80% correct use observed.	2,500
# of people reached by health promotion messages (water/hygiene, malaria, cholera, warning signs).	10,000
% of Community-Based Surveillance (CBS) alerts reported and relayed to health authorities within 24 hours.	90
# of prioritised alerts investigated and closed with feedback to the community.	-

% of households reporting that they know at least three diarrhoea prevention measures (treated water, handwashing, sanitation).	80
# of people who received first-level psychosocial support (PFA) or listening sessions.	2,500
# of clean-up/desilting campaigns carried out in the targeted neighbourhoods (one per week × 10 localities × a minimum of 2 months, adjusted according to access).	40

Priority Actions

• Deployment of mobile teams of 150 volunteers trained in first aid and EpiC, equipped with 80 first aid kits, to stabilise, refer and direct patients to health facilities in the two departments.
• Distribution of, and demonstrations on the use of, 6,000 insecticide-treated mosquito nets (two per targeted household), with messages on correct hanging, drying and maintenance.
• Promotion of preventive measures (safe water treatment and storage, hand hygiene, sanitation). • Community-based surveillance and early warning (CBS/EpiC): establishment of a network of 75 sentinel volunteers (within the 150) to detect and notify priority signals within 24 hours (acute watery diarrhoea/suspected cholera, fevers, acute respiratory infections, unusual deaths), with weekly feedback to communities.
• Psychosocial support (MHPSS): integration of Psychological First Aid (PFA) into community activities and distributions.

Water, Sanitation And Hygiene

Budget: CHF 58,444
Targeted Persons: 12,500

Indicators

Title	Target
# of households receiving Aquatabs, two jerrycans and hygiene messages.	2,500
# of Aquatabs distributed for 30 days.	250,000
% of households correctly demonstrating water treatment and storage during spot-check visits.	80
# of clean-up/desilting campaigns carried out in the targeted neighborhoods.	24
# of water points tested	50
# of HHs tested	2,500
# of volunteers trained and operational for residual chlorine monitoring	50
# of organized PDM	1

Priority Actions

• Hygiene promotion and prevention of waterborne diseases: neighborhood and mass sessions (French/Lingala in Brazzaville; French/Kituba–Monokutuba in Pointe-Noire) on the “critical times” for handwashing, correct use of Aquatabs, rainy-season preparedness, prevention of cholera/diarrhea and malaria; IEC materials adapted for low literacy levels.
• Weekly community sanitation campaigns: drain clearance, solid waste management, reduction of larval habitats in affected neighborhoods, with the provision of 18 sanitation kits to local committees and PPE for 150 volunteers; coordination with municipal services for waste removal.
• Distribution of handwashing facilities to the six health centers (three in Brazzaville and three in Pointe-Noire).
Training of 150 volunteers in WASH basics, chlorine dosing, IPC, waste management and chemical safety (HTH/chlorine solutions).

- Monitoring of residual chlorine at communal water points and at household level.
- Post-distribution monitoring.

Protection, Gender And Inclusion

Budget: CHF 45,269
Targeted Persons: 10,000

Indicators

Title	Target
# of volunteers and staff members trained in GBV/PSEA/safeguarding	160
% of activity sites compliant with accessibility and safety standards (priority lines, ramps/seating, lighting, separate/lockable latrines)	90
% of distributions with at least one female volunteer per distribution line and mixed teams	90
# of accessibility adaptations implemented (ramps, accessible signage, separate spaces)	10
% of sensitive cases (GBV/PSEA/child protection) referred within 24 hours according to SOPs	100
# of women and adolescent girls who received a dignity kit and MHM messages	1,000
% of households reporting that assistance is delivered in a safe, dignified and non-discriminatory manner	85

Priority Actions

• Establish the safeguarding framework: finalize and disseminate PGI/PSEA and child safeguarding SOPs, have all staff and the 150 volunteers sign the Code of Conduct, and appoint a PGI focal point for each department (Brazzaville and Pointe-Noire).
• Organize sessions for the 150 volunteers and staff members on Minimum Standards for PGI in emergencies, PSEA, ethical management of disclosures, informed consent, confidentiality, safe referral (GBV, child protection) and disability inclusion; integrate a practical module on inclusive crowd management.
• Conduct a rapid protection risk assessment in each locality (Talangaï, Ouenzé, Djiri, Mfilou, Madibou; Loandjili, Mvoumvou, Tié-tié, Lumumba, Tchamba-Nzassi).
• Ensure physical accessibility and safety: set up priority queues, ramps and seating; create separate, well-lit spaces around latrines/water points; ensure separate, lockable latrines; assign at least one female volunteer per distribution queue and mixed-gender teams for home visits; arrange home deliveries for people with reduced mobility.
Integrate menstrual hygiene management: in coordination with WASH, distribute dignity kits to targeted women and adolescent girls.
• Organize community sensitization sessions on available GBV and child protection services.
Train volunteers on handling sensitive feedback and on establishing confidential, gender- and disability-sensitive feedback mechanisms.•

Community Engagement And Accountability

Budget: CHF 17,939
Targeted Persons: 10,000

Indicators

Title	Target

% of households reporting that they know the targeting criteria, the voucher value and the schedule.	90
# of people reached (disaggregated by age, sex and disability) by messages.	10,000
% of sites with visible and up-to-date displays (criteria, schedules, contacts).	90
# of interactions handled through CEA mechanisms (helpdesks, hotline, suggestion boxes, meetings).	1,500
% of non-sensitive complaints resolved within 72 hours.	80
% of feedback recorded with sex/age/disability disaggregation.	90
# of volunteers trained/briefed on CEA (disaggregated by age, sex and disability).	150
# of radio programmes broadcast	36
# of local complaints management committees trained for the collection of feedback.	20
# of community meetings organized to validate the lists.	20

Priority Actions

• Establish a package of information and feedback channels, operational in each locality: information/listening points (helpdesks) at all distribution sites; a freephone helpline.
• Produce and disseminate clear, multilingual messages (French/Lingala in Brazzaville; French/Kituba–Monokutuba in Pointe-Noire), with materials adapted for low literacy levels (audio/visual).
Set up a system for monitoring rumors and perceptions.
• Operationalize a feedback/complaints management mechanism: registration, categorization (questions, suggestions, non-sensitive/sensitive complaints), processing timeframes (72 hours for non-sensitive; 24 hours for sensitive/PSEA).
• Train 80 CEA volunteers (and brief all 150 volunteers) on CEA.
• Organize and broadcast radio programmes.
• Establish and train local complaints management committees to collect feedback related to targeting and distribution.
• Hold community meetings to define and validate the selection criteria.

Secretariat Services

Budget: CHF 35,889
Targeted Persons: 500

Indicators

Title	Target
# of volunteers insured	500
# of lunch meeting organized	1
# of joint monitoring missions organized in the field	4
# of DREF monitoring calls organized during implementation	4

Priority Actions

•Organize a lunch meeting with the Ministry, the CRC and other partners.
• Volunteer insurance (Group insurance).

• Organize joint monitoring missions in the field.
• Organize a mandatory DREF follow-up call one month after launch.

National Society Strengthening

Budget: CHF 70,753
Targeted Persons: -

Indicators

Title	Target
# of lessons learned workshops organized	1
# of preparatory meetings organized	2
# of field missions organized by headquarters staff	6

Priority Actions

• Organize a lesson learned workshop before the end of the operation.
• Organize a preparatory meeting and operations planning with branch managers and National Staff.
• Headquarters staff mission to monitor activities.

About Support Services

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

CRC Volunteers: 150 in total (including 15 team leaders/field supervisors), distributed between Brazzaville (80) and Pointe-Noire (70).
- 1 Operations Manager: overall management, planning, risk management, reporting.
- 2 Branch Coordinators (Brazzaville and Pointe-Noire): local coordination with authorities and partners, team supervision.
• 1 Health Focal Point: first aid, community-based surveillance, PSS, links with health facilities.
• 1 WASH Focal Point: hygiene promotion, sanitation.
• 1 CEA/GBV Focal Point: information, feedback/complaints mechanisms, inclusion and PSEA.

Cross-cutting support:
• 1 PMER: monitoring and evaluation, PDM, S/A/D data, lessons learned.
• 1 Logistics/Procurement: supply chain, warehousing, distribution.
• 1 Finance/Administration: compliance, disbursements, financial justification.
• 1 Communication: public messaging, media, visibility.
• 1 Security Focal Point: security SOPs, briefings, incidents.
• 2 Drivers: mobility of teams and supplies.

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

The CRC volunteer network broadly reflects the gender, age and cultural diversity of the communities in Brazzaville and Pointe-Noire, but there are still gaps that are being addressed. The current composition is approximately 45% women and 55% men, with good representation of youth (nearly one-third between 18 and 25 years old) and a majority of adults aged 26 to 40; the volunteers are mainly from the targeted neighborhoods and speak French as well as Lingala in Brazzaville and Kituba/Monokutuba in Pointe-Noire. This social and linguistic proximity fosters community acceptance and the quality of dialogue with affected people.

The CRC also strengthens the inclusive skills of all teams. All volunteers undergo mandatory modules on protection, gender and inclusion, prevention of sexual exploitation and abuse (PSEA), community engagement, disability inclusion and ethical management of disclosures and referrals.

The CRC deploys mixed-gender and bilingual teams for home visits and confidential interviews, and produces information materials in multiple languages adapted to low literacy levels, with interpretation in Lingala or Kituba/Monokutuba when necessary.

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

Procurement of CHF 50,000 or more will be conducted by the IFRC, with support from the regional office (Africa logistics unit) and in close coordination with the CRC, in accordance with the IFRC Procurement Manual.
Procurement below CHF 50,000 may be carried out by the CRC, with technical support from the IFRC delegation (file review, compliance, specification validation), in strict compliance with IFRC procedures and thresholds (procurement committees, three quotations, segregation of duties, due diligence).
Priority will be given to local suppliers to accelerate timelines and support markets: WASH kits (Aquatabs/NaDCC, 20L food-grade jerrycans, soap), PPE, voucher printing services.

International procurement through the IFRC could be undertaken in case of local unavailability or specific quality requirements, particularly for IFRC standard tarpaulins, and possibly LLINs if not available through the Ministry of Public Health/partners. The IFRC will mobilize logistics hubs (e.g. Nairobi/Dubai) and existing contractual frameworks.

How will this operation be monitored?

The monitoring of the operation will be based on a clear PMER framework, simple digital tools and joint CRC-IFRC supervision. From the start, a logical framework and monitoring plan will be validated, with indicators, sources of verification and a collection schedule. The CRC will lead daily data collection through its field teams, while the IFRC will provide methodological support and quality reviews, as well as joint monitoring visits.

In practical terms, teams will complete distribution forms and digital forms (Kobo/ODK) for all key activities (vouchers, WASH, mosquito nets, awareness-raising and SBC). Beneficiary lists will be disaggregated by sex/age/disability and cross-checked with 4Ws to avoid duplication.

Progress will be monitored at three levels:
1) Daily, team leaders will consolidate outputs and incidents and transmit their reports to departmental coordinators.
2) Weekly, the CRC will produce a situation report (sitrep) including numbers assisted, geographical coverage, risks and adaptations, as well as an update on community feedback (CEA) and complaints handling.
3) Monthly, a progress report will put achievements into perspective against targets, analyze gaps and propose programmatic adjustments. A mid-term review (around week 4-6) and an end-of-operation lessons learned workshop will draw lessons and formalize recommendations.

Please briefly explain the National Societies communication strategy for this operation

The CRC will ensure effective internal communication through multiple channels:
• Daily briefings between field teams, team leaders and branch coordinators to share operational updates, challenges and adaptations.
• Weekly situation reports (sitreps) circulated among CRC leadership, departmental coordinators, IFRC delegation and headquarters staff.
• WhatsApp groups and phone calls for real-time coordination and incident reporting among field teams.
Monthly coordination meetings bringing together all technical focal points (Health, WASH, CEA, PMER, Logistics) to review progress and align strategies.

External Communication with Stakeholders and Partners:
• Regular coordination meetings with Ministry of Health, local authorities, UN agencies and humanitarian partners to share 4W updates and avoid duplication.
• Participation in cluster/sector meetings (Health, WASH, Protection) to share information and coordinate response.

Communication with Affected Communities:
The CRC will ensure transparent and two-way communication through:
• Community meetings at the start of activities to explain assistance criteria, distribution schedules and accountability mechanisms

• Door-to-door visits by volunteers delivering information in local languages (Lingala, Kituba/Monokutuba).
• Information materials (flyers, audio messages) adapted to low literacy levels and displayed at distribution sites and community gathering points.
• Community radio broadcasts with key messages on health promotion, WASH practices and where to access assistance.
• Feedback and complaints mechanisms (hotline, suggestion boxes, community focal points) with regular analysis and response to community concerns.
•Public display of beneficiary selection criteria and distribution calendars at visible community locations
Media and Public Communication Strategy:

A proactive media strategy will include:
• Press releases at operation launch, mid-term and completion to highlight CRC response and humanitarian needs.
• Media field visits organized for local and national journalists to document Red Cross action while respecting beneficiary dignity and consent.
• Social media updates (Facebook, Twitter) with photos, videos and human-interest stories showcasing assistance and community resilience.
• Photo and video documentation following IFRC standards on informed consent, data protection and dignified representation.
Visibility materials (banners, branded items) at distribution sites acknowledging donors (IFRC DREF) and partners.

Budget Overview

IFRC

DREF OPERATION

MDRCG026 - Congolese Red Cross
Congo Floods 2025

Operating Budget

Planned Operations	**392 626**
Shelter and Basic Household Items	0
Livelihoods	0
Multi-purpose Cash	233 664
Health	37 309
Water, Sanitation & Hygiene	58 444
Protection, Gender and Inclusion	45 269
Education	0
Migration	0
Risk Reduction, Climate Adaptation and Recovery	0
Community Engagement and Accountability	17 939
Environmental Sustainability	0
Enabling Approaches	**106 642**
Coordination and Partnerships	0
Secretariat Services	35 889
National Society Strengthening	70 753
TOTAL BUDGET	**499 267**

all amounts in Swiss Francs (CHF)

Internal 26/11/2025 #V2022.01

Click here to download the budget file

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Click here for the reference