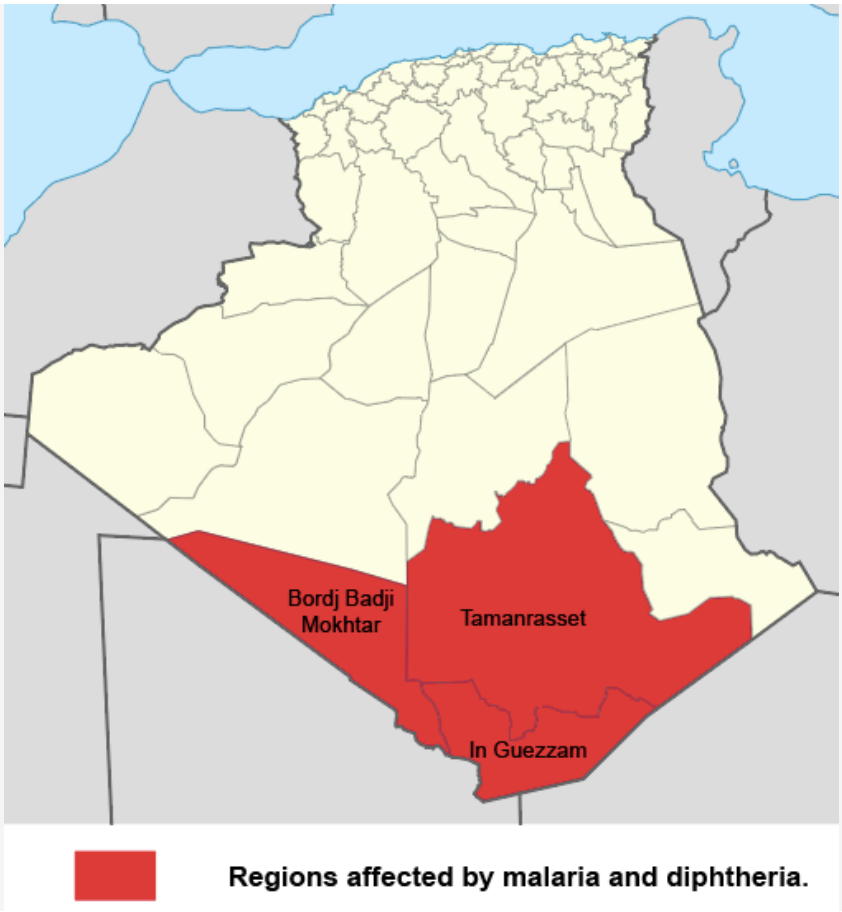
DREF Final Report

South Algeria Malaria and Diphtheria

Appeal: **MDRDZ012**	Total DREF Allocation: **CHF 214,695**	Crisis Category: Yellow	Hazard: **Epidemic**
Glide Number: **-**	People Affected: **6,000 people**	People Targeted: **6,000 people**	People Assisted: **6,000 people**
Event Onset: **Sudden**	Operation Start Date: **28-10-2024**	Operational End Date: **30-04-2025**	Total Operating Timeframe: **6 months**

Targeted Regions: **Tamanrasset**

Description of the Event



Regions affected by malaria and diphtheria.

Date of event

28-09-2024

What happened, where and when?

In July 2024, violent hostilities erupted in the Kidal region of northern Mali, near the Algerian border. Armed clashes between the Malian Armed Forces and rebel groups intensified the instability in the area, leading to widespread destruction and forcing thousands of civilians—particularly women and children—to flee their homes. By late July, an estimated 5,000 to 6,000 people had crossed into Algeria through the border town of Tinzaouatine in search of safety. This latest influx represented only the peak of a displacement movement that had started months earlier, resulting in tens of thousands of people on the move.

As the population movement continued, the southern Algerian wilayas of In Guezzam and Bordj Badji Mokhtar became rapidly overwhelmed. The sudden arrival of large numbers of displaced families placed significant pressure on already fragile local services and contributed to the rapid escalation of a public health crisis. By late September, health authorities reported 536 confirmed cases of malaria, including 40 deaths, and 115 cases of diphtheria, with 28 fatalities.

Environmental conditions further exacerbated the situation. Heavy rains in September created extensive stagnant water, providing ideal breeding grounds for mosquitoes and triggering a sharp rise in malaria cases. At the same time, low vaccination coverage among displaced populations—many coming from rural and underserved areas of Mali—accelerated the spread of diphtheria. The combination of high mobility, inadequate shelter conditions, and overstretched healthcare facilities created a perfect storm for the two outbreaks, placing thousands of vulnerable people at acute risk.

Faced with the rapid deterioration of the health situation, the Ministry of Health officially reported the confirmed outbreak figures on 3 October 2024 and requested the support of the Algerian Red Crescent (ARC) to strengthen the response in the affected regions. The

convergence of conflict-driven displacement, adverse environmental conditions and structural gaps in healthcare capacity resulted in a severe public health emergency in southern Algeria, prompting the launch of this DREF operation.

Scope and Scale

The humanitarian crisis in southern Algeria is multifaceted, involving several critical issues. The influx of tens of thousands of displaced individuals from Mali, ongoing migration flows, and the challenges faced by nomadic groups have stretched local resources to the breaking point. These displaced populations, predominantly women and children, lack adequate access to food, clean water, and healthcare, posing severe challenges for humanitarian response efforts. However, the most alarming issue has been the outbreak of malaria and diphtheria, which has escalated rapidly and poses the greatest threat to both displaced and local populations.

The outbreaks of malaria and diphtheria have significantly worsened the situation. These diseases have spread quickly among vulnerable groups already facing extreme hardship. The number of malaria cases was rising with daily malaria infections, indicating active spread of the disease. The mortality rate, although relatively low compared to the total number of cases, remains concerning, especially among children, emphasizing the importance of strengthening vaccination and prevention programs for young children. As of 3 October, the MoH reported, total confirmed cases were 536 with 40 deaths. While the total number of diphtheria cases appears lower than that of malaria, the emergence of new cases requiring isolation highlights the need for continued surveillance of this highly contagious disease. As of 3 October, the MoH reported, total confirmed cases were 115 with 28 deaths.

However, these confirmed cases did not represent all potential cases, given the large geographic area affected and the nature of the displaced population. Many individuals were on the move, and some cases have likely gone unreported. Additionally, the risk of the epidemic spreading rapidly necessitated an immediate and comprehensive intervention. The migrant population might not have had timely access to appropriate healthcare, further increasing the urgency of the situation and the potential for the outbreak to worsen.

These outbreaks had been exacerbated by the poor living conditions of the displaced populations and mobile groups, many of whom lack access to essential healthcare services, including vaccinations. Our focus on these outbreaks stemmed from the immediate threat they posed to public health, both within the mobile populations and the host communities. Disease transmission was being driven by precarious living conditions, including poor hygiene, the lack of adequate shelter, and the overall strain on healthcare systems in In Guezzam and Bordj Badji Mokhtar.

According to the WHO, vulnerable and marginalized groups tend to bear a disproportionately high burden of health problems. This observation was particularly evident in this crisis, where displaced persons, migrants, and nomads were disproportionately affected by health emergencies. Despite the various challenges in this crisis, the urgency of the outbreaks necessitated focused attention and action. Without immediate interventions, these diseases could have continued to spread unchecked, further exacerbating the health crisis and overwhelming local healthcare systems. Addressing the outbreaks was our top priority to mitigate the most severe impact on the affected populations and prevent a wider regional health crisis.

Source Information

Source Name	Source Link
1. Abdelhamid Afra : Nous sommes en phase de relèvement face à la Diphtérie et le Paludisme	https://news.radioalgerie.dz/fr/node/53066

2. Malaria and diphtheria epidemic ravages southeastern Algeria	https://www.msn.com/en-xl/news/other/malaria-and-diphtheria-epidemic-ravages-southeastern-algeria/ar-AA1rOxqs
3. Algeria says it registers cases of malaria, diphtheria among expatriates	https://www.reuters.com/world/africa/algeria-says-it-registers-cases-malaria-diphtheria-among-expatriates-2024-09-27/
4. Cas de Diphtérie et de Paludisme à l'extrême Sud du pays- Grande mobilisation pour maîtriser la situation	https://www.lesoirdalgerie.dz/actualites/grande-mobilisation-pour-maitriser-la-situation-123172
5. Crise sanitaire sans précédent au Nord du Mali : Nouveau flux migratoire à nos frontières	https://www.elmoudjahid.dz/fr/actualite/crise-sanitaire-sans-precedent-au-nord-du-mali-nouveau-flux-migratoire-a-nos-frontieres-224707

IFRC Network Actions Related To The Current Event

Secretariat	The IFRC country delegation team maintains daily cooperation with the NS, providing continuous support and operational coordination throughout this response to the malaria and diphtheria crisis. These efforts are part of the IFRC network's actions to respond effectively to the ongoing epidemic.
Participating National Societies	No Partner National Societies are currently contributing to this operation.

ICRC Actions Related To The Current Event

N/A

Other Actors Actions Related To The Current Event

Government has requested international assistance	No
National authorities	Local authorities and the Ministry of Health have been actively engaged in the response to the crisis. They are stationed at border points, regulating migrant access in order to control the outbreak, with borders only being opened twice a week. Authorities are also providing assistance on-site, facilitating the transport of urgent cases affected by the outbreak or referring individuals to shelters where organizations such as the Algerian Red Crescent (ARC) are operating. During the epidemic of malaria and diphtheria in In Guezzam and Bordj Badji Mokhtar, the government, through its health services, took the lead in initiating vaccination operations. The government later launched a large-scale vaccination campaign, supported by a sensitization effort to raise awareness about the disease. The Algerian Red Crescent (ARC) medical teams provided crucial assistance to these government-led efforts, particularly in helping with the vaccination of students in primary schools, achieving complete coverage. The ARC teams also extended their support to reach nomadic populations in remote areas like Timiaouine and Tinzaouatine, ensuring that the most vulnerable were not left behind.

	A medical commission has been dispatched by the MoH to the affected areas to assess the situation and provide necessary medical supplies. Large quantities of medications, anti-diphtheria serums, and protective equipment have been sent to the affected regions in addition to the establishment of 60-bed hospital and 2 ambulances in Bordj Badji Mokhtar wilaya. The MoH has also started a vaccination campaign of all residents in affected areas including boost-shots to those previously vaccinated. The Ministry of Health is continuously assessing and monitoring the situation. Currently, the outbreak remains confined to the southern regions, with local authorities implementing safety measures to prevent its spread across the country.
UN or other actors	No United Nations actors have responded to this event.

Needs (Gaps) Identified

Health

The health response revealed a set of structural, operational, and contextual gaps that significantly constrained the ability to contain and manage both outbreaks. Limited awareness of preventive measures remained a key barrier, particularly among nomadic and migrant populations whose mobility, linguistic diversity, and restricted access to information reduced the effectiveness of conventional health communication approaches. In remote areas, delayed health-seeking behaviors further compounded these challenges.

Local health infrastructure was critically under-resourced. Peripheral facilities operated with insufficient clinical and paramedical personnel, limited triage capacity, and constrained ability to manage a rapid surge in caseloads. Shortages of essential medicines, diagnostic tools, and medical equipment hindered timely case management, while a lack of support staff affected the application of infection prevention and control (IPC) protocols. These limitations were especially detrimental for populations living far from fixed health structures and for communities continually moving between border zones.

Diagnostic and surveillance capacities also proved inadequate. The absence of structured community-based surveillance mechanisms, combined with fragmented reporting pathways, prevented early detection and rapid notification of cases among highly mobile groups. Health data flows between provincial health authorities, local health facilities, and community-level actors were not harmonized, resulting in delays that affected both response coordination and epidemiological monitoring.

Vector control capacity remained insufficient to address the environmental conditions contributing to malaria transmission. Stagnant water proliferation, exacerbated by seasonal rains, created persistent breeding sites that could not be effectively managed with existing local resources. Access to essential malaria diagnostic tools, such as rapid tests and microscopy, remained limited in remote health posts, reducing the capacity for early detection and case confirmation.

Vaccination gaps represented another critical vulnerability. Low immunisation coverage among recently displaced populations—especially children from areas with weak routine vaccination systems—created a large reservoir of susceptible individuals. The absence of harmonized vaccination records further complicated risk assessments and the planning of targeted immunisation campaigns for mobile communities.

Additional constraints emerged from the broader operational context. Remote border areas were difficult to access due to long distances, poor road infrastructure, and intermittent security restrictions, which delayed the deployment of medical teams and the distribution of health supplies. Local health systems demonstrated limited surge capacity and remained dependent on external reinforcements to sustain an extended emergency response. Communication strategies were not always tailored to the linguistic, cultural, and social specificities of displaced and nomadic communities, reducing their reach and impact.

Finally, the response revealed gaps in isolation capacity for highly contagious diseases. Health structures lacked designated isolation facilities and had to rely on temporary setups to separate suspected and confirmed cases, underscoring the need for more robust surge infrastructure in border areas.

Taken together, these gaps illustrate the urgent need for a more decentralized, flexible, and culturally adapted health preparedness and response system, capable of reaching mobile populations, strengthening diagnostic and treatment capacities, and improving early warning mechanisms in remote high-risk regions.

Water, Sanitation And Hygiene

In the context of the humanitarian crisis that affected the southern regions, the WASH needs of mobile populations became increasingly critical. The presence of stagnant water in the affected areas facilitated the spread of disease, particularly malaria. Displaced families arriving from Mali, as well as regular migratory flows, often lacked access to basic hygiene resources, increasing the risk of diphtheria transmission.

Access to essential hygiene items was necessary to reduce the spread of disease. However, awareness efforts promoting key practices—such as handwashing, safe water handling, and disinfection—remained insufficient, especially in rural and hard-to-reach areas. Many communities had limited access to clean drinking water and adequate sanitation facilities, which affected their overall living conditions.

There was also a need for equipment to support the drainage and treatment of stagnant water, as well as for the installation of community handwashing stations with reliable water supply. Priority WASH needs included the distribution of hygiene kits, strengthened hygiene-promotion activities, and improved access to safe drinking water. These interventions were essential to protect vulnerable populations and limit disease transmission in a context of high mobility and limited infrastructure.

Operational Strategy

Overall objective of the operation

The overall objective of the operation was to provide urgent assistance to people affected by the outbreaks in South of Algeria, including people in the move and host communities, with a focus on health (Malaria and Diphtheria). This operation aimed to assist 6,000 affected people residing in the southern regions, including those directly impacted by the outbreaks in the WASH and health sectors, for 6 months.

Operation strategy rationale

In its response, the National Society implemented a strategy focused on deploying medical teams to the affected areas, ensuring the procurement and replenishment of essential medical supplies used throughout the operation, supporting the Ministry of Health's vaccination campaigns, and organizing community awareness-raising activities. The operation also strengthened ARC's ability to prevent, identify, and address epidemic-prone diseases by advancing efforts related to community-based surveillance in coordination with the Ministry of Health and other health stakeholders.

Under this DREF operation, the health strategy covered the following components:

- Deployment of medical teams:
  - Mobilisation of 40 doctors and 20 nurses,
  - Organized into 6 teams of 10 members,
  - Operating through 10-day rotations over a two-month period,
  - Ensuring early detection, clinical follow-up, and functioning referral pathways.

- Medical supplies and PPE:
  - Procurement and replenishment of essential medical items used during the response,
  - Provision of PPE to ensure safe working conditions for frontline teams.

- Support to MoH vaccination campaigns:
  - Assistance to mass vaccination activities targeting remote and mobile populations,
  - Community mobilisation to increase coverage among schoolchildren, displaced families, and nomadic groups.

- Community health awareness:
  - Organisation of community health awareness sessions through local committees and volunteers,

Focus on prevention, early symptom recognition, and protective health behaviors.

- Strengthening NS responder capacity:
  - Reinforcement of skills in Risk Communication and Community Engagement (RCCE),
  - Enhancement of Community-Based Health (CBH) approaches,
  - Improved coordination with the Ministry of Health and health stakeholders for epidemic preparedness.
- Under this DREF operation, the following WASH activities were prioritized:
  - Replenishment of hygiene kits:
  - Replacement of the 1,000 hygiene kits initially distributed to ensure continuous access to essential hygiene items,
  - Supporting improved hygiene practices and helping prevent disease transmission, particularly diphtheria.
  - Replenishment of drinking water supplies:
  - Replenishment of the 4,000 packs of safe drinking water distributed to affected families,

- Ensuring access to clean and safe water for populations living in temporary or informal settlements.
- Community awareness campaigns:
  - Organisation of awareness sessions on protective hygiene practices,
  - Focus on malaria prevention, diphtheria transmission, and safe water handling.

- Volunteer engagement:
  - Mobilisation of volunteers with per diems to conduct hygiene-promotion activities,
  - Support to awareness campaigns and other community-based interventions.

- Procurement of mosquito nets:
  - Acquisition of 1,200 mosquito nets for distribution to vulnerable households,
  - Reducing exposure to mosquito bites and limiting malaria transmission.

- Environmental sanitation and vector control:
  - Procurement of cleaning materials to support community-led efforts to remove stagnant water,
  - Conducting clean-up and drainage campaigns in coordination with local authorities.

Targeting Strategy

Explain the selection criteria for the targeted population

The operation targeted groups identified as most at risk due to their exposure, mobility, and limited access to essential services. Priority was given to:
• People crossing into Algeria through southern borders, who face significant barriers to healthcare and are more vulnerable to infectious diseases.
• Host communities in affected areas, whose local systems were under pressure due to the influx of displaced populations.
• Border regions such as In Guezzam, Bordj Badji Mokhtar, and Tinzaouatine, where the outbreaks were most concentrated and where rapid intervention was required.
• Vulnerable individuals, including children, pregnant women, the elderly, and people with pre-existing health conditions, due to their higher risk of severe illness.

Total Assisted Population

Assisted Women	**3,500**	Rural	**90%**
Assisted Girls (under 18)	**-**	Urban	**10%**
Assisted Men	**2,500**	People with disabilities (estimated)	**2%**
Assisted Boys (under 18)	**-**		
Total Assisted Population	**6,000**		
Total Targeted Population	6,000		

Risk and Security Considerations (including "management")

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

Risk	Mitigation action
Risk of Contamination Among Volunteers and Deployed Health Personnel: Close contact with patients suffering from diphtheria, or presence in low hygiene environment exposes volunteers and health personnel to a high risk of infection.	Provide appropriate personal protective equipment (PPE), train personnel on infection prevention practices, and establish strict safety protocols to minimize the risk of transmission.
Safety of Personnel in High-Risk Border Areas: Teams operating in border regions may face challenges due to the instability of the area and difficulties in accessing certain locations.	Implement enhanced safety measures for personnel, work closely with local authorities for continuous risk assessment, and proactively adjust routes and work schedules to ensure a secure working environment for all deployed teams on the ground.
Logistical risks and funding shortage: The remote locations of affected populations and the extent of the territory to cover, create logistical challenges in delivering healthcare services and humanitarian aid. Also there is a risk of funding shortages due to increased needs , stretching the capacity of the Algerian Red Crescent	- Coordination with Local Stakeholders To overcome logistical challenges, close coordination with local stakeholders, including regional health authorities, local NGOs -Resource Mobilization and Request for a DREF to address the risk of funding shortages - Prioritization of Activities Given the extent of the area and the logistical constraints, it will be crucial to prioritize activities based on the severity of needs, Priority will be given to the most vulnerable populations in remote and hard-to-reach areas.
Overwhelmed Health Systems, and risk of further transmission in isolated areas	Provide immediate support through mobile health units, ensure the replenishment of medical stocks, and coordinate with local health authorities to expand capacity
Has the child safeguarding risk analysis assessment been completed?	No

Implementation

Health

Budget: CHF 130,869
Targeted Persons: 6,000
Assisted Persons: 6,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
#of deployed Doctors	40	40
#of deployed nurses	20	20
#of volunteers deployed	-	40

Narrative description of achievements

The health component of the operation achieved its objectives by ensuring continuous medical coverage, strengthening diagnostic and treatment capacities, and supporting national immunisation and prevention efforts. Through the deployment of rotating mobile medical teams, the Algerian Red Crescent maintained a sustained presence in remote and high-risk locations, enabling early case detection, timely follow-up, and improved referral pathways for malaria and diphtheria.

Medical supplies and PPE were replenished to guarantee uninterrupted service delivery and maintain safe working conditions for frontline teams. In close coordination with the Ministry of Health, ARC teams contributed to vaccination efforts targeting remote and mobile populations, while volunteers played a central role in community outreach and awareness-raising activities.

Community health sessions conducted by local volunteers and committees helped to reinforce preventive behaviors and encourage early health-seeking practices among displaced families, migrants, nomads, and host communities. The operation also contributed to strengthening the National Society's internal capacity in epidemic response, improving preparedness for future public-health emergencies.

Lessons Learnt

• Rotating mobile teams demonstrated high impact, ensuring uninterrupted medical coverage where fixed services could not reach.

• Trust-building and community engagement emerged as key drivers for early reporting and cooperation during outreach.

• Strong alignment with Ministry of Health teams proved essential for targeted vaccination and harmonized response actions.

• Tailoring outbreak-response strategies to mobile and nomadic communities remains critical for future operations in southern border regions.

Challenges

• Reaching remote border areas proved demanding, with long distances and harsh terrain slowing medical deployment and limiting follow-up.

• Constant population movement created a shifting epidemiological landscape, complicating case tracing and isolation efforts.

• Local health structures, already fragile, struggled with limited staff and diagnostic capacity, increasing the operational burden on ARC teams.

• Environmental conditions—particularly widespread stagnant water—sustained favorable grounds for malaria transmission throughout the operation.

Water, Sanitation And Hygiene

Budget: CHF 41,345
Targeted Persons: 3,000
Assisted Persons: 3,000
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
#of hygiene kits replenished	1,000	1,000
#of water bottles distributed	24,000	24,000
#of mosquito nets distributed	1,200	1,200

Narrative description of achievements

The WASH component was implemented to improve hygiene conditions, ensure access to safe water, and reduce environmental risks that contribute to the spread of malaria and diphtheria, particularly among displaced, nomadic, and host communities in the affected border regions.

• Replenishment of 1,000 hygiene kits previously distributed, ensuring continuous access to essential hygiene items and supporting the prevention of diseases, particularly diphtheria.
• Distribution of 4,000 packs of safe drinking water to affected families, with each pack containing six bottles, to ensure reliable access to clean and safe water.
• Mobilisation of volunteers with per diems to support hygiene-promotion activities, community mobilisation, and awareness campaigns across remote and mobile communities.
• Distribution of 1,200 mosquito nets to vulnerable households as part of malaria-prevention efforts, especially in areas with high vector density.

Challenges

• Difficult access to remote desert areas limited ARC's ability to reach all households in a timely manner.
• High mobility of displaced and nomadic populations reduced the consistency of hygiene messaging.
• Limited local WASH infrastructure forced ARC teams to adapt distributions to very basic conditions.
• Environmental constraints (stagnant water, heat, dust) complicated vector-control and hygiene efforts.
• ARC branches in the south were overstretched, balancing multiple operational demands simultaneously.

Secretariat Services

Budget: CHF 14,740
Targeted Persons: 100
Assisted Persons: 100
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual
# of lessons learnt workshop conducted	1	1
#field visits	2	2

National Society Strengthening

Budget: CHF 27,741
Targeted Persons: 0
Assisted Persons: 0
Targeted Male: -
Targeted Female: -

Indicators

Title	Target	Actual

Narrative description of achievements

Covering operational costs including communications, admin and logistics expenses

Financial Report

Selected Parameters			
Reporting Timeframe	2024/10-2025/12	Operation	MDRDZ012
Budget Timeframe	2024/10-2025/12	Budget	APPROVED

DREF Operation

FINAL FINANCIAL REPORT

Prepared on 15/Apr/2026

All figures are in Swiss Francs (CHF)

MDRDZ012 - Algeria - Epidemic Malaria and Diphtheria

Operating Timeframe: 28 Oct 2024 to 30 Apr 2025

I. Summary

Opening Balance	**0**
Funds & Other Income	**214,695**
DREF Response Pillar	214,695
Expenditure	**-197,804**
Closing Balance	**16,891**

II. Expenditure by planned operations / enabling approaches

Description	Budget	Expenditure	Variance
PO01 - Shelter and Basic Household Items			**0**
PO02 - Livelihoods			**0**
PO03 - Multi-purpose Cash			**0**
PO04 - Health	122,883	122,839	**44**
PO05 - Water, Sanitation & Hygiene	38,822	38,402	**420**
PO06 - Protection, Gender and Inclusion			**0**
PO07 - Education			**0**
PO08 - Migration			**0**
PO09 - Risk Reduction, Climate Adaptation and Recovery	13,104	13	**13,091**
PO10 - Community Engagement and Accountability			**0**
PO11 - Environmental Sustainability			**0**
Planned Operations Total	**174,808**	**161,254**	**13,554**
EA01 - Coordination and Partnerships			**0**
EA02 - Secretariat Services	13,840	7,931	**5,909**
EA03 - National Society Strengthening	26,048	28,618	**-2,570**
Enabling Approaches Total	**39,888**	**36,550**	**3,338**
Grand Total	**214,696**	**197,804**	**16,892**

www.ifrc.org
Saving lives, changing minds

IFRC

[Click here for the complete financial report]

Contact Information

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

National Society contact: Laribi El Mansour, Program Coordinator, ARC, program.coordinator@cra.dz

IFRC Appeal Manager: Hosam Faysal, Head of HDCC-MENA, hosam.faysal@ifrc.org

IFRC Project Manager: Hosam Faysal, Acting Head of Delegation IFRC Algeria, hosam.faysal@ifrc.org

IFRC focal point for the emergency: Nader Bin Shamlan, Operations Coordinator-MENA, nader.binshamlan@ifrc.org

Media Contact: Mey Al Sayegh, Head of Communications MENA, mey.elsayegh@ifrc.org

Click here for reference