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World Health Organization
Eastern Mediterranean Region

The work of WHO in the Eastern Mediterranean Region

Annual report of the Regional Director

2025/2026



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The work of WHO in the Eastern Mediterranean Region. Annual report of the Regional Director, 2025/2026

Web ISBN: 978-92-9274-813-5
Print ISBN: 978-92-9274-812-8

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Suggested citation. The work of WHO in the Eastern Mediterranean Region: annual report of the Regional Director 2025/2026. Cairo: WHO Regional Office for the Eastern Mediterranean; 2026. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at https://iris.who.int/.

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This report describes the work of the World Health Organization (WHO) in the WHO Eastern Mediterranean Region from 1 July 2025 to 30 June 2026. The reporting period spans the transition from the Thirteenth General Programme of Work 2019–2025 (GPW 13) to the Fourteenth General Programme of Work 2025–2028 (GPW 14). During the first half of the reporting period, the WHO Regional Office for the Eastern Mediterranean continued to advance the Triple Billion targets of GPW 13 by promoting health and well-being, expanding universal health coverage and strengthening protection from health emergencies. The second half marked the start of implementation of GPW 14 and continued implementation of the Strategic Operational Plan for the Eastern Mediterranean Region 2025–2028, under which the Region has adopted six strategic priorities – promote, provide, protect, polio, power and perform – supported by the Regional Director's three flagship initiatives. The report is structured around these six regional priorities and highlights the progress made during this period of strategic transition towards improved health and well-being for all people in the Eastern Mediterranean Region.

ABBREVIATIONS

cVDPV	circulating vaccine-derived poliovirus
DHIS2	District Health Information Software 2
eIDEWS	electronic Integrated Disease Early Warning System
EWARS	Early Warning Alert and Response System
GCC	Gulf Cooperation Council
GLASS	Global Antimicrobial Resistance and Use Surveillance System
GPW 13	Thirteenth General Programme of Work, 2019–2025
GPW 14	Fourteenth General Programme of Work, 2025–2028
HIV	human immunodeficiency virus
HPV	human papillomavirus
ICD	International Classification of Diseases
IHR	International Health Regulations (2005)
mhGAP	Mental Health Gap Action Programme
TB	tuberculosis
WASH	water, sanitation and hygiene
WHO	World Health Organization
WPV	wild poliovirus

FOREWORD BY THE REGIONAL DIRECTOR



Dr Hanan Balkhy
WHO Regional Director
for the Eastern Mediterranean

1. The WHO Eastern Mediterranean Region is facing a particularly difficult moment for health. Conflict, population displacement and climate-related shocks continue to strain already fragile health systems across many countries and territories. As at June 2026, more than 117 million people in the Region require humanitarian assistance – representing almost half of global humanitarian needs – despite the Region accounting for only 9% of the world's population.

2. At the same time, attacks on health care remain alarmingly high, disrupting essential services and putting the lives of health workers and patients at grave risk. Between July 2025 and June 2026, the Region recorded 632 attacks on health care, resulting in 1531 deaths – 86% of all deaths linked to such attacks globally – and severely disrupting the delivery of health services.

3. These pressures are mounting as the global health environment becomes more constrained. Rising geopolitical tensions and sustained reductions in official development assistance for health are limiting resources just as needs are growing. Without sustained investment and cooperation, the progress achieved over recent decades risks being reversed.

4. This is the first annual report following WHO's Organization-wide reprioritization and the adoption of a reduced financial envelope. In response, the Organization must focus resources strategically and direct support to areas where its technical expertise, normative leadership and convening power can achieve the greatest impact.

5. The Eastern Mediterranean Region continues to face an unprecedented convergence of large-scale health emergencies. The experience of the past year – culminating in renewed regional escalation amid protracted crises in Afghanistan, the Gaza Strip, Somalia, Sudan and Yemen – demonstrates that these are not isolated events. The Region's emergency burden is persistent and interconnected, requiring equally integrated and sustained responses.

6. At the same time, experience shows that investments in preparedness deliver results when crises occur. Lebanon's mass casualty training, Sudan's cholera vaccination campaigns, Yemen's rapid response teams, and the activation of emergency coordination mechanisms during the 2026 regional escalation demonstrate what sustained investment, coordination and dedicated health workers can achieve. The Region also remains central to the final push to eradicate polio worldwide, as the world enters the last mile of this historic effort.

7. Yet without predictable and sustained financing, many of these gains remain fragile. Countries must continue strengthening national action plans for health security, expanding implementation of the International Health Regulations (2005) (IHR), and investing in workforce capacity, risk communication and interoperable surveillance systems.

8. Importantly, responding to emergencies must not overshadow the broader public health agenda. Continued progress under the Promote and Provide priorities remains essential – preventing disease, addressing major risk factors such as tobacco use and environmental threats, strengthening immunization and surveillance, and expanding access to good quality health care for all, including the most vulnerable. This will require sustained investment in the health workforce, which averages just 16.5 nurses and midwives per 10 000 population in the Region, compared with 39.4 globally.

9. Despite these challenges, the Region continued to deliver results. Countries advanced disease elimination, immunization, digital health, regulatory strengthening and access to essential services, while responding to multiple emergencies. Health ministries and frontline workers are strengthening public health systems and expanding essential services.

10. Looking ahead, the *Strategic operational plan for the Eastern Mediterranean Region 2025–2028* provides a clear framework for action, while the Regional Director's three flagship initiatives will accelerate progress on expanding equitable access to medical products, investing in a resilient health workforce and accelerating public health action on substance use. The Region is also working to drive system-level change while advancing universal health coverage and health security.

11. Over the 2024–2025 biennium, the Region mobilized US$ 1.6 billion in voluntary contributions, primarily for polio eradication and health emergencies, one of the highest levels among WHO regions. Nevertheless, a dual funding challenge remains: many technical areas essential for stronger health systems and high-burden disease prevention and control are underfunded, while growing humanitarian needs continue to outpace funding for health responses across the Region.

12. Closing these gaps will require sustained investment in both health security and health system strengthening to ensure that countries are better prepared for future crises while continuing to advance universal health coverage. This includes investing in the health workforce, strengthening the provision of primary health care, expanding equitable access to medical products, and building resilient public health institutions capable of meeting the Region's growing and increasingly complex health needs.

13. In a time of growing uncertainty for global health, continued partnership, commitment and investment will be essential to protect progress and build stronger, more resilient health systems for all people in the Eastern Mediterranean Region.


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INTRODUCTION

14. This report describes the work of WHO in the Eastern Mediterranean Region from 1 July 2025 to 30 June 2026. It should be read in conjunction with the Regional Director's verbal address at the 73rd session of the WHO Regional Committee for the Eastern Mediterranean (2026) and the accompanying documentation, including the progress reports on technical matters.

15. The reporting period covers the transition from the *Thirteenth General Programme of Work 2019–2025* (GPW 13) to the *Fourteenth General Programme of Work 2025–2028* (GPW 14), including the implementation of the *Strategic operational plan for the Eastern Mediterranean Region 2025–2028* (hereinafter "the Regional Strategic Operational Plan") and the Regional Director's three flagship initiatives, endorsed by the 71st session of the WHO Regional Committee for the Eastern Mediterranean in 2024. The first half of this period (July–December 2025) falls within the final year of GPW 13. During this time, the Regional Office continued to drive progress towards the Triple Billion targets of one billion more people enjoying better health and well-being, one billion more people benefiting from universal health coverage and one billion more people better protected from health emergencies. The second half (January–June 2026) marked the start of implementation of GPW 14, which builds on the achievements of GPW 13 while shifting from the Triple Billion framework towards broader population-level targets and a strategic focus on resilient, integrated health systems capable of delivering lasting impact, with recalibrated global targets set for 2028.

16. The report is structured around the six regional priorities of the Regional Strategic Operational Plan, namely: (i) promote health and prevent disease and associated risk factors; (ii) make good quality health care more accessible to all, especially the hard-to-reach and most vulnerable populations; (iii) expand country capacities to tackle the health demands of the climate crisis, epidemics and pandemics, conflicts, natural disasters and other emergencies; (iv) achieve and sustain polio eradication; (v) improve knowledge sharing and evidence-based policy-making and expand digital health to enhance public health; and (vi) optimize WHO's performance to boost cooperation and better influence global health. Progress across these priorities contributes directly to GPW 14's goals of improving health and well-being, expanding universal health coverage and strengthening protection from health emergencies.

17. The Region faces an emergency burden of unprecedented scale, structural complexity and human cost. Nine countries and territories in the Region are classified as fragile or conflict-affected. As at June 2026, WHO was responding to 14 graded emergencies, with more than 117 million people in need of humanitarian assistance – representing almost half of the global total – despite the Region accounting for only 9% of the world's population. A major regional escalation of conflict beginning in February 2026 added further acute dimensions to this burden, with cascading impacts across health systems, supply chains and the wider humanitarian response.

REGIONAL PRIORITY 1 (PROMOTE)

Promote health and prevent disease and associated risk factors



Reducing risk factors for noncommunicable and communicable diseases, violence and injury, and poor nutrition, and promoting mental health

Elimination of priority communicable diseases

18. The Eastern Mediterranean Region has continued to advance the elimination of priority communicable diseases despite varied capacities and burdens across countries. Sustained WHO support, strengthened surveillance and laboratory systems, and strong leadership by national programmes have consolidated progress across multiple elimination agendas. To accelerate action on eliminating communicable diseases, WHO has initiated a regional initiative to integrate interventions across programmes, harmonize service delivery and measure progress through routine monitoring. The approach prioritizes the elimination of 14 communicable diseases while enabling countries to further define priority diseases and elimination plans. A technical paper and resolution will be presented to Member States at the 73rd session of the WHO Regional Committee for the Eastern Mediterranean in 2026. At the 79th World Health Assembly in May 2026, the WHO Regional Office for the Eastern Mediterranean formally signed a new Memorandum of Understanding with the Global Institute for Disease Elimination (GLIDE) to foster technical collaboration and partnerships across the Region.

19. Key achievements during the reporting period included WHO validation of the elimination of trachoma as a public health problem in Egypt (November 2025), Libya (February 2026) and Tunisia (May 2026). Egypt has also sustained progress towards eliminating hepatitis C through strengthened surveillance and continued implementation of the "100 Million Seha" initiative. Endorsed by the Regional Validation Committee, Oman maintained its achievements in eliminating mother-to-child transmission of HIV and syphilis. Progress against vaccine-preventable diseases remains strong. Bahrain, Egypt, the Islamic Republic of Iran and Oman maintained their WHO-verified measles and rubella elimination status, while Kuwait and Qatar attained elimination status for the first time. Supplementary immunization activities provided 72 million measles vaccine doses, reaching 60 million children across seven countries and strengthening population immunity. Egypt became the first country in the Region to achieve hepatitis B control (in May 2025) and in November 2025, Morocco was officially validated by the Regional Validation Committee as having achieved hepatitis B control.

20. The Region continues to demonstrate strong tuberculosis (TB) control, maintaining the highest global treatment success rate for drug-susceptible TB (consistently exceeding 90%), as the incidence of drug-resistant TB declines. WHO missions to Egypt, Sudan and the Syrian Arab Republic strengthened case detection and management, while Pakistan's Multisectoral Accountability Framework accelerated progress towards the global End TB targets. Eleven countries have reduced TB incidence by more than 20% since 2015. Nevertheless, regional declines in TB incidence (5.9%) and mortality (3.8%) between 2015 and 2024 remain well below the end TB strategy milestones of 80% and 90%, respectively, by 2030.

21. In Yemen, WHO supported a strategic redesign of the national onchocerciasis elimination programme, shifting from static clinic-based delivery to community-led door-to-door mass drug administration. More than 419 volunteers administered over 1.2 million donated Mectizan tablets, achieving population coverage of 91% in Hajjah and Al-Mahweet and 86.5% in Taiz, well above the WHO-recommended threshold (80%). The campaign expanded access to previously unreached households and marked a major milestone towards elimination of onchocerciasis.

Antimicrobial resistance, infection prevention and control, and One Health

22. Antimicrobial resistance is an urgent global crisis and a major and growing public health threat in the Region. According to a comprehensive analysis of the burden of antimicrobial resistance in the Region from 1990 to 2021 by the EMR Antimicrobial Resistance Collaborators,

antimicrobial resistance is the direct cause of an estimated 92 800 deaths annually and is associated with a further 380 000 deaths. Data from the WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS) for 2023 (published in 2025) show that, in the Region, nearly one in three bacterial infections is resistant to antibiotics, among the highest rates globally. Such high levels of antimicrobial resistance increase the risk of treatment failure, health care costs and complications associated with routine medical procedures.

23. During the reporting period, countries continued to strengthen antimicrobial resistance surveillance, governance, infection prevention and control, and One Health approaches. In 2026, all countries in the Region responded to the annual Tracking Antimicrobial Resistance (AMR) Country Self-Assessment Survey (TrACSS), according to which 21 countries had national antimicrobial resistance action plans, 19 had multisectoral governance structures and four were updating their plans as at August 2026. Sixteen countries regulated antibiotic prescription and sale, while 11 incorporated the Access, Watch, Reserve (AWaRe) antibiotic classification into essential medicines lists. A total of 20 countries submitted resistance data to GLASS in the most recent cycle – the highest regional participation globally – and 13 reported antimicrobial use data.

24. Pakistan became the first country in the Region to develop a national bacterial and fungal priority pathogens list using WHO methodology. The Islamic Republic of Iran completed the second round of tricycle surveillance of extended-spectrum beta-lactamase-producing *Escherichia coli*. Bahrain strengthened surveillance and stewardship of antimicrobial resistance, convening a high-level roundtable with the WHO Collaborating Centre for Health Professionals' Educational Development at the Arabian Gulf University to align workforce education and strengthen coordinated national action. Qatar expanded its GLASS antimicrobial use surveillance network to include additional private-sector facilities and community pharmacies, while Qatar and Kuwait convened national workshops on antimicrobial use surveillance, and several countries organized a multisectoral World Antimicrobial Awareness Week campaign promoting a One Health approach to containing antimicrobial resistance. WHO conducted the first regional training-of-trainers course for action plan prioritization and costing in July 2026.

25. Infection prevention and control capacity also improved. Eighteen countries had established national infection prevention and control programmes as at June 2026. Countries of the Gulf Cooperation Council (GCC) achieved 90% infection prevention and control capacity, and Egypt reached 80%, although surveillance of health care-associated infections and safe facility environments require further investment. Qatar demonstrated regional leadership by implementing national and regional awareness campaigns and conducting large-scale training initiatives reaching thousands of health workers. Following the conflict-related disruption of disease surveillance in the Gaza Strip, WHO and the Ministry of Health rapidly established the Early Warning, Alert and Response System (EWARS) to monitor communicable diseases and detect outbreaks.

26. One Health coordination advanced across the Region. Djibouti, Egypt, Iraq, Jordan, Libya, Oman, Pakistan, Tunisia, the United Arab Emirates and Yemen strengthened multisectoral governance, surveillance and coordination mechanisms, while Pakistan established five provincial One Health hubs through Pandemic Fund support. The Quadripartite[1] partners endorsed a regional One Health workplan and strengthened formal coordination mechanisms.

27. Despite these gains, significant gaps remain. Only three countries (Bahrain, Qatar and Saudi Arabia) fully implemented and financed national antimicrobial resistance action plans. Just five have implemented antimicrobial stewardship programmes across most facilities, six have dedicated infection prevention and control budgets,

[1] The Quadripartite comprises the Food and Agriculture Organization of the United Nations (FAO), the United Nations Environment Programme (UNEP), WHO and the World Organisation for Animal Health (WOAH). These partners collaborate to advance the One Health approach through coordinated action across human, animal, plant and environmental health.

seven have their antimicrobial resistance planning integrated with a national One Health strategy or coordination mechanism, and only 12 have functional water, sanitation and hygiene (WASH) services in all health care facilities. Sustained progress will require greater domestic financing, stronger One Health governance and accelerated implementation of costed national action plans.

28. A Regional Committee resolution on strengthening national laboratory biosafety and biosecurity policies and frameworks in the Region (EM/RC72/R.5), adopted in 2025, called for stronger governance and regulatory mechanisms for laboratory biosafety and biosecurity, including through comprehensive national policies and frameworks aligned with international standards. Laboratory capacity and diagnostic readiness also expanded significantly. Adoption of the regional rubella elimination goal through resolution EM/RC72/R.2 (2025) was supported by the expansion of molecular diagnostic capacity for measles and rubella in 15 countries. In Djibouti, integrated laboratory assessments informed a roadmap to restore and optimize diagnostic services for TB. Jordan published a National One Health Laboratory Strategic Plan (2026–2030) and accompanying Laboratory Quality Management System Guidance in 2025, while advancing a national genomic surveillance strategy for emerging diseases and antimicrobial resistance to complement the national antimicrobial resistance plan.

29. Strengthening data systems has also improved prevention and early detection. Adoption of District Health Information Software 2 (DHIS2) case-based tracking by national TB and HIV programmes enhanced real-time surveillance and decision-making, while laboratory information management systems improved reporting and data management. WHO also expanded training in GLASS and in WHONET – a systems and software application for managing and analysing microbiology laboratory data – to strengthen antimicrobial resistance surveillance. Immunization surveillance and data management capacities were strengthened across all 22 countries and territories in the Region.

30. These investments are improving understanding of the disease burden and enabling more targeted prevention strategies. Countries used district-level data to tailor malaria interventions in Somalia, Sudan and Yemen, while regional monitoring of antimalarial drug resistance informed Sudan's decision to update diagnostics in 2026. Through the Horn of Africa Network for Monitoring Antimalarial Treatment (HANMAT), WHO supported subregional surveillance of antimalarial treatment efficacy and emerging resistance patterns, strengthening evidence-based malaria control and elimination efforts.

Noncommunicable diseases

31. Noncommunicable diseases remain the leading cause of mortality in the Eastern Mediterranean Region, accounting for about two thirds of all deaths – more than 2.8 million annually. Cardiovascular diseases, cancers, diabetes and chronic respiratory diseases dominate, driven by tobacco use, unhealthy diets and physical inactivity. An estimated 56% of deaths occur prematurely before the age of 70, imposing substantial economic and social costs. Diabetes affected more than 74 million people in 2023, with costs projected to rise from 639 billion international dollars to 1.5 trillion international dollars by 2050. Nearly half of people with hypertension remain unaware of their condition. Cancer incidence is projected to double by 2045, highlighting the urgent need to strengthen prevention, early detection and treatment services.

32. Despite progress in strengthening monitoring systems and policy frameworks for noncommunicable diseases, major challenges remain in closing gaps across the continuum of prevention, diagnosis, treatment and control, and in improving data governance and equitable access to services. In response, countries continued to strengthen prevention, surveillance and service delivery through primary health care, advancing monitoring systems, cancer control, risk factor surveillance and more integrated models of care.

33. Recognizing the Region's humanitarian context, the Regional Office has integrated the WHO Package of Essential Noncommunicable

Disease Interventions (PEN) and HEARTS[2] technical package within its broader regional framework for action on addressing noncommunicable diseases in emergencies (2024), supporting countries to maintain continuity of care for cardiovascular diseases, diabetes and other noncommunicable diseases during crises. In countries such as Lebanon, Somalia, Sudan and the Syrian Arab Republic, efforts have focused on strengthening primary health care services, ensuring the availability of essential medicines and diagnostics, building the capacity of frontline health workers and adapting clinical protocols for use in emergency contexts. The Region is also promoting innovative service delivery models, deployment of noncommunicable disease emergency kits, strengthened referral pathways, and integration of noncommunicable disease indicators within emergency preparedness and response mechanisms.

34. Strengthened facility-based monitoring systems are improving the availability and use of data. WHO is supporting regional efforts to strengthen surveillance of hypertension and diabetes at the primary health care level. A regional workshop held in early 2026 focused on developing standardized dashboards for real-time monitoring of hypertension and diabetes indicators, enabling countries to better track performance across the continuum of care and identify bottlenecks. Djibouti and Egypt, for example, have made progress in developing facility-based monitoring systems for noncommunicable diseases in primary health care facilities.

35. The Region has made substantial progress in advancing the three global cancer initiatives: the Global Initiative for Childhood Cancer (GICC), the Cervical Cancer Elimination Initiative (CCEI) and the Global Breast Cancer Initiative (GBCI). Building on WHO guidance, the Regional Office has adapted these initiatives to regional needs through the development of tailored strategies, technical guidance, capacity-building activities and direct country support. WHO is supporting countries to introduce human papillomavirus (HPV) vaccination, strengthen screening programmes, and expand access to treatment and palliative care. In 2025, 10 countries have introduced the HPV vaccine, many of them using school health platforms. Nine countries have established screening programmes. In collaboration with St. Jude Children's Research Hospital, the Region is advancing implementation of the GICC and supporting countries to improve early diagnosis, referral pathways and treatment outcomes. Two countries (Jordan and Pakistan) are strengthening access to essential childhood cancer medicines through stronger supply chains and medicine availability. WHO is working with Member States to strengthen early detection, reduce diagnostic delays and improve access to high-quality treatment for breast cancer, with the goal of reducing breast cancer mortality by 2.5% annually. Five countries across the Region have made significant efforts to strengthen engagement with people living with cancer, ensuring the inclusion of patient voices in decisions affecting their own health.

36. WHO renewed its joint action plan with the International Agency for Research on Cancer (IARC), launching the sixth phase of collaboration to strengthen cancer surveillance in the Region. WHO has also supported the development and strengthening of national cancer control plans, improved the early detection of childhood cancers, and facilitated the greater inclusion of people with lived experience of cancer in policy processes. Afghanistan is being supported to establish a hospital-based cancer registration system. Egypt completed a national evaluation of its cancer registration system. In Palestine, WHO supported the development and endorsement of a cancer control strategy, strengthened cancer governance through a dedicated Ministry of Health focal point, and mapped mammography services in the Gaza Strip to assess breast cancer screening capacity. The People Living with Cancer initiative was piloted in Egypt, Jordan, Morocco, Qatar and the Syrian Arab Republic to strengthen patient-centred

[2] PEN and HEARTS are WHO technical initiatives designed to strengthen the prevention, diagnosis and management of noncommunicable diseases, especially cardiovascular diseases and diabetes, in primary health care, particularly in low-resource settings. PEN is a prioritized set of cost-effective, evidence-based interventions. HEARTS is a six-module technical package with an implementation guide.

support, alongside expanded awareness and advocacy on cancer prevention and screening for the countries' diverse workforces.

37. Surveillance of noncommunicable disease risk factors continued to advance, with countries progressing at different stages of implementation of the WHO STEPwise approach to noncommunicable disease risk factor surveillance (STEPS).[3] Egypt completed field data collection for the fourth round of its national STEPS survey in 2026. Iraq released its 2025 Global School Health Survey results in April 2026, with WHO supporting the Ministry of Health to implement the survey and translate its findings into policy briefs on adolescent health and well-being. Jordan, Lebanon, Oman and Qatar released STEPS survey findings in 2025 and early 2026 and are using them to inform national policy and planning, while Kuwait and Tunisia are advancing survey implementation. New survey modules on hearing and vision have been introduced, alongside continued prioritization of mental health.

38. WHO is advancing therapeutic patient education as a key pillar of person-centred diabetes care, enabling people living with diabetes to effectively self-manage their condition. The Regional Office has developed a comprehensive, competency-based curriculum on therapeutic patient education for health-care professionals and supported digitalization, translation and pilot testing in selected countries, including Lebanon and Jordan. This work represents a major regional investment in empowering people living with diabetes, strengthening provider capacity and integrating self-management support within routine diabetes services across the Region.

39. Countries across the Region are advancing multisectoral approaches to reduce risk factors for and strengthen prevention of noncommunicable diseases. Jordan has expanded smoking cessation services from five clinics in 2019 to 29 nationwide by 2025 through policy reform and integration into primary care. In Egypt, implementation of the WHO Verification System for Trans Fat Elimination is supporting compliance with trans-fat regulations and sustaining progress towards elimination, while expanded national screening and cancer control programmes are improving early detection and referral pathways at scale. In Kuwait, WHO supported the development of a national coordination mechanism to prevent obesity, establish obesity reduction targets for 2030, implement regulatory measures including restrictions on energy drink sales to minors, and strengthen school nutrition standards and action on trans fats. In Libya, WHO supported the development and launch of the national multisectoral strategy for noncommunicable diseases 2025–2030, alongside new hypertension guidelines, and the finalization of national diabetes management guidelines, strengthening the policy and service-delivery foundations for their prevention and control. In Qatar, childhood obesity remains a national priority, with the Shura Council endorsing recommendations in 2026 to strengthen food labelling, public awareness and healthy school food environments.

Nutrition and the double burden of malnutrition

40. The Region faces a double burden of malnutrition: undernutrition in fragile and conflict-affected settings, and rising obesity elsewhere. Malnutrition in all its forms remains a defining public health challenge across the Region.

41. Implementation of the regional strategy on nutrition 2020–2030 (2019) is helping countries address the full spectrum of nutrition challenges through stronger governance, healthier food environments and more integrated service delivery. Increasingly, nutrition interventions are being embedded within primary health care, public health programmes and humanitarian response platforms, helping countries address both undernutrition and diet-related diseases. All countries now include promotion of healthy diets or obesity prevention in national policies or strategies.

42. Iraq endorsed a multisectoral national nutrition strategy in mid-2025, bringing together the Ministry of Health and five other ministries to strengthen coordinated action on nutrition. WHO

[3] STEPS is a simple, standardized method used to collect, analyse and disseminate data on key risk factors for noncommunicable diseases.

validated Oman, Saudi Arabia and the United Arab Emirates as having eliminated industrially produced *trans*-fatty acids from domestically manufactured foods; six additional countries have adopted best-practice policies and are advancing towards full elimination. In parallel, 11 countries have introduced taxes on sugar-sweetened beverages, with tax rates reaching 50% in some cases.

43. Undernutrition remains a critical and deadly dimension of the Region's malnutrition burden. According to the UNICEF–WHO–World Bank Joint Child Malnutrition Estimates (2025), stunting affects an estimated 26% of children aged under 5 years in the Region, with rates exceeding 40% in Afghanistan and Yemen. Wasting affects approximately 6.3% of this age group, with severe acute malnutrition – a direct cause of child mortality – recorded at crisis levels in the Gaza Strip, Sudan and Yemen. An estimated 80% of children with severe acute malnutrition in the Region do not receive treatment, reflecting persistent gaps in service coverage, supply chains and financing.

44. WHO is supporting countries to expand integrated approaches to managing acute malnutrition through community-based management, including inpatient care for severe acute malnutrition with medical complications, strengthen supply chains for essential medical supplies and ready-to-use therapeutic foods, and integrate nutrition into primary health care and emergency responses.

45. In Pakistan, WHO has supported the establishment of 24 new nutrition stabilization centres since 1 July 2025, bringing the total number supported to 169 centres nationwide. With more than 700 trained staff, these centres provide lifesaving treatment for up to 65 000 children annually and nutrition counselling for over 100 000 mothers and caregivers each year.

46. In Palestine, WHO supported the expansion of nutrition services amid a rapidly deteriorating food security situation. By the end of 2025, approximately 55 000 children had been screened for malnutrition, treatment services for severe acute malnutrition had been established and expanded, and inpatient care had been sustained through eight stabilization centres in the Gaza Strip, seven of which remained operational. WHO-supported services treated more than 4300 cases of acute malnutrition, referred more than 1000 severe cases for inpatient care and provided micronutrient support to more than 95 000 people. Although no areas in the Gaza Strip were classified as Integrated Food Security Phase Classification (IPC) Phase 5 (famine) following the ceasefire, approximately 1.6 million people are projected to remain acutely food insecure into 2026.

47. In Sudan, WHO supported 156 stabilization centres and severe acute malnutrition treatment services, contributing to the treatment of 42 625 children with severe acute malnutrition and medical complications while maintaining recovery rates above international standards despite ongoing conflict and access constraints. During the reporting period, WHO continued to strengthen nutrition services by supporting nutrition surveillance, providing essential supplies for nutrition stabilization centres, establishing dedicated breastfeeding corners and building the capacity of frontline health workers.

48. In Yemen, WHO expanded nutrition surveillance to 324 routine and 101 integrated sentinel sites, supported by harmonized tools and digital reporting systems, with reporting completeness exceeding 90%. Integrated outreach initiatives restored services in hard-to-reach areas, delivering more than 969 000 nutrition services. Between July 2025 and April 2026, a total of 20 970 children aged under 5 years were admitted and received lifesaving health and nutrition services in 96 therapeutic feeding centres. Despite funding constraints that reduced the number of such operational centres to 53 in 2026, service quality continued to improve, as reflected in key performance indicators: a 97% recovery/cure rate and a 1% death rate.

Tobacco control

49. Tobacco use remains a leading preventable cause of death and disease in the Region, responsible for an estimated almost half a million deaths in 2023. Adult prevalence is approximately 18%, with rates among males exceeding 47% in

some countries. The Region records the world's highest rates of waterpipe (shisha) use. Despite stronger governance and control measures, the Region remains off track to achieve the global target of a 30% relative reduction in tobacco use by 2030. Monitoring capacity remains a major gap, while the emergence of new tobacco and nicotine products presents an additional and growing regulatory challenge.

50. Tobacco control efforts are increasingly shifting from policy development towards implementation and enforcement. Countries are strengthening legislation, taxation, packaging requirements, cessation services and regulation of emerging nicotine products, while accelerating implementation of the WHO Framework Convention on Tobacco Control and MPOWER[4] measures. At its 70th session in October 2023, the WHO Regional Committee for the Eastern Mediterranean endorsed the extension of the implementation period of the regional strategy and action plan for tobacco control to 2030 through resolution EM/RC70/R.1, reaffirming the Region's commitment to its implementation.

51. Progress has been most evident in strengthened policy frameworks, enforcement and implementation. Twelve countries in the Region now implement health warnings on tobacco packaging at the highest level of achievement, including large graphic warnings or plain packaging. Saudi Arabia advanced plain packaging and graphic health warnings, while Pakistan strengthened legislation through tighter restrictions on tobacco advertising, promotion and sponsorship and expanded warning labels. In the Islamic Republic of Iran, sustained regulatory action and WHO support strengthened implementation of the WHO Framework Convention on Tobacco Control, including measures on legislation, surveillance, illicit trade, tobacco industry interference and plain packaging. Morocco significantly increased tobacco taxation through higher excise duties and successive price increases. Across northern Africa, countries strengthened packaging and labelling requirements and expanded bans on tobacco advertising, promotion and sponsorship. Jordan and Lebanon advanced smoke-free policies and public awareness measures while the Syrian Arab Republic maintained core tobacco control measures in a complex operating environment. In Somalia, progress focused on advancing tobacco control legislation. In other fragile and conflict-affected settings, efforts centred on sustaining core tobacco control measures and integrating cessation support into primary health care where feasible.

52. At the community level, WHO supported initiatives such as Tobacco-Free Sports and Health Villages across multiple countries, combining smoke-free policies, cessation support and targeted awareness activities. At the same time, countries across the Region are strengthening regulation of electronic nicotine delivery systems and other novel nicotine products, particularly to reduce uptake among young people.

Mental health

53. Mental health needs in the Eastern Mediterranean Region are among the highest globally, driven by protracted conflict, displacement and repeated crises. The prevalence of mental disorders is estimated at 15.7%, almost wholly accounted for by prevailing emergencies in the Region. Despite these challenges, the latest (2024) estimates show that suicide rates have declined by 17% since 2019 in the Region, reflecting growing efforts to expand access to care and strengthen mental health services. However, access to care remains extremely limited. Treatment gaps reach up to 90% in some countries, and the workforce averages just 4.7 mental health workers per 100 000 population – compared with 15.4 globally. Substantial disparities exist in human resources for mental health care by emergency status, with a median of 2.6 mental health workers per 100 000 population compared with 12.8 per 100 000 population in non-emergency countries. Services are often concentrated in urban tertiary

[4] MPOWER is a set of six evidence-based, cost-effective measures introduced by WHO in 2008 to help countries implement the WHO Framework Convention on Tobacco Control and reduce tobacco demand. The MPOWER measures are to Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion and sponsorship; and Raise taxes on tobacco products.

settings, while stigma, underinvestment and weak integration into health systems leave most people without support.

54. Nonetheless, mental health is becoming more firmly integrated within national health systems across the Region. Progress during the reporting period focused on expanding community-based services, strengthening integration within primary health care, and embedding mental health and psychosocial support within emergency preparedness and response systems.

55. WHO supported 14 countries to scale up community-based mental health services through the Mental Health Gap Action Programme (mhGAP).[5] Integration into primary care has advanced, with the share of countries meeting four of five integration criteria rising from 25% in 2020 to 38% in 2025, and 95% of countries reporting that they had trained primary health care workers in mental health management. These efforts have helped expand access to mental health services and strengthen mental health care at the community level.

56. In Bahrain, mhGAP training for family physicians expanded frontline capacity to identify and manage priority mental health conditions. In Iraq, WHO supported the Ministry of Health in developing the national mental health and substance use strategy (2025–2030). In Jordan, the Region's first mental health investment case was completed, strengthening the evidence base for policy and financing decisions. WHO also supported the integration of mental health into primary care by training nearly 300 family physicians under mhGAP and introducing a national screening tool for children and adolescents to improve early detection and referral. In Qatar, an updated mental health action plan (2026–2030) was finalized, a national committee was established to support implementation of the Mental Health Law (2016), and work commenced on a patients' rights charter, alongside continued global advocacy on autism.

57. Member States adopted the Regional action plan for mental health and psychosocial support in emergencies 2024–2030 at the 71st session of the WHO Regional Committee for the Eastern Mediterranean in 2024. By 2025, more than three quarters of countries in the Region had mental health and psychosocial support components integrated within their emergency preparedness and response plans and/or disaster risk management plans (up from 52% in 2020), and 81% delivered such support during emergencies (compared with 45% globally). Among these countries, 76% had multisectoral coordination platforms, and mental health specialists supported training and supervision of primary care staff in all emergency-affected countries and 85% of other countries. WHO strengthened capacities for mental health and psychosocial support across multiple crisis settings. However, only 56% of countries reported dedicated financing (compared with 69% globally), and just 44% documented progress or impact – showing that system development still outpaces funding and evaluation.

58. In the Islamic Republic of Iran, WHO supported the Ministry of Health and Medical Education in establishing a technical working group on mental health in emergencies and strengthening health workforce capacity through training on mental health and psychosocial support in emergency settings. In Lebanon, WHO supported the integration of mental health and psychosocial support into emergency preparedness and response systems, strengthened workforce capacity in psychological first aid and crisis management, and reinforced coordination and service delivery mechanisms to maintain access to mental health care during emergencies. In Libya, WHO supported the launch of the national mental health strategy, strengthened primary health care workforce capacity through mhGAP and psychosocial support training, and expanded access to specialized mental health services for Sudanese refugees and other vulnerable populations. In Palestine, WHO co-led coordination for mental health and psychosocial support, convened more than 24 partner meetings, trained over 350 school counsellors and over 700 humanitarian workers in emergency mental health interventions, strengthened community mental health services, and procured 23 essential

[5] mhGAP was launched by WHO in 2008 to address the significant gap between the high prevalence of mental, neurological and substance use disorders and the limited resources available to treat them.

psychotropic medicines for the Ministry of Health and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). Rehabilitation of Bethlehem Psychiatric Hospital and support to school-based mental health programmes further strengthened service capacity and emergency preparedness. In Somalia, WHO integrated trauma-informed care and psychological first aid into emergency care and malnutrition management training, with implementation scaled up through WHO co-led multisectoral coordination. In Sudan, WHO integrated mental health and psychosocial support into primary health care and emergency services, including through mobile clinics serving displaced populations. In 2025, Qatar hosted the Ministerial Summit on Mental Health, bringing together Member States and global experts.

Regional flagship initiative: accelerating public health action on substance use

59. Substance use is an insidious public health challenge across the Region, shaped by conflict, displacement, rapid social change and expanding illicit markets. An estimated 6.7% of the population uses drugs, with opioid use disorder accounting for around half of drug use and nearly 80% of disability-adjusted life years attributable to substance use disorders. The Region accounts for approximately 17% of global opioid deaths despite representing only 9% of the world's population, reflecting both the high burden of opioid use disorder and the near-total absence of opioid agonist therapy in many countries, as detailed in the World drug report 2025. Despite the scale of the problem, treatment coverage remains low: only one in 13 people with substance use disorders in the Region received treatment in 2022, reflecting gaps in services, persistent stigma and weak surveillance systems.

60. Countries are increasingly recognizing substance use as a public health challenge requiring coordinated action across prevention, treatment, harm reduction and recovery services. In 2024, the 71st session of the WHO Regional Committee for the Eastern Mediterranean endorsed a regional flagship initiative on accelerating public health action on substance use, promoting a balanced, public health-oriented approach. Regional collaboration was further strengthened through the development of a joint action plan on substance use for the Regional Health Alliance.

61. At the country level, progress continued in strengthening substance use prevention and treatment. In Iraq, mental health and substance use services were further integrated into primary health care through endorsement of a unified national protocol for substance use disorders. WHO also supported the preparation of national media and community guidelines to reduce stigma and strengthen prevention and awareness, and supported the launch of a drug situational analysis report in 2025[6] to inform policy and planning. In Kuwait, a WHO scoping mission assessed the public health response to substance use, informing a joint United Nations proposal with the United Nations Office on Drugs and Crime (UNODC) funded by the Government of Kuwait. In Egypt, WHO supported a national multi-stakeholder dialogue to review substance use policies and legislation, alongside expanded treatment and recovery services. In Lebanon, a similar dialogue, convened with the national mental health programme, informed an update of the national substance use strategy and legislative reform. In the Syrian Arab Republic, a policy dialogue complemented WHO support for a multisectoral strategic plan for substance use prevention and treatment, and WHO supported a similar plan in Somalia. Treatment and recovery services also expanded in Afghanistan and in Pakistan, where a national policy dialogue is planned for November 2026.

Injuries, violence and road safety

62. Injuries and violence represent a major and growing public health burden in the Region, accounting for more than 433 000 deaths annually and disproportionately affecting young people and vulnerable populations. Road traffic injuries alone account for nearly one third of injury-related deaths, with the Region recording the second highest mortality rates globally – 19.6 deaths per

[6] Prepared in collaboration with the United Nations Office on Drugs and Crime (UNODC).

100 000 population – which is significantly above the global average of 15.3, as detailed in the WHO Global status report on road safety 2023. Drowning remains a leading cause of death among children, while violence against women and children remains a major public health and social concern, with impacts exacerbated in fragile and conflict-affected settings. WHO has strengthened regional and national capacity to prevent injuries and violence through policy support, data systems and multisectoral coordination.

63. During the reporting period, 18 countries used a regional monitoring tool to track implementation of road safety interventions. Developed following the publication of the Global status report on road safety 2023, the tool has since been consistently applied across the Region. Targeted initiatives, including a United Nations Road Safety Fund-supported programme on two-wheeler safety, are advancing legislative and enforcement frameworks in high-burden countries. In Qatar, a comprehensive road safety action plan was developed in late 2025, grounded in data-driven analysis, evidence-based interventions and multisectoral engagement. In Tunisia, WHO supported implementation of the national multisectoral road safety strategy through strengthened governance and accountability mechanisms, including support to the National Road Safety Observatory. A pilot "Zone 30" initiative in Tunis is applying Safe System principles to protect vulnerable road users through speed management and safer urban design. Regional collaboration has also expanded through technical workshops, research and knowledge exchange to strengthen prevention strategies.

64. On violence prevention, WHO supported 11 countries and territories to strengthen health system responses to violence against women and children through policy development, capacity-building and service integration. More than 1500 health workers were trained to deliver survivor-centred care, and national facilitator guidance on violence against children was developed in November 2025, strengthening the role of the health sector in prevention, early identification and response.

65. At the regional level, WHO issued new prevalence estimates on violence against women in April 2026, showing that 27.2% of women in the Eastern Mediterranean Region have experienced physical and/or sexual violence by an intimate partner in their lifetime, equivalent to approximately 90 million women and representing the third highest prevalence globally. WHO also supported country contributions to the second global status report on preventing violence against children – due to be launched during the Second Global Ministerial Conference on Ending Violence Against Children (Manila, the Philippines, 18–19 November 2026) – and began implementation in 2025 of a regional strategic workplan on preventing violence against women (2025–2030), including a monitoring, evaluation, accountability and learning framework.

66. At country level, WHO supported Iraq to revise national referral pathways, standard operating procedures and clinical guidelines for violence against women response, alongside dissemination of an updated national strategy to combat violence against women and girls 2025–2030. In Afghanistan, WHO updated national treatment protocols for survivors of violence, trained more than 200 health workers, and supported the National Advanced Gender-based Violence Referral Centre to provide medical, psychosocial and counselling services to more than 5000 survivors. In Kuwait, WHO strengthened child protection through training for health and school health professionals, improved referral pathways and enhanced multisectoral accountability. In Libya, WHO supported national stakeholders to strengthen the prevention of violence against children, with particular emphasis on inclusive approaches and the protection of children with disabilities. In Sudan, WHO integrated violence against women services into primary health care and emergency response programmes, including through digital and telemedicine approaches that expanded access in conflict-affected and hard-to-reach areas. In Yemen, WHO supported endorsement of the national protocol on violence against women and the Ministry of Public Health and Population's code of conduct, trained more than 420 government, health sector and civil society personnel, and initiated high-quality assessments to strengthen

health facility readiness to respond to cases of violence against women.

67. Drowning remains a major yet preventable public health issue, causing an estimated 35 000 deaths in 2021, or around 12% of the global total. The Eastern Mediterranean Region has the world's second-highest drowning mortality rate (4.4 per 100 000 population) and the highest rate among children aged 0–4 years, with males and young people disproportionately affected.

68. WHO supported multisectoral drowning prevention through a biregional workshop convened by WHO's Eastern Mediterranean and African regional offices and involving 11 countries. The workshop facilitated the exchange of best practices, identified priorities for data systems and resource mobilization, and strengthened links with road safety and child health strategies. In Lebanon, WHO supported the Ministry of Public Health to launch the country's first national drowning prevention initiative, including a public awareness campaign, risk communication materials and a multisectoral consultation involving government agencies, civil defence, municipalities and development partners. These efforts helped elevate drowning prevention as a public health priority and laid the groundwork for strengthened surveillance, policy development and coordinated action. WHO also contributed to a technical workshop on submerged vehicles at the World Conference on Drowning Prevention in November 2025.

Empowering key population groups and expanding community engagement in health

69. Countries are increasingly adopting whole-of-government and whole-of-society approaches to health promotion, recognizing that health outcomes are shaped by social, environmental and behavioural determinants. Guided by Regional Committee resolution EM/RC69/R.4 (2022), WHO has supported implementation through a regional roadmap, Health in All Policies approaches, and strengthened mechanisms for governance, coordination and accountability.

70. Healthy settings – including healthy cities, healthy villages, age-friendly cities, health-promoting schools and healthy universities – are being promoted and expanded across the Region to establish platforms for multisectoral action and create environments conducive to healthy lifestyles and well-being. The Regional Healthy Cities Network expanded from 105 registered cities in 2022 to 186 as at June 2026. Concurrently, the number of countries adopting the Global Standards for Health-Promoting Schools increased from one country to eight countries. The Regional Healthy Universities Network more than doubled in size during the reporting period, with 23 registered universities as at June 2026, reflecting growing commitment to embedding health and well-being across communities and institutions.

71. Country implementation accelerated. In Saudi Arabia, the Healthy Cities programme expanded to 21 WHO-designated cities, while Bahrain designated all four governorates as Healthy Cities by 2025. In the United Arab Emirates, Sharjah emerged as a regional model combining Healthy Cities and Age-friendly Cities approaches and serving as a hub for regional knowledge exchange. In Qatar, all eight municipalities, together with Education City and Qatar University, were re-designated as Healthy Cities and Healthy Universities respectively in 2026, reflecting sustained commitment to the healthy settings approach. In Morocco, Casablanca joined the Global Partnership for Healthy Cities in early 2026, and Agadir showed interest in joining the Regional Healthy Cities Network.

72. Progress was also recorded in healthy university initiatives. Bahrain designated eight higher education institutions as WHO Health-Promoting Universities between 2023 and 2025, expanding from zero to eight over three years and marking a regional first. In 2026, Al-Alamein International University in Egypt and three universities in Oman also received Healthy University recognition. Implementation of the Integrated Care for Older People (ICOPE) approach expanded to eight countries, supported by the WHO Collaborating Centre for Ageing and Dementia at Hamad Medical Corporation in Qatar.

73. WHO also supported countries to apply behavioural and cultural insights, strengthen health literacy and institutionalize community engagement. Through implementation of a regional framework for community engagement, countries expanded mechanisms for participation, civil society engagement and community feedback. In Libya, Pakistan, Somalia and Sudan, these approaches supported risk communication, addressed misinformation and improved vaccine uptake during immunization campaigns. In the Islamic Republic of Iran, a primary health care-based approach to addressing social determinants of health reached more than 2 million people through standardized protocols, capacity-building and strengthened multisectoral coordination. In Kuwait, the nationwide *Dayem* positive parenting programme reached more than 400 families, strengthening community-level pathways for health promotion and protection.

Addressing the health risks and impacts of climate change

Climate change and environmental health

74. The Eastern Mediterranean Region remains one of the most climate-vulnerable regions globally, with rising temperatures, water scarcity, air pollution and extreme weather compounding conflict and displacement. In October 2025, through resolution EM/RC72/R.6, the WHO Regional Committee urged Member States to advance the finalization of the Operational action plan for climate change and health in the Eastern Mediterranean Region (2026–2030). The Region's first costed plan on climate and health focuses on surveillance, climate-resilient health systems, sustainable financing and a regional health security observatory.

75. Countries are increasingly moving from awareness of climate-related health risks towards practical adaptation and resilience-building measures. Progress during the reporting period focused on strengthening evidence, integrating climate considerations into health planning and preparedness, and expanding access to climate and health financing opportunities.

76. During 2025/2026, country-level evidence for climate adaptation was strengthened through health vulnerability and adaptation assessments finalized in Jordan, Iraq and Oman, building on earlier work in the Islamic Republic of Iran, Lebanon, Morocco, Saudi Arabia and Sudan. Fifteen countries remain engaged in the Alliance for Transformative Action on Climate and Health (ATACH). In Iraq, WHO supported a climate-related migration and health assessment; a knowledge, attitudes and practices survey in Basra; development of the Basra Climate and Health Adaptation Plan; and a competency-based Training of Trainers programme on migration and health. In Yemen, WHO supported the preparation and endorsement of a national climate change and health adaptation action plan, providing a framework to strengthen climate-resilient health systems and preparedness for climate-related health risks in one of the Region's most vulnerable settings.

77. Climate and health financing also advanced. WHO supported regional work on climate-resilient health systems in low-income countries. Afghanistan was supported to engage with the Global Fund and World Bank on climate-related health financing. A US$ 5 million Adaptation Fund concept note was developed with Libya, and consultations on the Fund for responding to Loss and Damage were initiated with Jordan, Iraq, Kuwait, Lebanon and Pakistan.

78. During the hostilities of early 2026, WHO activated rapid environmental health risk assessment capabilities across the Gulf, deploying satellite-based monitoring of water security, air quality, fire-signature tracking, and chemical, biological, radiological and nuclear risks. Assessments of environmental health risks related to Kharg Island and to petroleum-related releases resulting from strikes on the Tehran oil depot informed WHO-led situation reports and inter-agency coordination. WHO also supported the Iranian Ministry of Health and Medical Education in awareness-raising, risk communication and community engagement, and response efforts following the oil depot strikes in Tehran.

79. Environmental health systems continued to strengthen across the Region. More than 120 cities now report air quality data, while regional networks for chemical safety, poison centres and food safety supported preparedness and response. WHO also supported implementation of the WHO global strategy for food safety 2022–2030 through assessments of national food safety systems and surveillance.

Water, sanitation and hygiene

80. Progress on WASH, health care waste management and occupational health and safety focused on strengthening systems in health care facilities. Training in and implementation of the Water and Sanitation for Health Facility Improvement Tool (WASH FIT) expanded across several countries, including the Islamic Republic of Iran, Lebanon, Libya, Morocco and the Syrian Arab Republic, while 21 of 22 countries and territories contributed to global reporting on WASH in health care facilities, presented at a high-level meeting held during the United Nations General Assembly in September 2025. In fragile and conflict-affected settings, WHO supported continuity of essential health services through WASH interventions: in Yemen, this included provision of more than 60 million litres of safe water to health facilities, rehabilitation of WASH infrastructure in referral hospitals, and training of health and WASH personnel on WASH FIT, while in Libya WHO strengthened WASH services in Al-Kufra alongside emergency medical teams, and in Palestine WASH improvements supported infection prevention and control, and reduced communicable disease transmission.

Occupational health and safety

81. In occupational health and safety, WHO supported countries including Qatar, Saudi Arabia and the United Arab Emirates to strengthen programmes protecting health workers, alongside broader partnerships with the Food and Agriculture Organization of the United Nations (FAO), the International Federation of Red Cross and Red Crescent Societies (IFRC), UNICEF and national authorities to advance safer, more resilient and sustainable health systems across the Region.

Reducing health inequities by addressing social, economic, environmental and other determinants of health

82. Health outcomes across the Region continue to be shaped by conditions well beyond the health sector, and these conditions are not shared equally. Environmental risks alone account for an estimated 23% of the total disease burden in the Region, contributing to close to 1 million premature deaths a year – linked to air pollution, unsafe water and sanitation, toxic chemicals and unsafe food – and exposure is heavily skewed: nearly the entire regional population lives with unhealthy air quality, and more than 40% lack access to safely managed water and sanitation services, with the burden falling hardest on disadvantaged and marginalized communities. Conflict, displacement and constrained fiscal space widen these gaps further across the Region's fragile and crisis-affected settings.

83. WHO supported countries to translate this evidence into targeted district- and community-level action. Building on the recommendations of the Eastern Mediterranean Commission on Social Determinants of Health (2022), countries were supported to apply the Regional Social Determinants Toolkit for developing national and subnational strategies and plans for addressing the social determinants of health and equity. The toolkit is available on an electronic platform that takes users step by step through the development of strategic and action plans, translating the Commission's recommendations into action according to the national context and priorities, using whole-of-government and whole-of-society approaches and integrating Health in All Policies. This complements the Region's broader commitment to diagnosing and addressing the root causes of public health issues and the specific conditions that drive avoidable differences in health within and among countries.

REGIONAL PRIORITY 2 (PROVIDE)

Make good quality health care more accessible to all, especially the hard-to-reach and most vulnerable populations



Strengthening access to quality services for noncommunicable diseases, mental health and communicable diseases

Noncommunicable diseases and integrated service delivery

84. Countries are strengthening integrated service delivery through primary health care, with WHO support focused on standardizing care, improving early detection and aligning services with the objectives of universal health coverage. Partnerships such as Resolve to Save Lives have mobilized funding to implement hypertension and diabetes management systems using the WHO HEARTS technical package, with Egypt and Pakistan leading implementation. Fourteen countries now use evidence-based guidelines to manage noncommunicable diseases through the primary health care approach. This shift towards integrated care oriented around primary health care is translating into more coordinated and accessible services, reducing fragmentation and improving continuity of care.

85. In the Islamic Republic of Iran, standardized service packages reduced fragmentation and informed universal health coverage benefit design. Oman strengthened primary health care by ensuring sustained investment and improving early diagnosis, continuity of care and management of noncommunicable diseases. Jordan integrated noncommunicable disease and mental health services into primary health care, including expanded mhGAP implementation. Morocco, Pakistan, Somalia, Tunisia and Yemen expanded integrated services for noncommunicable diseases through primary health care and community platforms, while Djibouti strengthened workforce capacity and service delivery to improve noncommunicable disease care. In Palestine, WHO supported the Gaza Health Ministry to sustain essential noncommunicable disease services during the humanitarian emergency by ensuring the coordinated delivery of services, a minimum package of care, training for more than 400 health workers, and provision of essential medicines and supplies and specialist emergency medical teams.

TB and communicable disease services

86. TB service delivery is strengthening through more integrated models of care oriented around primary health care. Multisectoral accountability mechanisms are expanding, with the number of countries implementing these approaches expected to nearly double from 11 to 20 by 2028. Regional Green Light Committee missions in Egypt, the Syrian Arab Republic and Sudan have supported the transition to all-oral treatment regimens and improved the programmatic management of drug-resistant TB, bringing care closer to patients and reducing the treatment burden.

Immunization and zero-dose children

87. WHO is accelerating support to national immunization programmes to reverse declining routine immunization coverage and address widening equity gaps across the Region. In 2025 alone, an estimated 2.4 million children were zero-dose and 3.7 million had missed their first dose of measles-containing vaccine (MCV1). Even before hostilities intensified across the Middle East in 2026, coverage was slipping: the first dose of diphtheria–tetanus–pertussis-containing vaccine (DTP1) fell from 89% in 2019 to 88% in 2025, and MCV1 from 82% to 81%, well below the ≥ 95% coverage threshold required to sustain measles elimination. Between 2020 and 2025, a cumulative estimated 14.6 million children in the Region (12.8% of 114 million surviving infants) did not receive DTP1. In 2025 alone, there were an estimated 2.4 million zero-dose children, of whom about 94% resided in six countries: Yemen (29.2%), Afghanistan (20.2%), Pakistan (19.5%), Sudan (11.5%), Somalia (7.5%) and the Syrian Arab Republic (6.2%).

88. Supplementary immunization activities delivered 72 million measles-containing vaccine (MCV) doses, reaching 60 million children across

seven countries, while the Big Catch-Up initiative[7] reached 53% of zero-dose children with DTP1 and 67% with MCV1, administering around 9.9 million DTP-containing vaccine doses and 13.4 million MCV doses. In Afghanistan, an additional 695 dedicated vaccinators were deployed across all 34 provinces. Djibouti and the Syrian Arab Republic expanded their immunization coverage. Jordan trained 4000 health workers and expanded its cold chain capacity. Libya developed a costed, equity-focused national immunization strategy. In Pakistan, 7000 vaccinators were mobilized in Azad Jammu and Kashmir, Balochistan, Islamabad and Khyber Pakhtunkhwa; WHO supported the country's first HPV vaccination campaign, protecting more than 9.6 million girls aged 9–14 years, as well as a preventive campaign that vaccinated 34 million children against measles and rubella and 19 million children against poliomyelitis in 88 high-risk districts. In Somalia, in 2026, nearly 700 000 zero-dose children received their first dose of pentavalent vaccine, which protects against diseases such as diphtheria and pertussis. In Yemen, 6000 health workers were trained and equipped to deliver routine immunization services, including the Big Catch-Up initiative. In Palestine, three multi-antigen catch-up vaccination campaigns were conducted across the Gaza Strip for children who had missed routine immunization, vaccinating nearly 37 000 children aged under 3 years and strengthening protection against vaccine-preventable diseases after two years of conflict and service disruption.

89. Service delivery is increasingly integrated. In the Islamic Republic of Iran, WHO-supported introduction and expansion of pneumococcal and rotavirus vaccines – combined with workforce training and strengthened surveillance – is improving equitable access, and national Expanded Programme on Immunization policies were updated to include catch-up vaccination for children aged under 5 years. In the Syrian Arab Republic and Yemen, immunization is delivered alongside maternal, child health and nutrition services. Updated tools were rolled out across the DHIS2 platform in Afghanistan, Somalia, Sudan and the Syrian Arab Republic, while Pakistan introduced an electronic immunization registry. Sudan also completed a vaccine-preventable disease surveillance review to identify gaps and strengthen the performance of the national surveillance system.

90. At its meeting in December 2025, the Regional Verification Commission for Measles and Rubella Elimination in the Eastern Mediterranean Region reviewed country data and confirmed that Bahrain, Egypt, the Islamic Republic of Iran and Oman had maintained their measles and rubella elimination status through 2024. The Commission also concluded that Kuwait and Qatar had interrupted transmission of endemic measles and rubella viruses for at least 12 consecutive months, based on 2024 data, and were progressing towards verification of sustained elimination, subject to continued evidence of interruption of transmission and fulfilment of the verification criteria. Fifteen countries[8] achieved adequate surveillance sensitivity, and a regional measles and rubella dashboard was established at the Regional Office for the Eastern Mediterranean to monitor epidemiology and provide real-time guidance to countries. Bahrain also achieved designation of its measles and rubella laboratory as a National Reference Laboratory, strengthening national surveillance capacity and consolidating the country's elimination gains. Qatar introduced respiratory syncytial virus and herpes zoster (shingles) vaccines and continued awareness efforts to support the expansion of HPV vaccination through school-based programmes. The maturity of national immunization technical advisory groups

[7] The Big Catch-Up, launched during World Immunization Week 2023, operated from April 2023 to March 2026. This historic, multi-year, multi-country effort was led by WHO, UNICEF, Gavi (the Vaccine Alliance) and other partners to address declines in vaccination coverage and close immunity gaps among children, particularly those who missed routine vaccines. The initiative targeted zero-dose children (that is, children who have never received any vaccine) and under-immunized children to ensure they received essential vaccines such as measles-containing vaccine and inactivated polio vaccine.

[8] Afghanistan, Bahrain, Djibouti, Iran (Islamic Republic of), Iraq, Jordan, Libya, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, the Syrian Arab Republic, United Arab Emirates and Yemen.

(NITAGs)[9] improved markedly across the Region, increasing from 59% in 2020 to 86% in 2025, reflecting stronger immunization policy processes and enhanced national ownership. WHO supported new vaccine introductions, including 13-valent pneumococcal conjugate vaccine and rotavirus vaccine in Somalia and HPV expansion in Pakistan, and evaluation after introduction of the 10-valent pneumococcal conjugate vaccine and rotavirus vaccine in the Islamic Republic of Iran and related research.

Expanding access to health services based on a primary health care approach to accelerate universal health coverage

Universal health coverage and health system resilience

91. The Eastern Mediterranean Region faces the most severe gap in access to quality and timely care of any WHO region, driven by conflict and compounded by fragilities, weak public financing, workforce shortages and wide disparities across and within its 22 countries and territories. The universal health coverage (UHC) Service Coverage Index ranges from 30 in Somalia to 84 in the United Arab Emirates, reflecting stark disparities in access to essential health services across and within countries. Financial protection remains fragile, with high out-of-pocket spending deterring care or pushing families into poverty. In fragile settings, even basic services cannot be assumed.

92. Countries are responding through a focus on health system resilience, under the regional agenda endorsed by the 69th session of the WHO Regional Committee for the Eastern Mediterranean in 2022. WHO is supporting this accelerated shift towards integrated, people-centred systems anchored in primary health care through policy dialogue, technical assistance and system-wide reform.

93. Service delivery and integration are being strengthened. The Islamic Republic of Iran has initiated the gradual expansion of a family physician programme to improve access to health services through a strengthened referral system and enhanced financial protection. Afghanistan, Iraq and Libya are being supported to update their primary health care service packages. In Iraq, a WHO-supported health system review informed reforms in primary health care, health financing, workforce planning, disease surveillance, digital health and pharmaceutical systems. In Jordan, WHO supported the rehabilitation and equipping of approximately 20 health centres, significantly improving access, quality of care and service readiness, particularly for vulnerable populations. Lebanon and Yemen accelerated the development of national public health institutes in 2025, bringing the regional total to 11. National hospital sector strategies were developed in Pakistan and Tunisia, while six countries began planning and implementing primary health care-oriented roadmaps. In Tunisia, WHO also supported the establishment of a national hospital resilience programme and trained hospital leaders in risk assessment, service continuity and crisis management. WHO supported the identification and documentation of good practices in primary health care on data-driven primary care transformation in the Islamic Republic of Iran, Oman, Pakistan and Somalia. These good-practice examples will be included in a global compendium of primary care good practices, scheduled for publication in 2027.

94. Countries are advancing health system reforms in different ways. Egypt's universal health insurance expansion continued to improve access to services in participating governorates, with service accessibility improving by more than 80%, demonstrating the potential of sustained investment in financial protection and service delivery. Libya advanced implementation of the Essential Package of Health Services and strengthened community health outreach through national tools, standard operating procedures and municipal pilots linking households with primary health care facilities, expanding access for vulnerable and underserved populations. Pakistan strengthened integrated district-level delivery by

[9] NITAGs are multidisciplinary bodies of national experts that provide evidence-based recommendations to policy-makers and immunization programme managers.

linking services for noncommunicable diseases, mental health and maternal health.

95. Despite this progress, significant challenges remain, including persistent workforce shortages, financing constraints and high out-of-pocket spending. Countries, including Djibouti, the Islamic Republic of Iran, Jordan, Morocco and Oman, continued reforms to strengthen quality of care, workforce capacity, primary health care and health financing, with WHO supporting implementation through policy advice, capacity-building and technical assistance.

96. Twenty countries updated their quality of care and patient safety strategies, strengthening governance, service quality and accountability across health systems. In the Islamic Republic of Iran, WHO supported the development of national standard operating procedures and digital tools for implementing the WHO Patient safety assessment manual for primary care (2022) in addition to developing a patient safety rights charter for primary health care. In Oman, WHO supported the integration of patient safety into broader health system and primary health care reforms, thereby strengthening national governance mechanisms, embedding quality and safety within essential health services, and advancing patient and family engagement as part of a sustained national quality agenda. In the United Arab Emirates, WHO patient safety frameworks were institutionalized across public and private health facilities, with capacity-building of quality and safety evaluators enabling a locally driven, sustainable rollout that is improving patient outcomes. In Yemen, WHO supported the implementation of a nationally endorsed quality of care strategy by adapting WHO quality and patient safety frameworks, establishing quality focal points and teams, and developing roadmaps to improve facilities.

97. In fragile settings, WHO support has been critical to sustaining services while laying the foundations for recovery. In Afghanistan and the Syrian Arab Republic, facility rehabilitation and system rebuilding are restoring the availability of services. In the Gaza Strip, in 2025, amid near-total system collapse, WHO's Health Cluster coordinated over 80 partners reaching an average 391 000 people per week, supported 52 emergency medical teams delivering more than 1.8 million consultations and 24 283 surgical operations, and facilitated medical evacuations alongside early recovery efforts. In Sudan – where nearly 40% of facilities are not functional – WHO led Health Cluster coordination, supported 54 hospitals and 78 primary health care facilities across all states, restored supply chains, strengthened systems such as the Health Resources and Services Availability Monitoring System (HeRAMS), and supported a national recovery strategy. In Yemen, WHO has supported hospitals, therapeutic feeding centres, laboratories, blood transfusion services and disease surveillance systems to maintain essential health services during the crisis.

98. WHO strengthened hospital preparedness and continuity of care through operational guidance in five countries[10] and regional alignment on emergency, critical and operative care. WHO is supporting countries to ensure continuity across the full care pathway – from pre-hospital services to rehabilitation.

99. Environmental sustainability is increasingly integrated with pilot assessments of low-carbon health systems. In Yemen, WHO supported the solarization of six governorate referral hospitals, reducing reliance on diesel fuel while strengthening resilient health infrastructure.

Health system recovery and the humanitarian–development–peace nexus

100. WHO supports countries to advance recovery through a humanitarian–development–peace nexus approach, recognizing that recovery must begin early and be integrated with the emergency response. Progress includes, in Afghanistan, post-disaster needs assessments following major earthquakes; in Iraq, Libya and Sudan, the advancement of recovery processes; in Palestine, preparatory work for post-conflict recovery; in Sudan, the development of the National Health Sector Recovery Strategic Plan (2026–2030), led

[10] Iraq, Jordan, Pakistan, the Syrian Arab Republic and Tunisia.

through the Health Sector Recovery and Reform Forum, providing a nationally owned framework for transitioning from emergency response to recovery and resilience-building while maintaining essential services during ongoing conflict; in the Syrian Arab Republic, a health sector recovery alliance established alongside the alignment of the 2026 Humanitarian Needs and Response Plan with the Ministry of Health Strategic Plan 2026–2028 and its eight strategic objectives; and, in Yemen, continued efforts to strengthen health system resilience. At its 72nd session in 2025, the WHO Regional Committee for the Eastern Mediterranean adopted resolution EM/RC72/R.3 on health systems recovery in fragile and conflict-affected situations in the Eastern Mediterranean Region, reinforcing the need for coordinated, context-specific approaches.

Improving health service coverage across the life course

Maternal, newborn, child and adolescent health

101. According to the latest available data published in 2025, the maternal mortality ratio in the Eastern Mediterranean Region fell by 56% between 2000 and 2023, from 378 to 167 deaths per 100 000 live births, while the under-5 mortality rate declined from 82 deaths per 1000 live births in 2000 to 42 in 2024. However, these regional averages mask stark inequities, with maternal mortality ranging from single-digit levels in some countries to more than 500 deaths per 100 000 live births in countries affected by conflict and fragility, and under-5 mortality ranging from as low as 5 to more than 100 deaths per 1000 live births. The Region's highest-burden countries continue to record some of the poorest maternal, newborn, child and adolescent health outcomes globally, including Somalia (563 maternal deaths per 100 000 live births and 101 under-5 deaths per 1000 live births), Afghanistan (521 maternal deaths per 100 000 live births and 53 under-5 deaths per 1000 live births) and Sudan (256 maternal deaths per 100 000 live births and 62 under-5 deaths per 1000 live births).

102. WHO is expanding evidence-based, high-impact interventions in the highest-burden countries (Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen). In Afghanistan, WHO supported the implementation of a national reproductive, maternal, newborn, child, and adolescent health strategy and established maternal and newborn death review committees across 26 hospitals. In Djibouti, more than 200 health workers were trained in antenatal care standards. In Pakistan, provider training and quality-of-care tools improved reproductive, maternal, newborn, child and adolescent health service standards for 5.25 million women and children, while the primary health care model of care expanded integrated service delivery to more than 1 million people. In Yemen, WHO supported the establishment of maternal death surveillance and review committees in 26 hospitals, the adoption of a national paediatric death audit guide and the rollout of early essential newborn care.

103. Progress also continued in other settings. In Iraq, the Women's, Children's and Adolescents' Health Action Plan (2025–2027) was launched in August 2025, alongside the expansion of early essential newborn care in 17 hospitals to help reduce neonatal mortality during the first 24 hours of life. In Palestine, WHO sustained essential sexual, reproductive, maternal, newborn and child health services despite severe constraints. WHO provided obstetric, midwifery and caesarean section kits, as well as medicines and supplies, to 56 health facilities in the Gaza Strip, contributing to services for more than 63 400 women of reproductive age and more than 19 000 reported deliveries, and trained 165 health workers in safe delivery, quality intrapartum care and reporting. In the Syrian Arab Republic, the rollout of integrated nutrition surveillance across 941 health facilities delivered more than 826 000 nutrition screening services, detected more than 22 000 cases of acute malnutrition, and supported the treatment of more than 1500 children with severe acute malnutrition through 25 stabilization centres.

104. Nutrition interventions are increasingly integrated into primary health care. WHO has supported countries and territories such as Afghanistan, Palestine, Somalia and Yemen to strengthen management of acute malnutrition and sustain services in crisis settings. In Pakistan,

integration of nutrition services within primary health care and community platforms has expanded coverage in high-burden districts. In Egypt and Morocco, national strategies and policy reforms are strengthening governance, capacities and service delivery of nutrition and food systems and addressing nutrition and diet-related risk factors. In Yemen, nutrition assessment services were integrated into maternal and child health platforms, screening nearly 200 000 pregnant and lactating women and strengthening early detection of maternal malnutrition, anaemia and low birth weight.

Rehabilitation, assistive technology and post-injury care

105. An estimated 190 million people in the Eastern Mediterranean Region have conditions for which rehabilitation services could be beneficial, and only about 10% of assistive technology needs are currently met. These figures are projected to rise due to population ageing, increasing noncommunicable diseases, trauma and the heavy impact of emergencies. A regional situation analysis of disability-inclusive health systems conducted in 15 countries highlighted major gaps in the availability and accessibility of rehabilitation services, underscoring the need to strengthen rehabilitation services, workforce capacity and quality at all levels of care, supported by appropriate referral pathways.

106. WHO continues to support country efforts towards strengthening rehabilitation and assistive technology services across health systems, emergency settings and primary care, in accordance with resolution WHA76.6 (2023) on strengthening rehabilitation in health systems. Eighteen countries of the Region participated in the WHO consultation for global rehabilitation indicator selection. Countries and territories across the Region advanced rehabilitation planning, integration into health information systems and assessment of assistive technology needs, including Djibouti, Iran (Islamic Republic of), Iraq, Jordan, Morocco, Oman, Pakistan, Palestine and Qatar. WHO and the International Committee of the Red Cross (ICRC), in collaboration with the Iranian Red Crescent Society (IRCS), organized a second multi-country event on early rehabilitation in the Islamic Republic of Iran, convening participants from the same 18 countries to strengthen capacity and share experiences.

107. In parallel, WHO supported the continuity of rehabilitation and assistive technology services during emergencies. In the Gaza Strip, WHO strengthened rehabilitation services through coordinated provision of more than 12 000 assistive products, establishment of a centralized tracking system serving approximately 19 000 beneficiaries, and training of rehabilitation professionals to improve access to quality rehabilitation and assistive technology services in a highly constrained humanitarian setting. In Lebanon, WHO with the public health emergency operations centre provided online and hands-on training in hearing loss and low vision rehabilitation in conflict settings, in collaboration with the WHO Collaborating Centre at the Ophthalmic Hospital of Rome and coordinated with the Syndicat des Opticiens et Optométristes du Liban (the Union of Opticians and Optometrists of Lebanon). In Sudan, WHO supported the establishment of the Intersectoral Rehabilitation Coordination Mechanism. WHO also contributed to webinars on rehabilitation in conflict hosted by World Physiotherapy to orient rehabilitation professionals in affected locations on their role in emergency response.

Improving the health care workforce, health financing and access to medical products

Regional flagship initiative: investing in a resilient health workforce

108. The Region has just 16.5 nurses and midwives per 10 000 population against a global average of 39.4, with some countries reporting single digit rates, a graduate rate of 7.1 per 100 000 population versus the global average of 22.6 and a projected shortfall of 1.2 million nurses by 2030. Insufficiently developed training pipelines, urban concentration of skilled workers and workforce losses from migration, burnout and conflict-related displacement compound these structural inequities.

109. In response, the Regional Director designated health workforce strengthening as a flagship priority. A regional commission is advancing analysis of supply, distribution, financing and labour markets to inform planning and retention strategies. Labour market analyses in eight countries, workforce modelling, and targeted nursing reform support in Iraq and Pakistan have translated this agenda into action. WHO also supported Iraq, Pakistan, the Syrian Arab Republic and Yemen to identify workforce requirements for models of care, and a new competency framework for essential public health functions is informing national training.

110. Regulatory capacity is also strengthening. WHO supported the Pakistan Nursing and Midwifery Council, the establishment of the Somalia Health Professionals Council, and academic partnerships between Afghanistan and Pakistan and between Sultan Qaboos University (Oman) and Aden University (Yemen) on nursing education. In the Islamic Republic of Iran, WHO supported the first competency-based training course on implementing essential public health functions, equipping hospital managers with the knowledge and skills to strengthen hospital performance within integrated, people-centred models of care. In Morocco, capacity-building across priority areas reached 225 health professionals, and a new master's programme in rehabilitation is expanding specialized capacity.

111. System-level accountability is improving through expanded reporting via the National Health Workforce Accounts (NHWA).[11] New WHO collaborating centres designated in Kuwait, Qatar and Saudi Arabia are advancing work on workforce well-being and regulation, while the Regional Health Alliance has enabled joint country missions to strengthen the primary care workforce. Interprofessional education planning is under way in Saudi Arabia, and the Saudi Disaster Medical Assistance Team's classification as the Region's first WHO-classified Emergency Medical Team in March 2025 marks a milestone in emergency workforce capacity.

112. Training-of-trainers programmes have prepared more than 220 national trainers, and the WHO global Primary Health Care Leadership Programme has supported 28 participants from across the Region. A regional consultation on postgraduate health specialty education is informing reforms in collaboration with the Arab Board of Health Specializations.

Strengthening health financing for universal health coverage

113. Health financing has become one of the most pressing structural and political challenges facing the Eastern Mediterranean Region, which represents 9% of the world's population yet accounts for less than 2% of global health spending. Two in three people cannot access the care they need, an estimated 28% experience financial hardship from out-of-pocket payments and one in five is forced to cut spending on food or education just to seek care. Fiscal constraints, sustained reductions in official development assistance and the ongoing burden of conflict are compounding these pressures, making current financing models unsustainable.

114. Countries are advancing reforms across a common set of priorities: strengthening domestic public financing for primary health care; expanding prepayment and risk-pooling to reduce out-of-pocket spending; revising universal health coverage benefit packages based on the universal health coverage compendium and service package delivery interventions (SPDIs); improving efficiency through strategic purchasing and digital tools; and deploying innovative financing instruments – including health taxes, blended financing and Islamic financing – to expand fiscal space.

115. In Palestine, for example, WHO continues to support health financing reforms through strengthened monitoring of financial hardship, revision of the essential health services package, and development of a renewed health financing strategy, including reforms to government health insurance aimed at improving equity, affordability and access to essential health services. WHO is also supporting the Ministry of Health to conduct a

[11] The NHWA is a WHO tool that countries use to collect, organize and report data about their health workforce.

health workforce labour market analysis, which is important for supporting the delivery of quality care for all.

116. To accelerate progress, WHO convened a health financing ministerial roundtable on the margins of the Seventy-ninth World Health Assembly in May 2026, bringing together health ministers and senior officials from across the Eastern Mediterranean Region and beyond to build political commitment for financing reform. Building on this momentum, a regional health financing task force was established, which is developing a regional technical paper and a draft resolution on health financing sustainability and financial protection for consideration by the WHO Regional Committee for the Eastern Mediterranean at its 73rd session in October 2026. Additionally, a high-level World Health Assembly side event co-organized by Burkina Faso, Jordan, Türkiye and the Organisation of Islamic Cooperation on innovative and solidarity-based financing mechanisms explored opportunities to leverage instruments such as Waqf (endowments) and other solidarity financing approaches to complement public financing and support health system sustainability.

Regional flagship initiative: expanding equitable access to medical products

117. Many countries face barriers to accessing essential medicines and vaccines: weak regulation, stockouts, high prices, fragmented supply chains and protracted emergencies. The Regional Director's flagship initiative on expanding equitable access to medical products aims to ensure safe, effective and affordable medical products through stronger regulation, resilient supply chains and expanded local production.

118. WHO advanced regional approaches to improve access and affordability, including laying the foundation for a pooled procurement mechanism, informed by the experience of the Pan American Health Organization, updating national medicines policies in several countries, and conducting pharmaceutical sector surveys in seven countries to establish baseline data on regulatory, pricing and supply systems. A vaccine pricing analysis in Jordan and engagement at the Fourth Global Fair Pricing Forum in February 2024 reinforced the Region's commitment to ensuring affordability and price transparency, while a regional survey on substandard and falsified medical products is informing a coordinated response.

119. Regulatory strengthening accelerated significantly. Saudi Arabia achieved WHO Maturity Level 4 (ML4) in 2023 and is advancing towards WHO-Listed Authority designation. Egypt – the first country in Africa to reach Maturity Level 3 (ML3) for both medicines and vaccines as a producing country in December 2024 – is progressing towards ML4, while the Islamic Republic of Iran, Jordan, Morocco, Pakistan and Tunisia are advancing towards ML3. In Tunisia, WHO supported the national regulatory authority for medicines and vaccines through implementation of a quality management system and reforms aligned with the WHO Global Benchmarking Tool, accelerating progress towards regulatory maturity. Morocco, Tunisia and the United Arab Emirates have established autonomous regulatory agencies; the North African Medicines Regulatory Harmonization initiative launched in 2025 is driving regional convergence; and the WHO Collaborative Registration Procedure has enabled fast-track approvals in Jordan, Pakistan, Qatar, Tunisia and Yemen. Pharmacovigilance capacity expanded in Iraq, Jordan and Yemen, and membership of the WHO Programme for International Drug Monitoring grew to 17 Member States. In fragile settings, regulatory progress was equally notable: Somalia operationalized its National Medicines Regulatory Authority – a landmark achievement given the collapse of the country's regulatory framework in 1991 – with WHO providing technical support for the legal foundation, core regulations, staff training and a digital regulatory information management system; the Somali Medicines Bill has since been approved by both chambers of the Federal Parliament.

120. Supply chain reforms are translating into measurable results. In Iraq, a digital warehouse management system was rolled out in the Kurdistan Region. In Jordan, a package of logistics reforms increased storage capacity by around

50%, reduced stockouts by 30% and cut delivery times to remote areas by up to 40%; in addition, WHO supported the design and launch of a supply chain professional diploma to institutionalize best practices and strengthen national capacities in supply chain management. These results are underpinned by substantial infrastructure investment, including the operationalization of 14 modern warehouses, which have significantly enhanced national storage capacity, cold-chain management and resilience, and improved access to medical products across the country. In Lebanon regulatory inspections assessed 12 pharmaceutical manufacturers for compliance with WHO good manufacturing practices. In 2025, Pakistan's Ministry of National Health Services, Regulation and Coordination joined the Global Platform for Access to Childhood Cancer Medicines, enabling free-of-charge, quality-assured treatment for more than 8000 children diagnosed annually, with four hospitals set to begin receiving medicines by the end of 2026. Essential medicines lists were updated in 12 countries between 2021 and 2025, and national supply chain assessments in Jordan, Libya and the Syrian Arab Republic are guiding targeted system reforms.

121. Local production is advancing across the Region. Egypt and Pakistan progressed their national vaccine production strategies, while Egypt continued investing in local manufacturing capacity and workforce development. Most recently, the Centre for Continuing Professional Development at the Egyptian Drug Authority was designated a WHO Regional Training Centre for Biomanufacturing. In addition, Egypt achieved clinical self-sufficiency in the production of four key plasma-derived medicinal products listed as essential medicines.[12] In Iraq, a local pharmaceutical manufacturing capacity assessment was conducted to inform policy dialogue on strengthening domestic production and improving access to essential medicines. Tunisia completed the proof-of-concept phase under the WHO mRNA technology transfer initiative, which aims to build sustainable regional capacity to produce mRNA-based health products.

At the regional level, a Regional Vaccine Production Strategy was developed in 2024, covering policy, research and development, manufacturing and regulatory readiness.

122. In fragile settings, WHO support remained critical. In Palestine, WHO sustained deliveries of medicines, trauma supplies and fuel under extreme conditions. In the Syrian Arab Republic, more than 7 million people benefited from essential medicines and supplies for dialysis, cancer care and noncommunicable diseases. In Yemen, WHO sustained the availability of essential medicines, laboratory supplies and other health commodities through strengthened supply chains, including 18 flights funded by European Civil Protection and Humanitarian Aid Operations (ECHO) and consolidated shipments to Sana'a and Aden, delivering more than 7800 tonnes of supplies to nearly 350 health facilities and supporting health services for more than 5.8 million people.

[12] Human albumin, intravenous immunoglobulin, and coagulation factors VIII and IX.

REGIONAL PRIORITY 3 (PROTECT)

Expand country capacities to tackle the health demands of the climate crisis, epidemics and pandemics, conflicts, natural disasters and other emergencies



The scale and intensity of the challenge

123. The Eastern Mediterranean Region remains the global epicentre of health emergencies, facing a scale and intensity unmatched by any other WHO region. As at June 2026, WHO was responding to 14 graded emergencies – including eight at Grade 3 (six protracted and two acute crises) – representing over one third of the global total. More than 117 million people in the Region have required humanitarian assistance in 2026 to date out of 252 million worldwide, nearly half of the global need, despite the Region accounting for just 9% of the world's population.

124. The Region hosts three of the world's largest displacement crises – Sudan (14.3 million), the Syrian Arab Republic (13.5 million) and Afghanistan (10.3 million) – and accounts for 46% of global internal displacement and 57% of refugees. Nine countries and territories are classified as fragile or conflict-affected, with 130 000 conflict-related deaths reported in 2024–2025. At least seven countries and territories are classified as IPC Phase 3 (crisis) or higher on the IPC Acute Food Insecurity scale, affecting nearly 80 million people. In 2025, Famine (IPC Phase 5) was confirmed in Gaza Governorate and in Al-Fasher, Sudan. While no areas of the Gaza Strip have been classified as being in Famine since December 2025, 1.6 million people – 77% of the population – remained acutely food insecure into 2026; in Sudan, Famine was not reconfirmed in the most recent IPC analysis (May 2026), though risk persists across multiple areas in Darfur and Kordofan.

125. Globally, climate-related events are an exacerbating factor for more than 75% of Grade 3 emergencies, a pattern acutely felt in the Eastern Mediterranean Region, where flooding, drought and heat stress compound conflict and displacement. In 2025, floods, earthquakes and heatwaves affected at least 12 countries and territories in the Region, affecting nearly 33.5 million people, including in Pakistan, where floods killed more than 1000 people and affected 6.9 million, and in Afghanistan, where earthquakes caused more than 2200 deaths and 3600 injuries.

126. Attacks on health care remain a defining feature of crises: 632 attacks were recorded across the Region between 1 July 2025 and 30 June 2026, causing 1531 deaths and 1429 injuries, accounting for more than 43% of global attacks and 86% of fatalities. Attacks were recorded in seven countries and territories, including Afghanistan, the Islamic Republic of Iran, Lebanon, Palestine, Sudan, the Syrian Arab Republic and Yemen. During the first half of 2026, 47% of all recorded attacks globally affected the Region.[13]

127. Funding shortfalls have had direct operational consequences. Globally, the WHO Contingency Fund for Emergencies ended 2025 with a balance of only US$ 19.5 million – the lowest in recent years – against a 2024–2025 programme budget gap of US$ 553 million for emergency operations, placing further strain on the Organization's ability to mount timely responses worldwide. In 2025, funding constraints affected 1950 health facilities, of which 1027 (52.7%) suspended operations and 923 were operating at reduced capacity, affecting an estimated 25.9 million people across the above-mentioned seven countries.

128. The onset of a major regional escalation from February 2026 added a further, acute dimension to this burden, affecting at least 14 countries in the Eastern Mediterranean Region, with cascading impacts across health systems, supply chains and the broader humanitarian response. Beyond conflict casualties, the crisis expanded public health risks into multiple domains – infectious disease transmission in overcrowded shelters, disrupted immunization and chronic disease management, mental health needs among displaced populations, attacks on health care, and threats to critical energy and water systems. Several countries in the Region depend on desalination for more than 70% of their municipal water supply, and the Region accounts for nearly 47% of global desalination capacity, making attacks on or near water infrastructure a direct public health threat with long-term consequences.

[13] Globally, there were 1483 WHO-verified attacks (resulting in 1781 deaths and 2006 injuries) between 1 July 2025 and 30 June 2026. During the first half of 2026, there were 853 attacks globally, 400 of which occurred in the Eastern Mediterranean Region.

Ensuring rapid and effective detection of and response to public health threats

129. WHO strengthened epidemic and pandemic preparedness through integrated approaches to surveillance, laboratory capacity, workforce development and coordination. As at 30 June 2026, there were 48 active outbreaks affecting 17 countries and territories, including dengue, measles, cholera, circulating vaccine-derived poliovirus type 2 (cVDPV2), mpox and malaria. Progress towards ensuring all countries can test and sequence priority pathogens advanced through expanded genomic sequencing capacity in 21 countries and sustained diagnostic readiness, including in fragile settings.

130. Regional preparedness for respiratory pathogens, including influenza viruses and severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), was strengthened despite major constraints, including the withdrawal of United States laboratory funding affecting national influenza centres in Afghanistan, Sudan, the Syrian Arab Republic and Yemen. Integrated influenza virus and SARS-CoV-2 surveillance operated in 18 countries, while the Eastern Mediterranean Flu Network (EMFLU 2.0) reporting system expanded to 19 countries. Functional National Influenza Centres were maintained in 18 of 22 countries and territories, and sequencing capacity was strengthened across 21. WHO also supported Egypt, Iraq, Jordan, Lebanon, Tunisia and Yemen to use disease burden data and forecasting tools to inform vaccination policy. The Region's first community protection operational strategy for respiratory diseases was developed alongside the global community protection workshop hosted in Jordan. In Iraq, the first seasonal influenza vaccination campaign was launched following adoption of the national influenza vaccination policy, reaching approximately 800 000 people – around 90% of the target population – within the first three months. Morocco updated its national preparedness and response plan for influenza pandemics and emerging respiratory pathogens in line with the WHO Preparedness and Resilience for Emerging Threats (PRET) approach, while strengthening infodemic management through enhanced workforce capacity and a national emergency activation roadmap.

131. Public health intelligence systems were strengthened significantly. WHO's regional centre processed more than 2.4 million signals in 2025, identifying and managing priority events across conflict, displacement and climate-affected settings. Integrated early warning systems and rapid response teams were expanded across the Region. In Iraq, event-based surveillance and DHIS2 integration advanced. In Lebanon, data-driven surveillance prioritization was introduced. Morocco strengthened public health intelligence by expanding event-based surveillance and deploying the WHO-led Epidemic Intelligence from Open Sources (EIOS) platform nationwide. Tunisia institutionalized epidemic intelligence and event-based surveillance. Workforce capacities were also strengthened: in Kuwait, WHO, in partnership with the Eastern Mediterranean Public Health Network (EMPHNET) and the Kuwait Centre for Disease Control, conducted a training needs assessment to support the institutionalization of the Field Epidemiology Training Programme, while the Syrian Arab Republic advanced field epidemiology training. Tunisia additionally strengthened emergency care, hospital resilience and risk communication capacity, reaching more than 1000 health professionals.

132. WHO developed the All-Hazards Information Management (AIM) Toolkit – an artificial intelligence-enabled platform created with the WHO Berlin Hub for Pandemic and Epidemic Intelligence, WHO headquarters and Norwegian Capacity for International Operations (NORCAP). AIM automates production of key emergency information products, reducing turnaround times from days or weeks to minutes and cutting production time for core outputs by more than 99%. Tested during the Middle East escalation, the Ukraine response and a measles outbreak in Morocco, AIM enables faster evidence-based decision-making from the earliest stages of emergencies. A regional workshop in Jordan established a framework for national deployment.

133. Country-level preparedness and outbreak response capacities were strengthened across the Region. In Sudan, WHO restored diagnostic capacity through relocation of the national public health laboratory, rehabilitation of laboratories and deployment of mobile units, while strengthening case management for malaria and dengue through clinical mentorship and technical support, including in conflict-affected states. These efforts supported detection and response for more than 64 000 dengue cases and 650 000 malaria cases. Strengthened cholera surveillance and response contributed to the allocation of 12 million oral cholera vaccine doses through the International Coordinating Group mechanism, and helped reduce the cholera case fatality rate from 2.7% to 1.7% by mid-2025. Rapid response capacities expanded across several countries: Kuwait institutionalized a national rapid response team programme, Morocco enhanced risk assessment and outbreak response through continuous training of rapid response teams, and Pakistan strengthened surveillance and flood response coordination. Preparedness for epidemic and pandemic threats also advanced: Iraq strengthened influenza pandemic preparedness, while Egypt reinforced integrated surveillance and laboratory systems nationwide. In fragile settings, surveillance systems were further strengthened: Somalia enhanced surveillance and immunization to address poliovirus risks, and in Yemen, WHO supported the electronic Integrated Disease Early Warning System (eIDEWS), sentinel surveillance sites and rapid response teams, providing technical and operational assistance to more than 1500 trained responders across central, governorate and district levels.

134. WHO also strengthened laboratory and surveillance systems to support threat detection and response, including in humanitarian settings. In the Gaza Strip, WHO provided essential laboratory supplies and screening reagents, support for neonatal screening programmes, and capacity-building to help sustain essential diagnostic services during the humanitarian emergency. Somalia strengthened diphtheria confirmation capacity, and Sudan re-established laboratory functions for priority vaccine-preventable diseases. In Yemen, WHO supported the continued functioning of public health laboratories through the provision of essential reagents, laboratory supplies and quality assurance support, strengthening diagnostic and surveillance capacity. In the United Arab Emirates, integrated surveillance and data linkage systems strengthened real-time decision-making and emergency preparedness.

Escalation of conflict in the Middle East

135. The escalation of conflict across the Middle East from early 2026 placed additional strain on already fragile systems across at least 14 of the Region's 22 countries and territories, further exposing the systemic consequences of prolonged regional instability. In some countries, large-scale casualties and displacement overwhelmed hospitals, with emergency departments saturated and critical shortages emerging across trauma, cancer and noncommunicable disease care. Attacks on health care intensified sharply, further disrupting service delivery and putting health workers and patients at risk. Facilities were damaged or forced to close, while repeated strikes on ambulances and first responders severely constrained the emergency response. Environmental hazards – including fires affecting petroleum infrastructure and damage to desalination systems – introduced additional public health risks. Damage to nuclear and energy facilities also raised concerns regarding potential radiological hazards. WHO coordinated closely with the International Atomic Energy Agency (IAEA) to support risk assessment, preparedness and public health risk communication.

136. WHO's response was immediate and multi-country. In the Gaza Strip, WHO delivered critical supplies, coordinated emergency medical teams and supported medical evacuations. In the Islamic Republic of Iran, priority procurement of generators, uninterruptible power supply systems and trauma supplies was initiated to sustain critical health facility functions. WHO also donated four trauma and emergency surgery kits, each capable of supporting surgical care for up to 50 patients in emergency situations, assuming an average of two operations per patient. More than 4000 health care workers were trained to scale up mental health and psychosocial support services. In Iraq,

WHO strengthened emergency preparedness and response in priority hospitals through mass casualty management training, support for the development of a national emergency medical team programme and enhanced disease surveillance systems. In Lebanon, the public health emergency operations centre played a central coordination role, overseeing casualty referral and distribution and maintaining real-time communication with hospitals to optimize surge capacity; WHO delivered health supplies through land convoys from Dubai and charter flights from Europe for distribution to frontline hospitals. In the Syrian Arab Republic, more than 448 000 people had crossed from Lebanon by early June 2026, increasing pressure on health services already responding to hepatitis A clusters in Daraa and a laboratory-confirmed measles outbreak in Hassakeh. WHO supported health service delivery across Aleppo, Daraa, Hama, Homs, Idlib and Suweida governorates and parts of the north-east, including procurement of essential medicines and trauma supplies and reinforcement of surveillance and outbreak prevention. In Yemen, WHO strengthened preparedness through scenario-based contingency planning, support to emergency coordination and surveillance systems, capacity-building on incident management through public health emergency operations centres, rollout of electronic public health emergency management (ePHEM) tools to strengthen emergency reporting and event-based surveillance, and prepositioning of essential medicines, laboratory supplies and emergency kits to health facilities across 19 governorates.

137. The escalation of conflict also prompted a major strengthening of preparedness across GCC countries. Between April and June 2026, WHO deployed dedicated emergency preparedness and response expertise across Bahrain, Kuwait, Oman, Qatar and Saudi Arabia to enhance readiness for potential regional spillover risks. Support focused on all-hazards emergency management, public health intelligence, early warning systems, public health emergency operations centre interoperability, mass casualty and chemical, biological, radiological and nuclear preparedness, emergency logistics, medical countermeasures, risk communication and continuity of essential health services. The initiative reinforced national capacities while advancing a more coordinated GCC approach to health security, preparedness and response.

138. Bahrain advanced preparedness for operational testing and regional linkage, Kuwait expanded its role in humanitarian preparedness and health security coordination, Oman strengthened early warning and situational awareness capacities, Qatar consolidated integrated preparedness and response arrangements, and Saudi Arabia leveraged its advanced emergency operations, simulation and rapid response capabilities. The initiative strengthened collaboration among GCC countries and laid the foundation for a Member State-owned, Gulf CDC-aligned and WHO-enabled model for collective readiness, operational excellence and health security across the GCC region.

139. The escalation severely disrupted regional supply chains, temporarily halting operations at WHO's Hub for Global Health Emergencies Logistics in Dubai. Transportation costs increased by 50% compared with pre-crisis levels due to rising fuel surcharges and airspace restrictions, necessitating a shift towards overland and multimodal routes. Operations resumed through the implementation of innovative supply chain solutions, underscoring both the fragility of supply systems in complex regional crises and the critical importance of pre-positioned stocks and agile response capabilities supported by the delivery of supplies through donated emergency charter flights. Despite these constraints, from the start of the conflict escalation until mid-June 2026, the WHO Hub in Dubai dispatched health supplies worth US$ 5.9 million to 26 countries and territories, reaching more than 8 million beneficiaries.

Food insecurity and malnutrition

140. Acute food insecurity and malnutrition remained widespread across several emergency settings. WHO supported nutrition surveillance and inpatient care for severe acute malnutrition at stabilization centres across high-burden countries and territories – including Afghanistan, Pakistan, Palestine, Somalia, Sudan and Yemen –

helping sustain essential services despite severe operational constraints. Further details are provided under Regional Priority 1.

Managing communicable disease outbreaks in conflict and humanitarian settings

141. Protracted crises create ideal conditions for the spread of cholera, measles, diphtheria, dengue, malaria, Crimean–Congo haemorrhagic fever, mpox, typhoid and hepatitis A, while simultaneously eroding the diagnostic and treatment infrastructure needed to contain them. In 2025, 62 outbreaks were reported across 19 countries and territories; 48 remained active across 17 countries and territories as at 30 June 2026. WHO's response combined rapid field deployment, adaptive logistics, integrated multisectoral interventions and system rebuilding to keep mortality within manageable bounds. In Sudan, WHO supported integrated responses to cholera, dengue and malaria outbreaks, linking surveillance, case management, vector control, WASH, risk communication and community engagement interventions to reduce transmission and strengthen community-level prevention.

142. Cholera remained the most widespread and lethal threat. More than 359 000 cholera and acute watery diarrhoea cases and 2167 deaths were reported across six countries in 2025. A coordinated regional response – combining early laboratory confirmation, emergency vaccination and community outreach – kept case fatality rates below the 1% WHO emergency threshold in most settings. In Somalia, integrated vaccination, community outreach and prepositioning of emergency medical supplies reduced cholera cases – from 22 028 in 2024 to 9004 in 2025 – and reduced mortality from 135 to nine. In Sudan, confirmation of cholera transmission and ongoing epidemiological surveillance supported multiple requests through the International Coordinating Group mechanism, resulting in the allocation of more than 12 million oral cholera vaccine doses. Targeted mass vaccination campaigns contributed to reducing the case fatality rate from 2.7% to 1.7% by mid-2025. In Yemen, WHO supported 19 diarrhoea treatment centres, strengthened surveillance and case management, and supported oral cholera vaccination campaigns reaching more than 3 million people. Following severe flooding, WHO also reinforced outbreak prevention through emergency medical supplies, vector control and disease surveillance measures.

143. In Somalia, diphtheria cases rose sixfold to 3653 in 2025, predominantly in unvaccinated children aged 5–15 years. WHO and Federal Member States responded by vaccinating more than 1.8 million children and deploying diphtheria antitoxin to high-volume facilities, reducing the case fatality rate threefold, from 12.8% to 4.1%. In Sudan, EWARS – including EWARS Mobile in conflict-affected and hard-to-reach areas – enabled detection, reporting and response to over 64 000 dengue cases and more than 650 000 malaria cases, despite widespread disruption of the health system and the fact that many health facilities were not functioning. In the Syrian Arab Republic, WHO supported outbreak prevention and response, including for hepatitis A clusters and a laboratory-confirmed measles outbreak. Laboratory capacity for measles and rubella molecular testing was strengthened across 15 countries, accelerating outbreak confirmation. In the Gaza Strip, 1.6 million priority disease cases were detected and reported through the early warning and response system, enabling rapid partner coordination in a setting where routine surveillance had largely collapsed. In Yemen, vector control interventions including community mobilization helped protect an estimated 4 million people from dengue outbreaks.

144. Infection prevention and control was reinforced as a frontline outbreak mitigation tool. In 2025, the Region reached an overall infection prevention and control capacity score of 61%, level 3 ("developed capacity"), surpassing the global average despite several countries simultaneously managing active conflicts. WHO integrated infection prevention and control guidance into emergency preparedness frameworks, deployed infection prevention and control experts to high-risk countries, and maintained continuity of core practices through partnerships with the Wellcome Trust and WHO collaborating centres that expanded training and laboratory information management system

capacity. Integrated infection prevention and control programmes were strengthened across 11 countries, directly supporting the WHO commitment on infection prevention and control standards. The continuity of drug-resistant TB treatment – which is particularly vulnerable to service interruption – was protected through regional missions with the Global Fund in Sudan and the Syrian Arab Republic and emergency-aligned programme reviews in Afghanistan.

145. Sustaining these responses required adaptive logistics and system workarounds on a large scale. WHO relocated Sudan's national public health laboratory to Port Sudan, deployed three mobile laboratory units to camps for internally displaced persons and conflict-affected areas, and maintained diagnostic supplies in more than 80% of accessible health facilities. In Yemen, WHO maintained and strengthened eIDEWS and rapid response teams, contributing to timely detection and response to outbreaks and reinforcing national preparedness capacities. Cross-border coordination – particularly across the Horn of Africa – was strengthened to reduce the risk of international spread. Vector-borne disease preparedness was further reinforced through regional training on integrated vector surveillance and insecticide resistance management; evidence from molecular marker monitoring for antimalarial drug resistance informed Sudan's decision to switch rapid diagnostic tests in 2026, a concrete example of evidence-based adaptation under crisis conditions.

The rising trauma burden

146. Conflict-driven trauma is the Eastern Mediterranean Region's most acute and growing emergency health burden. Injuries and violence kill more than 433 000 people in the Region every year – the second-highest injury mortality rate among all WHO regions. The reporting period pushed these figures to a different scale entirely: the Region accounted for 43% of all attacks on health care documented globally and more than 86% of associated deaths. During the first half of 2026, the Region accounted for 47% of all WHO-verified incidents worldwide. In the Gaza Strip, more than 171 000 people were injured between October 2023 and 31 December 2025, approximately 25% of whom sustained life-altering trauma requiring long-term rehabilitation, including an estimated 5000 amputations. In Lebanon, the 2024 escalation produced more than 4000 fatalities and 16 600 injuries. In Sudan, according to Sudanese Ministry of Social Development estimates, more than 397 000 people are living with conflict-related disabilities. In the Islamic Republic of Iran, 2150 deaths and 27 931 injuries were reported by 2 April 2026. Across all settings, rehabilitation, trauma information systems and quality improvement remain critically under-resourced – a structural inequity that will compound the disability burden for years to come.

147. The Regional Trauma Initiative continued to function despite a complete withdrawal of dedicated funding in 2025 that forced significant team downsizing. Since its establishment in 2020, the initiative has supported responses to more than 200 mass casualty incidents, and in parallel supported trauma systems in the Region to provide care to an estimated 800 000 injured patients. Lebanon demonstrated the impact of the Regional Trauma Initiative most clearly: 7070 health care workers were trained across 548 facilities, and 112 activation drills were conducted. A landmark achievement was the institutionalization of a critical nursing care in conflict settings curriculum, certifying 23 national instructors. In parallel, 64 surgeons, anaesthesiologists and emergency physicians were trained in blast injuries, damage control resuscitation and war wound management. In the Gaza Strip, 77 trauma specialist missions were facilitated and more than 220 trauma and emergency surgery kits delivered; 36 medical evacuation missions enabled 557 patients and 1228 companions or caregivers to exit the Gaza Strip, with trauma pathway data used to inform advocacy on the protection of civilians. In the West Bank, WHO strengthened trauma care capacity through training of more than 1500 health workers and first responders, and by providing technical support, supplies and equipment to hospitals, trauma stabilization points and other health service points. In Egypt, in-house training was delivered to six hospitals. In Sudan, the Trauma Technical Working Group was re-established under the Health Cluster. In the Syrian Arab Republic, mass casualty

management training reached 13 hospitals. The designation of the Hamad Medical Corporation Trauma Centre in Qatar as a WHO Collaborating Centre established a scalable regional platform for standardized war surgery training, with the joint course repeated for 77 trainees from five WHO country offices in January 2026.

Enhancing preparedness, readiness and resilience

148. The WHO Pandemic Agreement, adopted by consensus at the Seventy-eighth World Health Assembly in May 2025, marked a major milestone in global preparedness, concluding over three years of intensive negotiations. Countries of the Eastern Mediterranean Region were actively engaged throughout, contributing substantively to shaping key provisions. In parallel, amendments to the International Health Regulations (2005) (IHR) officially entered into force in September 2025, strengthening surveillance capacities and promoting equity in access to health products. WHO continues to support Member States in the Region through awareness-raising, technical guidance, capacity-building, and the development of national implementation plans to facilitate the effective adoption and operationalization of both the Pandemic Agreement and the amended IHR.

149. All 22 countries and territories completed the States Parties Self-Assessment Annual Reporting (SPAR) cycle in 2025, but overall capacity levels have remained largely unchanged since 2018 – ranging between 63% and 66% – reflecting persistent underinvestment. Stronger performance was observed in surveillance, laboratory systems and service provision, while gaps remain in workforce, risk communication and chemical event preparedness. According to 2025 SPAR data, the highest average scores were in surveillance (83%), health service provision (74%) and laboratory (71%), while the lowest were in chemical events (55%), points of entry and border health (58%) and food safety (60%).

150. The National IHR Focal Point (NFP) peer learning programme[14] and community of practice continued to serve as key platforms for strengthening collaboration, knowledge exchange and capacity-building across the Eastern Mediterranean Region. A total of 21 community of practice sessions were conducted, bringing together NFPs and technical experts from across the Region. The sessions covered a broad range of technical topics and emerging public health issues, including updates on public health emergencies of international concern, ongoing outbreak situations, event assessment and notification, risk communication, points of entry and implementation of the IHR.

151. From July 2025 to June 2026, WHO facilitated 20 joint external evaluations globally and supported 22 national health security action plans and 59 simulation exercises. Three of these evaluations were conducted in or published for countries of the Region – Afghanistan, Libya and Tunisia – representing 15% of the global total. In addition, National Action Plans for Health Security were developed in Iraq, Libya and Qatar. The Region also conducted 17 simulation exercises of various types across Bahrain, Iraq, Jordan, Oman, Pakistan, Tunisia, the United Arab Emirates and Yemen. Notably, two of these exercises were conducted regionally and subregionally.

152. Progress on the commitment requiring all countries facing humanitarian emergencies to implement periodic health facility reporting was advanced through institutionalization of real-time monitoring tools: WHO strengthened national systems in the Gaza Strip and Sudan through HeRAMS, enabling real-time health facility monitoring and enhanced coordination across health partners, improving prioritization and

[14] The NFP peer learning programme is a WHO-led initiative designed to strengthen the capacity, coordination and operational readiness of national IHR focal points across all States Parties through shared experiences, best practices and collaborative learning. Under the IHR, each State Party must designate a National IHR Focal Point – typically a national office or centre – as the official, always-available communication link between WHO and the country. NFPs are responsible for notifying WHO of relevant public health events, relaying WHO advice to national sectors, and ensuring coordination across ministries and agencies.

resource allocation in highly constrained operating environments.

153. Implementation of the IHR was reinforced through coordinated infrastructure strengthening across multiple domains. Public health emergency operations centres were established in Egypt, Iraq and the Syrian Arab Republic, with Lebanon, Qatar, Sudan and Yemen receiving support to enhance existing centres. WHO supported capacity-building at points of entry for 10 countries across 304 designated points of entry, through targeted training, simulation exercises and cross-border coordination.

154. Financing for preparedness advanced despite persistent gaps, with eight countries securing a cumulative US$ 153.2 million from the World Bank-hosted Pandemic Fund across the first three funding rounds, representing 50% of all eligible countries in the Region. These investments are directly linked to assessments of the IHR and associated national action plans, supporting surveillance expansion, workforce development and emergency coordination systems. In Yemen, Pandemic Fund support delivered tangible results: surveillance coverage expanded through support to 2725 eIDEWS sentinel sites, increasing national coverage from 49.5% to 56%, while 670 health workers were trained and deployed as rapid response teams across 134 districts, conducting more than 142 000 field missions to verify and investigate outbreak alerts.

155. Recognizing the growing risks from chemical, biological, radiological and nuclear hazards, WHO supported Member States in strengthening integrated, all-hazards preparedness across the Region. Preparedness for these hazards was reinforced across 13 Member States – proving directly relevant during the 2026 escalation. Regional strategic and action plans were developed, and cross-regional collaboration with the African, South-East Asia and European regional offices reinforced knowledge exchange.

156. WHO supported Djibouti, Iraq, Jordan and Tunisia in developing national health risk profiles using the Strategic Tool for Assessing Risks (STAR), enabling countries to systematically identify, prioritize and plan for a wide range of public health threats. Hospital resilience was strengthened through the Hospital Safety Index and STAR-Hospitals tools in Iraq, Jordan and Tunisia, alongside crisis management training in Sudan. Emergency care systems were assessed in Somalia, with priorities identified for strengthening system capacity. Pakistan's emergency care system was supported by WHO through training frontline health care providers in basic emergency care to improve timely recognition and effective treatment of acutely ill and injured patients.

157. WHO strengthened risk-based planning for large-scale mass gatherings – including the Hajj and Umrah, the Arba'een in Iraq and the Africa Cup of Nations in Morocco – supporting countries to assess and manage public health risks at scale. This included the use of structured risk assessment tools, enhanced surveillance and early warning systems, infection prevention and control measures, and multisectoral coordination. Cross-border collaboration was reinforced to manage population movement and mitigate outbreak risks. WHO also conducted the first after-action review of the Arba'een gathering, generating critical lessons to further strengthen preparedness, response and regional knowledge-sharing for future high-risk events.

158. Risk communication, community engagement and infodemic management continue to be institutionalized as core components of emergency preparedness, readiness and response across the Region. Targeted training to strengthen national capacities continues to be rolled out in multiple countries, while community protection approaches under the global health emergency preparedness, response and resilience framework – which aim to improve links between health systems and populations – have been piloted and rolled out in Iraq and Jordan. Infodemic management training was conducted in Lebanon, Morocco, the Syrian Arab Republic and Yemen, and sustained social listening in the Islamic Republic of Iran, Jordan, Palestine, Sudan and the Syrian Arab Republic supported the integration of infodemic intelligence into risk communication and community engagement response planning and rollout; external evaluations and assessments

were used as critical resources to support national planning in Iraq, Libya, Morocco, Qatar, Sudan, the Syrian Arab Republic and Yemen, as part of institutionalized compliance with the IHR. The value of this investment was demonstrated during the 2026 Middle East escalation: when more than 140 000 people were displaced into schools and temporary shelters across Lebanon, WHO partnered with the Ministry of Public Health and mobilized non-traditional partners, including university student volunteers, to develop a practical health toolkit adapted to shelter conditions with messaging framed around systemic overcrowding rather than individual behaviour. The initiative addressed existing behaviours and needs in practical terms while encouraging care-seeking and identifying pathways to care.

Maintaining essential health service delivery in emergency and humanitarian settings

159. WHO sustained large-scale, life-saving operations across the Region using its all-hazards incident management system. Globally, during 2025, emergency medical teams facilitated over 3.5 million consultations in crisis settings. The Eastern Mediterranean Region accounted for the largest share: in the Gaza Strip in 2025 alone, 52 emergency medical teams delivered more than 1.8 million consultations, 24 283 emergency surgical procedures and care for 123 925 trauma patients.

160. Emergency care capacities were strengthened across the continuum – from community first response to advanced clinical care. In Egypt, basic emergency care training enhanced frontline clinical skills for the early recognition and management of life-threatening conditions. In Iraq, community-level first aid training expanded immediate response capacity, improving survival during the critical period before patients reach health facilities. In Somalia, emergency and critical care training has been institutionalized within the national university system, complementing previously ad hoc training efforts. At the same time, broader national planning is prioritizing and addressing critical gaps identified through recent system assessments. In Yemen, the Emergency Care Toolkit supported standardized protocols, triage and quality improvement in high-burden settings. Regional surge capacity also improved: in March 2025, the Saudi Disaster Medical Assistance Team became the first in the Region to achieve WHO classification as an Emergency Medical Team Type 2, strengthening national and regional readiness to deliver inpatient and surgical care during crises.

161. Overall, between July 2025 and June 2026, the WHO Global Health Emergencies Logistics Hub in Dubai shipped US$ 24.8 million in supplies globally and delivered close to 435 emergency orders to 74 countries worldwide. In 2025, WHO facilitated the delivery of US$ 41 million worth of medical supplies to the Gaza Strip amid the complex access constraints, movement restrictions and prolonged inspection procedures. WHO has coordinated nearly 100 charter flights since the onset of the crisis with the support of ECHO and the United Arab Emirates. WHO also supported the movement of 289 partner trucks across all corridors, directly enabling continued partner operations at a time when administrative changes and de-registration of international nongovernmental organizations severely limited partner autonomy. Additionally, WHO distributed 10.79 million litres of fuel inside the Gaza Strip, sustaining hospital generators and cold-chain systems critical for emergency and referral care.

162. At country level, WHO sustained essential health services at scale. In Afghanistan, nationwide service delivery continued despite access constraints, with 98% of outbreak alerts responded to within 96 hours, 57 000 children treated for severe acute malnutrition and more than 3.1 million consultations delivered. In Egypt, WHO supported the health system response to regional crises, helping sustain continuity of care for displaced populations from the Gaza Strip and Sudan through strengthened coordination, delivery of essential medical supplies, support for delivery of life-saving and essential health services and specialized services, including dialysis, oncology and emergency care. In Libya, WHO supported health and WASH services in Al-Kufra in response to the influx of refugees fleeing the conflict in Sudan. Emergency medical teams deployed across 14 locations provided 72 000 consultations, including

sexual and reproductive health, mental health and nutrition services, while strengthened referral pathways and WASH interventions helped reduce disease risks and sustain services for refugee and host communities. WHO supported Pakistan in strengthening preparedness and emergency response in 33 high-risk and priority flood-affected districts across Balochistan, Khyber Pakhtunkhwa, Punjab and Sindh. In Somalia, support to immunization and outbreak response reduced disease burden among vulnerable populations. In the Syrian Arab Republic, WHO supported more than 750 000 trauma consultations and more than 1.5 million outpatient, trauma and mental health consultations, while strengthening referral systems and continuity of care. In Yemen, support to more than 2300 health facilities helped sustain hospital operations through the provision of fuel, oxygen and essential medicines.

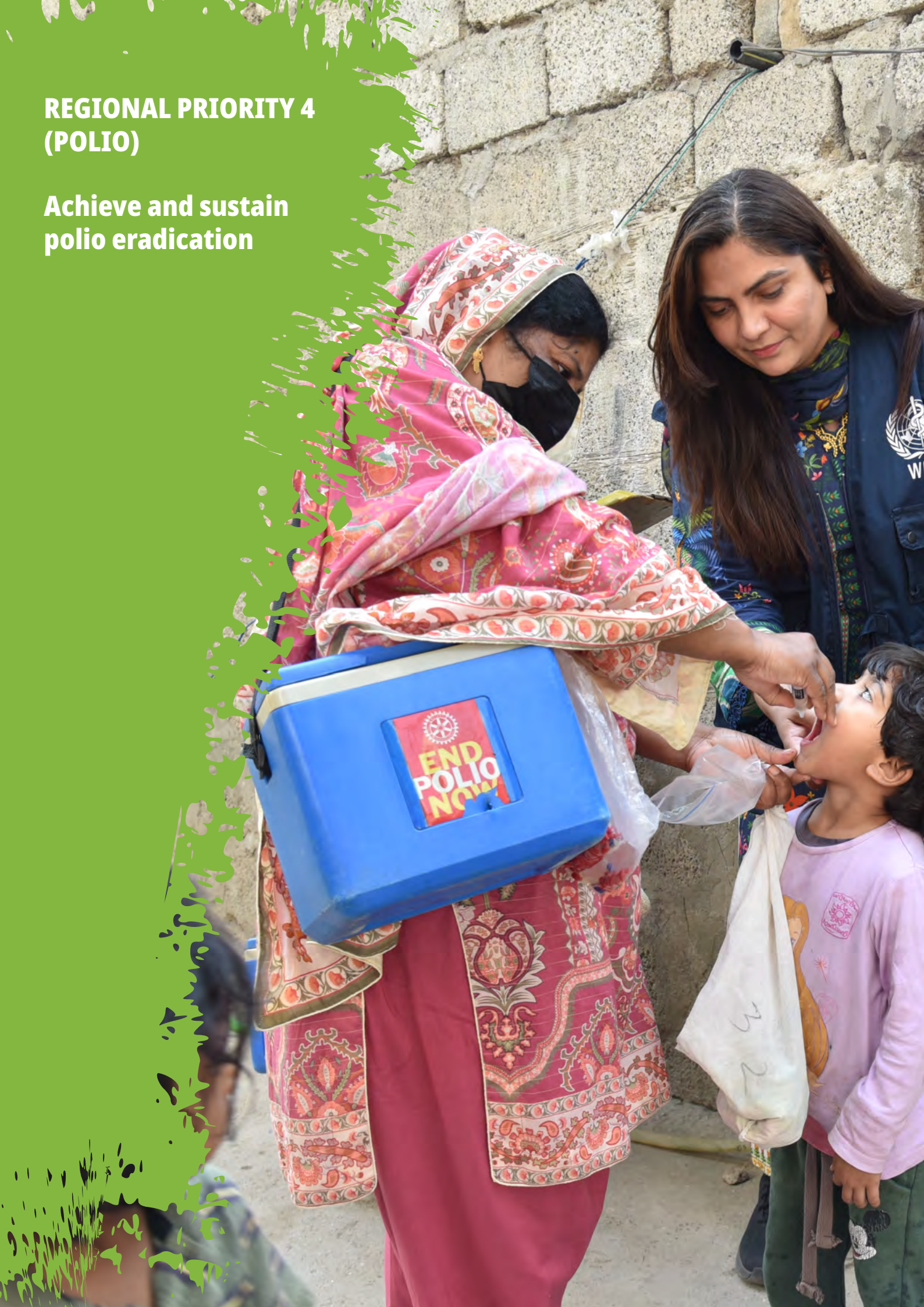
163. In Palestine, WHO's response spanned emergency operations, Health Cluster coordination and early recovery, including damage and needs assessments, rehabilitation of health facilities, restoration of health information systems and recovery planning. By the end of December 2025, only 18 of 36 hospitals were partially functioning, none in the northern Gaza Strip, while fewer than half of primary health care facilities remained operational and shortages had left 51% of essential medicines and 65% of medical consumables out of stock. Despite receiving only US$ 156.5 million of the US$ 648 million required, WHO and Health Cluster partners sustained hundreds of service delivery points providing nearly 15 million medical consultations. Around US$ 60 million in medical supplies were delivered, 34 emergency medical teams provided over 1.8 million consultations and 18 747 emergency surgical procedures, and support was provided for trauma care, referrals, orthopaedic surgery, severe acute malnutrition management and noncommunicable disease care. Disease surveillance was strengthened through EWARS, which detected more than 1.6 million priority disease cases, while community-based surveillance was introduced and three rounds of cVDPV2 vaccination had reached more than 600 000 children by early 2025.

164. In Sudan, WHO's response addressed an acute and deteriorating health crisis, with nearly 40% of health facilities rendered non-functional by conflict and 33.7 million people projected to require humanitarian assistance in 2026. Despite severe logistic constraints, WHO delivered more than 800 tonnes of medical supplies in 2025, sustaining services in conflict-affected areas, while more than 1.8 million people accessed essential health services through WHO-supported hospitals, primary health care facilities, and mobile clinics and laboratories. The Sudan Health Assistance and Response to Emergencies (SHARE) Project was launched in 10 hospitals, with DHIS2 training provided to 101 staff and 116 961 services recorded in February 2026 alone. Across 25 SHARE-supported primary health care centres in 13 states, essential services were maintained and targeted workforce training delivered on integrated management of childhood illness, gender-based violence and early essential newborn care. Acute care and trauma capacity was strengthened through referral coordination in 10 states, emergency care and triage training, deployment of trauma teams and support to frontline facilities. Immunization was sustained under exceptionally difficult conditions: following a decline in third-dose pentavalent vaccine (Penta3) coverage to 38% in 2024, WHO support helped restore coverage to 71% in 2025. Nationwide vaccination campaigns reached approximately 20.3 million people with coverage exceeding 95%, while Sudan became the first country in the Eastern Mediterranean Region to introduce and scale up the malaria vaccine, reaching more than 140 000 children in four states by the end of 2025. WHO also sustained services to combat neglected tropical disease, supporting leprosy, visceral leishmaniasis and dracunculiasis (Guinea-worm disease) surveillance activities, active case-finding, community awareness campaigns and technical supervision in multiple states despite ongoing conflict.

165. In Yemen, WHO helped sustain essential health services in one of the Region's most challenging humanitarian settings, despite severe funding constraints, operational disruptions and reduced partner presence. Through support for critical facility operations, including fuel, medical oxygen, safe water and essential medicines, WHO helped maintain a network of referral and secondary health facilities serving more than 20 million people across all governorates. These facilities provide approximately 12 000 inpatient beds, more than 1000 intensive care beds and more than 1000 nursery units. The support helped ensure uninterrupted access to care for an estimated 5 million vulnerable people in 2026. During 2025, WHO-supported facilities delivered more than 744 000 consultations, 341 000 inpatient admissions and 116 000 surgical procedures, including over 43 000 caesarean sections and more than 100 000 facility-based births.

REGIONAL PRIORITY 4 (POLIO)

Achieve and sustain polio eradication



Stopping the transmission of wild poliovirus in Afghanistan and Pakistan and of cVDPV2 in all countries of the Region

166. The international spread of wild poliovirus remains a public health emergency of international concern[15] and one of the Region's most consequential unfinished mandates. Afghanistan and Pakistan are the last two countries globally with endemic transmission of wild poliovirus type 1 (WPV1). Additionally, Djibouti, Palestine, Somalia, Sudan and Yemen continue to respond to outbreaks of circulating vaccine-derived poliovirus (cVDPV). In June 2026, Palestine completed 15 consecutive months with no poliovirus detected in either human or environmental samples. The continued spread of cVDPV2 – particularly in northern Yemen, where mass vaccination campaigns have not been permitted since the current cVDPV2 outbreak began in 2021, and in central and southern Somalia where access to children is restricted, with onward transmission across the Horn of Africa – poses a sustained regional risk, exacerbated by population movement and gaps in routine immunization.

167. During the reporting period, WHO continued to play a central role in supporting polio eradication efforts across the Region despite complex humanitarian, security and access challenges. In collaboration with Member States and Global Polio Eradication Initiative partners, WHO supported intensified eradication strategies, strengthened surveillance systems and coordinated outbreak responses to persistent environmental detection, helping to protect high-risk populations. The Polio eradication strategy 2022–2026, extended to 2029, and the Regional action plan for polio eradication 2026, continue to guide these efforts, with a focus on interrupting WPV1 transmission, stopping cVDPV outbreaks and strengthening integration with routine immunization systems. While significant donor contributions – including US$ 500 million for the Global Polio Eradication Initiative over the next five years from Saudi Arabia and US$ 140 million from the United Arab Emirates – have been secured, financing constraints persist, requiring increased efficiency and prioritization. The year 2026 represents a critical epidemiological window of opportunity to interrupt transmission, especially in the endemic countries.

168. Following intensified transmission in 2024, WPV1 declined in Afghanistan and Pakistan during 2025 and early 2026. Transmission is increasingly confined to specific geographical areas, reflecting the impact of strengthened programme strategies, improved campaign quality and sustained political engagement.

169. Progress has been most evident in the northern cross-border corridor – Afghanistan's East Region and Pakistan's Peshawar bloc – where strengthened coordination, improved microplanning and enhanced community engagement have reduced the number of missed children during vaccination campaigns and limited virus detection. Cross-border synchronization of vaccination campaigns and joint planning mechanisms have played a critical role in reaching mobile and underserved populations.

170. However, southern transmission zones remain the primary challenge. Southern Khyber Pakhtunkhwa and Karachi in Pakistan, and the South Region of Afghanistan, continue to harbour concentrated transmission, cause paralytic polio cases and facilitate the spread of virus nationally and internationally. Persistent access constraints – linked to insecurity, population movement and operational restrictions – continue to result in missed children. At the same time, refusals driven by social and trust-related factors require targeted community engagement and social mobilization strategies.

[15] Article 1 of the International Health Regulations (2005) (IHR) defines a public health emergency of international concern (PHEIC) as "an extraordinary event which is determined to constitute a public health risk to other States Parties through the international spread of disease and to potentially require a coordinated international response". On 5 May 2014, following the advice of the IHR Emergency Committee, the WHO Director-General determined that the international spread of wild poliovirus constituted a PHEIC and issued corresponding Temporary Recommendations under the IHR. The poliovirus situation continues to constitute a PHEIC, with the IHR Emergency Committee most recently recommending the extension of the Temporary Recommendations in March 2026.

171. WHO supported both countries in implementing programme adjustments to improve the quality of supplementary immunization activities, strengthen oversight and accountability, and enhance efforts to reach high-risk populations. In Afghanistan, optimization of the site-to-site vaccination approach improved access and acceptance, while polio programme assets were leveraged to strengthen routine immunization in high-risk areas. In Pakistan, intensified implementation of the National Emergency Action Plan – including strengthened oversight, revised microplanning and a renewed operational focus in high-risk districts informed by a 2025 programme audit in Karachi – contributed to improved campaign performance.

172. The Polio Legacy Challenge – led by the governments of Qatar, Saudi Arabia and the United Arab Emirates with support from the Gates Foundation – continued to link eradication efforts with broader health system strengthening through results-based financing, reinforcing accountability and performance.

173. High-level oversight missions sustained political commitment while highlighting the need for measurable improvements in remaining transmission zones. Measures to support the safety, retention and effectiveness of female frontline workers were maintained, recognizing their essential role in reaching children in underserved communities.

Containing vaccine-derived poliovirus outbreaks

174. WHO also coordinated responses to cVDPV outbreaks in several fragile and conflict-affected settings. Despite severe operational constraints, these efforts contributed to measurable progress in interrupting transmission in multiple contexts.

175. In Djibouti, response activities continued following outbreaks of cVDPV type 1 (cVDPV1) and cVDPV type 2 (cVDPV2) detected in 2024 and early 2025. The last confirmed detection was reported in May 2025; no additional cVDPV has been detected since then. Sustained vigilance remains essential given the role of Djibouti as a regional transit hub.

176. In Palestine, vaccination campaigns conducted during humanitarian pauses reached more than 600 000 children aged under 10 years in February 2025, achieving high coverage despite access constraints. Following the ceasefire in October 2025, three multi-antigen catch-up campaigns were conducted across the Gaza Strip, reaching an estimated nearly 36 000 children and strengthening protection against vaccine-preventable diseases after two years of conflict and service disruption. No further poliovirus detections have been reported since March 2025, although low-level transmission cannot be ruled out.

177. In Somalia, the world's longest-running cVDPV2 outbreak continues, with persistent transmission mainly in central and southern areas amid insecurity and access limitations. Cross-border coordination within the Horn of Africa has been strengthened through interministerial engagement to align and enhance outbreak response activities to prevent international spread.

178. In Sudan, WHO supported outbreak response campaigns and emergency surveillance measures, including cross-border laboratory arrangements, to sustain detection and response capacity. The use of novel oral polio vaccines contributed to high coverage in high-risk areas.

179. In Yemen, the absence of mass polio vaccination campaigns in the northern governorates since 2021 has contributed to continued transmission of the virus, compounded by disruptions to surveillance systems. Conversely, vaccination campaigns and strengthened routine immunization in southern governorates have helped improve population immunity.

180. Population movement within the Horn of Africa and onwards to Yemen and neighbouring Gulf States continues to heighten the risk of cross-border transmission of infectious diseases and other emerging public health threats. In May 2026, a ministerial consultation involving Djibouti, Somalia, Sudan and Yemen was convened on the sidelines of the 79th World Health Assembly to strengthen regional health cooperation and mitigate these risks. In Yemen, the national malaria control programme reported an increase in the

number of *Plasmodium vivax* cases, particularly in governorates hosting refugee and migrant populations.

Strengthening surveillance, laboratories and containment

181. Surveillance systems remain a cornerstone of eradication efforts. WHO supported Member States in strengthening acute flaccid paralysis and environmental surveillance, expanding coverage and maintaining a robust regional laboratory network. Environmental surveillance is now conducted in 18 of 22 countries and territories across more than 400 sites, with further expansion planned.

182. The inauguration of a regional environmental surveillance laboratory in Tunis in December 2025 significantly enhanced diagnostic capacity and reduced reliance on external networks. Surveillance for immunodeficiency-associated vaccine-derived poliovirus has also expanded, strengthening detection of less common transmission pathways. In Sudan, emergency measures ensured continuity of surveillance despite conflict.

183. All countries have completed Phase I of the Global Action Plan III for poliovirus containment. Progress on containment certification continues, although variations in national approaches underscore the need for sustained monitoring to maintain global standards.

Equity, gender and community engagement

184. Gender equity remains central to eradication efforts. The Regional Director serves as a Gender Champion for the Global Polio Eradication Initiative, advocating to reach every child and empower women in the final phase of eradication. Gender considerations are integrated into campaign planning and community engagement, particularly in areas with persistent refusals or access barriers. Evidence increasingly shows that the children most likely to be missed are in communities where trust, social norms and gender dynamics – not geography – determine access. In Afghanistan and Pakistan, targeted measures to support the safety, retention and effectiveness of female frontline workers have been maintained, recognizing their essential and often irreplaceable role in gaining entry to households and communities where male vaccinators cannot operate. In Yemen, expansion of community-based service delivery, including malaria case management and deployment of approximately 7000 community midwives, strengthened access to essential care in remote and hard-to-reach communities.

Polio transition and sustaining gains

185. Progress continues in transitioning polio assets into national systems. Iraq, Libya and the Syrian Arab Republic have completed transition, while Somalia, Sudan and Yemen have integrated essential functions but remain reliant on external financing. Afghanistan, Pakistan and Somalia continue to depend on support from the Global Polio Eradication Initiative owing to ongoing transmission, with transition planning to follow interruption. Experience underscores the need for early planning, integration with routine immunization and securing domestic financing to sustain gains.

186. Despite measurable progress – including reductions in WPV1 transmission and no further detections in Djibouti and the Gaza Strip since the first half of 2025 – poliovirus transmission persists in the Region's most challenging settings. The remaining reservoirs in southern Afghanistan and Pakistan present a critical opportunity: the tools to interrupt transmission exist, and 2026 is a key epidemiological window of opportunity.

REGIONAL PRIORITY 5 (POWER)

Improve knowledge sharing and evidence-based policy-making and expand digital health to enhance public health



Strengthening health information systems and advancing digital transformation

187. Across the Eastern Mediterranean Region, fragmented information systems, weak civil registration and limited institutional capacity have long constrained evidence-based decision-making. Data have often been siloed, of variable quality and insufficiently used at the subnational level – weakening service delivery, surveillance and accountability.

188. During the reporting period, WHO supported a shift towards more integrated, nationally-owned digital health and evidence ecosystems. This transformation is anchored in two key regional frameworks: the health information systems strategy (2024) (EM/RC71/6-Rev.2) and the regional digital health strategy (2022) (EM/RC69/8), which together provide a comprehensive architecture for strengthening data governance, interoperability and the systematic use of evidence in policy and planning. These efforts contribute directly to GPW 14's emphasis on digital transformation as an enabler of stronger health systems, universal health coverage and health emergency preparedness.

189. Implementation of the regional health information systems strategy is translating into measurable progress. All 22 countries and territories completed the WHO Survey, Count, Optimize, Review, Enable (SCORE) or Health Data Technical Package assessments, establishing a baseline for reform, and 16 countries updated their national health information systems or digital health strategies, strengthening governance and accountability. Capacity-building has advanced in parallel, including large-scale training in International Classification of Diseases coding and digital systems to support a skilled workforce.

190. Countries are consolidating fragmented systems into interoperable national platforms. Twelve countries have adopted DHIS2 to integrate surveillance, service delivery and programme data. In Iraq, institutionalization of DHIS2 as a unified national platform has enabled real-time reporting across programmes and strengthened early warning capacity. In Palestine, expansion in the West Bank improved data management, while cloud-based migration in the Gaza Strip helped preserve critical health data and facilitate the ongoing, phased restoration of functionality following widespread destruction. In Somalia, rollout across 548 facilities has enhanced surveillance and decision-making. In Sudan, DHIS2 was used for the first time to monitor the distribution of insecticide-treated nets nationwide and inform tracking surveys, strengthening real-time programme monitoring and decision-making. WHO also supported digital transformation through the development of a national digital health concept note and expanded the use of digital platforms for health information management and service delivery.

191. Digital transformation is advancing across health systems regionwide. In Bahrain, WHO supported implementation of the World Health Survey Plus, strengthened health-related monitoring and reporting on the Sustainable Development Goals, and enhanced mortality surveillance through training on the tenth revision of the International Classification of Diseases (ICD-10) and the ICD-11 coding. Egypt is advancing electronic health records to strengthen continuity of care and improve service efficiency. The Islamic Republic of Iran has institutionalized electronic prescribing within a national eHealth architecture. In Jordan, all Ministry of Health primary health care centres are expected to be connected to the Hakeem health information system by 2026, representing a major milestone in the country's digital health transformation. Jordan has also launched a virtual hospital and expanded telemedicine services. Libya established a national digitalization framework with a dedicated governance arrangement. In Oman, WHO supported the integration of digital safety tools and data governance frameworks into primary health care, embedding quality and patient safety management within routine service delivery. Pakistan approved a costed national digital health framework and launched the One Patient, One ID initiative. Saudi Arabia continues to demonstrate advanced digital maturity through virtual hospitals and artificial intelligence (AI)-enabled care.

192. Digital innovation is also strengthening emergency preparedness and response. WHO continued to develop and deploy the AI-enabled All-Hazards Information Management toolkit, which supports rapid generation of risk assessments, public health situation analyses and response plans. By accelerating the analysis and use of health information during emergencies, this toolkit is helping countries and WHO teams make faster, evidence-based decisions while strengthening preparedness capacities.

193. Progress is also evident in civil registration and vital statistics. Some 75% of countries and territories now operate sustainable systems for birth and death registration. In Lebanon, WHO supported modernization of mortality reporting through the introduction of a DHIS2-based hospital mortality and cause-of-death statistics system. More than 200 health professionals from 129 hospitals were trained in mortality reporting and death certification. In Morocco, digital transformation increased death registration coverage from 30% to 47%, more than doubled processed death certificates and reduced ill-defined causes of death. Qatar is using the WHO International Classification of Functioning, Disability and Health to inform the development of its updated national disability strategy.

194. Digital health is proving critical in fragile and conflict-affected settings. In Afghanistan, Somalia, the Syrian Arab Republic and Yemen, digital platforms support outbreak detection, mortality surveillance and service delivery despite damaged infrastructure. In Palestine, digital systems are helping to sustain service continuity under severe constraints, while in Sudan, telemedicine is expanding access to mental health and gender-based violence services.

Ensuring WHO health leadership through convening, agenda-setting, partnerships and communications

195. WHO has played a key convening role in advancing regional alignment on digital health and data governance. Adoption of the regional strategies on health information systems and digital health has strengthened coordination, governance and shared standards across countries, while supporting implementation of the WHO Pandemic Agreement through stronger surveillance, interoperability and data-sharing systems.

196. The Islamic Republic of Iran approved a national eHealth roadmap, while Libya accelerated its digital health transformation agenda through the development of a Digital Health Strategic Blueprint (2026–2030) and strengthened coordination mechanisms for integrated health information systems. In Jordan, WHO supported strengthened interoperability between DHIS2 and Hakeem, creating a more integrated national digital health ecosystem and improving the use of data for decision-making; this contributed to an increase in reporting of the Sustainable Development Goal 3 indicators from 36% in 2023 to 76% in 2025. In Palestine, national health information system coordination mechanisms were reactivated, reinforcing governance and alignment across the health sector. Saudi Arabia's National Health Command Centre was designated a WHO Collaborating Centre, providing regional leadership on interoperability and digital health transformation.

197. The Region is increasingly contributing to global innovation and collaboration. Implementation of the International Patient Summary during Hajj 2024 has enabled real-time cross-border data exchange to continue at scale. Regional platforms such as the World Innovation Summit for Health and WHO-supported AI initiatives are advancing research, innovation and governance, while the planned Regional Technical Advisory Group on AI in Health will support safe and equitable adoption of emerging technologies. WHO's 68 collaborating centres across the Region are an important part of this ecosystem, supporting knowledge generation, capacity-building and the translation of innovation into practice across countries.

198. Collaborating centres in the Region support WHO's work across a wide range of areas, including health systems and policy, communicable and noncommunicable diseases, maternal and child health, rehabilitation, nutrition, nursing, patient safety, mental health and substance use, emergency preparedness and response, and

infectious diseases such as malaria, HIV/AIDS, TB, neglected tropical diseases and viral haemorrhagic fevers.

199. The National Health Emergency Operations Centre at the Saudi Ministry of Health, a WHO Collaborating Centre for Disaster and Emergency Management, strengthened its partnership with WHO by combining WHO's normative and coordination role with the centre's operational and technical expertise. Through study tours, hybrid training and direct support to Member States, the centre advanced capacity-building in governance, staffing and operational readiness across the Region.

200. The WHO Collaborating Centre for Early Childhood Development and Developmental Disabilities at Sultan Qaboos University in Oman developed Arabic versions of the WHO Care for Child Development Package and WHO Global Scales for Early Development to support regional scale-up. Meanwhile, the WHO Collaborating Centre for Research and Training on Substance Use Disorders and Mental Health at Tehran University of Medical Sciences in the Islamic Republic of Iran conducted a comprehensive review and meta-analysis on drug use, treatment services, and the prevalence of HIV and hepatitis B and C among people who inject drugs.

201. The Network of Institutions for Evidence and Data to Policy (NEDtP) expanded to 35 member institutions from 22 countries and territories in 2025, including 18 academic institutions, alongside one observer institution from the African Region. The network continues to strengthen regional capacity for evidence-informed policy-making and knowledge translation. Health research output in the Region has doubled in recent years, from 6.7 publications per 100 000 population in 2018 to 12.3 publications per 100 000 population in 2025, with 17 countries recording a substantial increase.

Expanding access to WHO normative products

202. WHO supported countries to institutionalize the use of evidence in policy development, moving from ad hoc analysis towards embedded national systems. In Kuwait, application of WHO's rapid advice tool led to integration of evidence-informed approaches into the national health strategy (2024–2030). In the Syrian Arab Republic, this tool informed the development of a national strategy for evidence-informed health policies.

203. Uptake of WHO normative and technical products is also expanding. In Egypt, a national clinical guideline development programme was established, with more than 200 stakeholders trained and a nationally endorsed roadmap launched. In the Islamic Republic of Iran, WHO supported an integrated process for conducting health technology assessment studies across relevant authorities to strengthen evidence-informed decision-making in the development and revision of universal health coverage health insurance benefit packages. In Pakistan, WHO support strengthened the national clinical research ecosystem. In 2025, national health research prioritization was conducted in Qatar through collaboration between the Ministry of Public Health and WHO, helping align research efforts with national priorities and resource allocation.

204. WHO supported regional expert engagement and intercountry consultations to strengthen the conduct and governance of randomized clinical trials across countries in the Region. These efforts enhanced national capacities for high-quality trial design, implementation and oversight, while fostering collaboration and consistency in governance of such trials across Member States.

205. In 2025, WHO delivered a webinar series featuring leading institutions and internationally recognized experts to advance key elements of evidence-informed policy-making. The series covered core concepts and emerging priorities, including advances in evidence synthesis and the use of AI to enhance the efficiency, quality and timeliness of evidence generation.

206. The Eastern Mediterranean Health Journal continued to play a key role in addressing public health challenges and promoting innovation across the Region. In 2025, the journal produced several special editions aligned with regional priorities, including two focused on emergencies and conflict in the Gaza Strip, providing timely evidence and critical analysis to inform policy and practice.

REGIONAL PRIORITY 6 (PERFORM)

Optimize WHO's performance to boost cooperation and better influence global health



Strengthening country office capacity and leadership

207. WHO has strengthened its country-focused operating model in the Region to ensure support remains aligned with Member States' priorities and directed where needs are greatest. In line with the Regional Strategic Operational Plan and GPW 14, country offices have been empowered through more structured programme management, greater delegation of authority and responsibilities, and increased operational capacity.

208. More than 70% of regional resources for base programmes were allocated to country offices across the 2024–2025 and 2026–2027 biennia, bringing decision-making and implementation closer to Member States. The Core Predictable Country Presence (CPCP) model was replaced by the Core Country Operating Model (CCOM) from 2026 onwards, with the CCOM further expanding country presence through the establishment and recruitment of 115 new, funded long-term priority positions in country offices, reinforcing technical and operational capacity where needs were greatest. Targeted capacity-building for teams covering operations, human resources, strategic and operational risk management, prevention of and response to all types of misconduct, including sexual exploitation and misconduct, finance and procurement further strengthened country-level ownership, responsiveness and accountability.

209. Enhanced and clarified delegation of authority to WHO representatives brought decision-making closer to implementation, enabling faster, risk-informed action while maintaining strong oversight through reinforced compliance and risk management systems. This proved particularly important in emergency settings, where timeliness is critical to sustaining life-saving operations.

210. A phased and disciplined prioritization of human resources ensured that capacity was aligned with operational risk and critical needs. Across three rounds of review, positions were assessed based on criticality, with a focus on Grade 3 and Protracted Grade 3 emergency countries – protecting essential functions and frontline delivery in the most fragile contexts. This approach balanced fiscal constraints with the imperative to sustain WHO's presence and impact where it is most needed.

211. Investments in leadership and workforce development strengthened country-level capacity. The WHO Representative preparation programme – including structured leadership bootcamps, induction processes, assessment pathways and succession planning – strengthened leadership pipelines and readiness for senior roles, while real-time human resources dashboards and workforce planning tools improved transparency and responsiveness across the Region.

212. WHO institutionalized a more flexible and context-adapted approach to Country Cooperation Strategies in the Region. This strategic shift ensured that support remained high-quality and timely, while closely aligning with the Regional Strategic Operational Plan and regional flagship initiatives, as well as with national health plans. During the reporting period, four countries (Egypt, Lebanon, Qatar and Tunisia) finalized and endorsed their strategies, while three countries (Jordan, Oman and Somalia) completed strategy evaluations.

213. Country impact was further reinforced through high-level engagement and health diplomacy. Nine country visits by the Regional Director facilitated direct dialogues with heads of state, ministers and partners, translating into concrete policy actions, strengthened multisectoral collaboration and increased resource mobilization. These engagements helped advance reforms across universal health coverage, health security and health system resilience.

Enhancing regional coordination and governance

214. Collaboration within the United Nations system was also strengthened. The Regional Health Alliance, comprising 18 United Nations agencies, was restructured around shared priorities and operationalized through joint action plans, enabling more coordinated and effective delivery at country level. WHO's leadership in this platform ensured that health remained central within broader development agendas. A series of high-level coordination meetings were held, including

three dedicated meetings on the flagship initiatives to define areas for collaboration and joint work, with a focus on achieving country-level impact. A high-level meeting was held to accelerate action on maternal, newborn and child health and strengthen support for polio eradication in six high-burden countries,[16] with a planned framework to integrate these services into existing platforms.

215. Governance, risk management and accountability systems were further strengthened through implementation of regional risk management frameworks, compliance dashboards and financial assurance mechanisms. Financial assurance workplans were rolled out across the Region, while third-party monitoring arrangements were strengthened in high-risk operating environments. Improvements in audit performance and a reduction in outstanding recommendations reflected stronger internal controls and increased organizational accountability.

216. Member States' visibility and influence in WHO governing bodies were strengthened through improved preparedness, closer coordination between capitals, the Permanent Missions Health Group and an effective coordination role in Geneva, alongside a rethinking of Regional Committee processes. These improvements enabled more strategic and coherent engagement, resulting in a more proactive regional presence and greater impact on outcomes, including strengthened participation in global health governance and negotiations such as those on the WHO Pandemic Agreement. Regional cooperation was further strengthened through the Quadripartite Ministerial Health Cooperation Agreement among Djibouti, Somalia, Sudan and Yemen, which established a platform for ministerial coordination on shared health security priorities, cross-border surveillance, migrant health and climate-related health challenges.

[16] Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen.

Expanding partnerships

217. Amid declining development assistance and major shifts in the global health architecture, WHO strengthened its convening and stewardship role to keep health firmly positioned within regional political, economic and development agendas. The Regional Office expanded engagement with a broad range of partners, recognizing that increasingly diversified and strategic partnerships are essential to sustain progress in an evolving global financing environment. Engagement with the Organisation of Islamic Cooperation, the Islamic World Educational, Scientific and Cultural Organization and the League of Arab States led to the integration of WHO priorities – including universal health coverage, antimicrobial resistance, mental health and emergency preparedness – into regional strategic frameworks. A high-level dialogue co-hosted with the Islamic Centre for Development of Trade announced plans to establish a coalition for Islamic financing for health to advance innovative health financing mechanisms such as Zakat and Waqf[17] as potential sources of sustainable health investment.

218. WHO expanded its partnership portfolio in the Region through 19 new agreements at global, regional, interregional and country levels. These collaborations delivered tangible results, including strengthened surveillance and civil registration systems with the United Nations Economic Commission for Africa; expanded immunization and measles elimination support in Afghanistan and Pakistan through the IFRC; updated multisectoral national antimicrobial resistance action plans in Iraq and Pakistan; implementation of the AMR Future Fighters youth engagement and leadership programme in Egypt in collaboration with ReAct Africa; and

[17] Zakat is an obligatory form of charitable giving in Islam, whereas Waqf refers to an Islamic charitable endowment, the proceeds of which can be used to support social services, including health. Instruments such as Zakat and Waqf are grounded in principles of equity, solidarity and risk-sharing, and can help to finance services for vulnerable populations, strengthen pooling arrangements and enhance financial protection. When effectively governed and integrated into national systems, these mechanisms can contribute to more sustainable domestic health financing systems.

development of a mental health preparedness monitoring tool with the United Kingdom Health Security Agency. Engagement also expanded with multilateral development banks and philanthropic partners, complementing traditional partnerships and broadening opportunities to support country priorities.

219. WHO also deepened engagement with youth and civil society, institutionalizing more inclusive governance and decision-making. More than 50 civil society organizations participated in the first regional meeting for the WHO Civil Society Commission Steering Committee, while the EMR Youth Council contributed to 15 regional and global forums, including the 72nd session of the WHO Regional Committee for the Eastern Mediterranean, the launch of the State of the world's nursing report 2025 and engagement with the second *Lancet* Commission on Adolescent Health and Wellbeing (launched on 21 May 2025). Internally, phase 2 of the regional partnership capacity-building programme trained 40 staff, while new standard operating procedures, performance review mechanisms and a partnership mapping and tracking platform were developed to strengthen accountability, transparency and results-based management across WHO's partnership portfolio. These efforts strengthened WHO's capacity to develop, manage and sustain strategic partnerships that support the delivery of the Regional Strategic Operational Plan, the Regional Director's flagship initiatives, and GPW 14 priorities.

Strengthening delivery for impact

220. Operational performance improved through a combination of process simplification, strengthened accountability and digital transformation. By early 2026, 83% of workplans for the 2026–2027 biennium were managed through WHO's new Business Management System (BMS), improving planning discipline, transparency and real-time monitoring. More than 800 personnel were trained to support implementation of integrated planning, budgeting and reporting tools. Operational discipline remained high, with 99% compliance in the performance management and development system, supported by strengthened workforce planning and performance monitoring mechanisms.

221. WHO accelerated its transformation in the Region towards a more integrated, results-driven and accountable operating model. A comprehensive organizational realignment – including a revised organigramme, workforce mapping and reallocation of functions – aligned the Organization's structure with strategic priorities and projected resources. As part of WHO's Organization-wide reprioritization and readiness for GPW 14, the Regional Office completed a large-scale workforce review involving the abolition of more than 300 positions, more than 60 staff separations, and a Region-wide mapping and matching exercise to align staffing with priority functions and available funding.

222. Results-based management and theory-of-change approaches were institutionalized across the programme cycle, linking prioritization, planning, budgeting, implementation and evaluation. This enabled a shift from activity-based reporting to clearer articulation of outcomes and impact, supported by strengthened country intelligence and data systems.

223. Accountability mechanisms were reinforced through expanded independent evaluations. WHO's contributions in five countries (Jordan, Lebanon, Oman, Somalia and the Syrian Arab Republic) were evaluated by independent specialized firms to inform strategic repositioning and new Country Cooperation Strategies. Structured management responses and piloting of joint WHO–Member State contribution assessments were also conducted.

224. The Regional Office began regular operational planning dialogues between country offices and the Regional Office for the 2026–2027 biennium. This marked a shift towards more structured, results-focused engagement between country offices and regional technical departments. The process ensures coherence between GPW 14, the Regional Strategic Operational Plan and country workplans; realistic indicator target-setting in light of financial and human resource constraints; and strengthened shared accountability across the three levels of the Organization. The effective rollout of the System for Programme Management (SPM) as part of the new BMS, which replaces the Organization's current enterprise resource planning system, further consolidated integration and transparency across planning and budgeting platforms.

225. Organizational culture and workforce performance were strengthened through enhanced human resource systems and accountability frameworks. Leadership development, continuous learning and structured change communication supported staff adaptation during a period of significant transformation.

226. Safeguarding and staff well-being remained central to organizational resilience. Expanded counselling services, targeted psychosocial support and the work of the Regional Ombudsperson – who addressed more than 200 cases – helped maintain a supportive and functional workplace in high-pressure environments.

227. WHO also significantly strengthened its systems to prevent and respond to sexual misconduct. Dedicated coordinators and technical officers were deployed in high-risk countries, supported by systematic risk assessments integrated into emergency planning. Innovative country-level approaches, including community-based reporting mechanisms, Afghanistan's Prevention of and Response to Sexual Misconduct (PRS) Champions programme, Jordan's contract-linked compliance model and Somalia's Patient Rights Corners, improved accountability and access to reporting mechanisms.

228. Strategic media engagement expanded during the reporting period: 86 media interviews were conducted, including more than 40 with the Regional Director; five press conferences were held, primarily focused on health emergencies; 11 opinion editorials were placed in major international and regional outlets; and more than 180 press releases, web stories and statements were issued. Media monitoring recorded more than 470 000 regional mentions of WHO during the reporting period. Four regional town halls were held, with average participation ranging from 200 to 700 colleagues.

229. Programme communications marked more than 46 health observances, with major campaigns covering World No Tobacco Day, World Patient Safety Day, 16 Days of Activism against Gender-Based Violence, World Blood Donor Day, World AIDS Day and World Antimicrobial Awareness Week, coordinated across WHO levels. More than 2500 posts generated nearly 600 000 engagements and nearly 30 million impressions across six social media platforms. The website attracted more than 2.68 million users and more than 4.5 million page views.

230. Coverage of the 72nd session of the Regional Committee in 2025 demonstrated the impact of integrated communications delivery: 1735 media articles were generated – a 2.4-fold increase in coverage from the 71st Regional Committee in 2024 – alongside nearly 22 000 website page views and more than 11 500 social media engagements.

Securing flexible and predictable funding

231. WHO operated under significant financial pressure during the reporting period, driven by declining donor contributions, sustained reductions in official development assistance, shifting donor priorities and competing priorities for development financing. During 1 July 2025–30 June 2026, the WHO Eastern Mediterranean Region mobilized and distributed an estimated US$ 690 million in voluntary contributions, sustaining critical programme delivery across the Region. This builds on the strong performance of the full 2024–2025 biennium, during which a total of US$ 1.6 billion was mobilized, representing one of the highest levels of resource mobilization among WHO regions. Yet funding needs continued to exceed available resources. Some 53% of the funds mobilized during the reporting period supported emergency operations and a further 28% supported polio eradication, leaving around one fifth for base programmes. Against the WHO Regional Office for the Eastern Mediterranean's health emergency response requirement of US$ 633 million for 2026, more than 40% remained unfunded as at 30 June 2026.

232. Across the 2024–2025 biennium, more than 90% of the US$ 1.8 billion available to the Region (including all funding sources) – US$ 1.62 billion – was allocated to country offices, reflecting the sustained shift of resources and decision-making closer to countries. During the reporting period, the Regional Office continued to strengthen

financial resilience and stewardship. The donor base included 33 new contributors and nearly half of voluntary contributions were mobilized through multilateral and pooled mechanisms. Through scenario-based planning and prioritization, the Regional Office managed the impact of a regional funding gap of US$ 69.3 million, while maintaining critical programme delivery and directing flexible resources towards emergency preparedness and response. This was achieved through extensive high-level engagement with governments, international financial institutions, philanthropic actors and the private sector.

233. A key strategic shift has been towards more flexible, diversified and predictable financing. Nearly half of voluntary contributions were mobilized regionally through multilateral and pooled mechanisms, improving the Organization's ability to allocate resources based on need and respond to evolving priorities. Although funding opportunities were fewer than in previous years, their average value increased, reflecting sustained partner confidence and larger investments in WHO programmes. The donor base expanded significantly, including 33 new contributors, reducing reliance on a limited number of funding sources.

234. Engagement with GCC Member States evolved into structured, long-term partnerships, generating US$ 116 million in confirmed contributions and a pipeline exceeding US$ 147 million. WHO's strategic partnership with the King Salman Humanitarian Aid and Relief Centre (KSrelief) mobilized US$ 362 million during the 2024–2025 biennium to support emergency responses in the Gaza Strip, Sudan, the Syrian Arab Republic, Ukraine and Yemen, and to advance global polio eradication – bringing cumulative contributions to approximately US$ 755 million across 32 projects in 11 countries and territories, reaching an estimated 98 million beneficiaries and making KSrelief one of WHO's leading humanitarian partners in the Region. The Qatar Fund for Development contributed US$ 6 million to WHO's core voluntary funding during 2025–2026, further strengthening flexible financing for WHO's programme of work. At the same time, innovative financing mechanisms – including contributions to WHO's Investment Round, expanded engagement with the WHO Foundation and exploration of endowment models – opened new avenues for sustainable funding.

235. The 2025 funding disruption required disciplined realignment. The Regional Office undertook structured funding gap analyses, forward resource projections and human resource reviews to align commitments with realistic income scenarios. Tentative budget and flexible resource envelopes were recalibrated for country offices and departments to safeguard strengthened country capacities and identified priorities. Governance mechanisms, including the newly established Programme Governance Committee, reinforced evidence-informed decision-making across the programme cycle.

236. Financial management and oversight were significantly strengthened. The budget and financial services function was enhanced through real-time financial monitoring, scenario-based planning and transparent reporting. Budget centres were supported with financial modelling and resource alignment following major funding reductions.

237. Operational agility was demonstrated through adapted financial responses in emergency settings such as Afghanistan, Palestine and Sudan, ensuring continuity of operations despite disruptions. Strengthened assurance mechanisms – including external capacity assessments, spot checks and audits after implementation – further reinforced accountability and stewardship.

238. WHO supported a reimbursable procurement mechanism to provide the Islamic Republic of Iran with critical operational assistance, helping ensure continued access to essential medicines and vaccines amid international sanctions that had disrupted financial and procurement channels. By leveraging WHO's global procurement platform, the mechanism helped mitigate supply constraints and enable the timely acquisition of essential medical products.

Optimizing business processes

239. WHO advanced a major digital, operational and governance transformation to improve efficiency, standardization and organizational resilience. Regional and country office structures were aligned with strategic priorities, and procurement, human resources and finance processes were streamlined to reduce duplication and improve service delivery.

240. The rollout of the new enterprise resource planning system for WHO facilitated progress in the use of other integrated business management platforms, while modernization of the information technology infrastructure and strengthened governance systems enhanced organizational agility and support to technical programmes operating in some of the world's most complex health emergencies. Core platforms – including the System for Programme Management, Contributor Engagement Management and SAP Concur for travel and expense management – were deployed across the Region, replacing fragmented systems with integrated, end-to-end solutions.

241. These tools strengthened planning, risk management, financial tracking and contributor engagement, enabling more consistent and transparent operations. By March 2026, 83% of workplans for the 2026–2027 biennium had been approved in the new platform, reflecting improved planning discipline and operational readiness.

242. The transition was supported by a comprehensive capacity-building and change management programme. More than 800 staff completed certified training across multiple systems, supported by a network of 281 trained facilitators across all country offices and the Regional Office. User acceptance laboratories, e-learning modules and in-person training accelerated adoption and reduced transition costs.

243. Financial and administrative processes were further strengthened through enhanced delegation of authority, streamlined grant and loan agreement procedures and expansion of digital finance solutions beyond immunization to additional programme areas and countries, including Pakistan and Yemen. These improvements reduced bottlenecks, increased efficiency and strengthened internal controls.

244. Governance, risk management and compliance were reinforced through enhanced risk dashboards, compliance platforms and strengthened oversight committees, improving organizational accountability and decision-making. A network of risk champions embedded risk management across the Organization, while stronger implementation of the Framework of Engagement with Non-State Actors (FENSA) enhanced due diligence in engagement with non-State actors.

245. Assurance mechanisms, including administrative reviews, thematic assessments and targeted follow-ups, improved control effectiveness and accelerated corrective actions. These measures contributed to fewer outstanding audit recommendations and stronger internal audit performance.

246. External reviews and benchmarking confirmed continued progress towards a more mature operating model characterized by stronger governance, integrated systems, sound financial stewardship and greater organizational coherence.



CONCLUSION AND WAY FORWARD

247. The past year was defined by the tension between accelerating health needs and a contracting global health financing environment. Across the Eastern Mediterranean Region, WHO continued to deliver on its mandate under conditions that tested the resilience of health systems, the strength of partnerships and the operational capacity of the Organization itself. Conflict, displacement, climate-related shocks, pandemic threats and the growing burden of noncommunicable diseases did not pause as funding declined. Much of the story of this year is therefore one of sustaining essential services and protecting hard-won gains despite mounting pressures.

248. Against this backdrop, the achievements documented in this report represent more than programme outputs. The recovery of immunization coverage in Sudan from 38% to 71% for Penta3; the reduction of cholera case-fatality rates through rapid laboratory confirmation and vaccine mobilization; the expansion of service coverage for universal health coverage across multiple countries; and the milestones in regulatory maturity and local pharmaceutical production – these outcomes reflect the combined efforts of Member States, partners, frontline health workers and WHO staff working under extraordinary operational and personal pressures. They deserve to be recognized not as routine results but as genuinely hard-won gains.

249. The transition to GPW 14 and the Regional Strategic Operational Plan provides both an anchor and a mandate for the period ahead. The six regional priorities – Promote, Provide, Protect, Polio, Power and Perform – frame WHO's priorities precisely in terms of the Region's deepest deficits. The Region's UHC Service Coverage Index, its emergency burden, its noncommunicable disease mortality rates, and its unmet rehabilitation and mental health needs all point in the same direction: towards a Region that requires, and deserves, sustained and well-resourced WHO engagement.

250. For the coming year, several priorities stand out. Completing polio eradication remains a critical and time-sensitive mandate: 2026 is a unique epidemiological window of opportunity, and the tools to interrupt remaining transmission in southern Afghanistan and Pakistan exist. The same discipline, coordination and political commitment that have contained outbreaks across the Region must now be focused on closing the last reservoirs. At the same time, sustained investment in health systems will be essential to secure broader and more lasting health gains. The regional flagship initiatives on the health workforce, on equitable access to medical products and on substance use are translating regional priorities into measurable country-level action, while advancing progress towards universal health coverage. Progress made in building pooled procurement foundations, strengthening regulatory systems, and expanding local production capacity must be protected and accelerated.

251. The humanitarian portfolio will require continued adaptation. The funding disruption of 2025–2026 – which affected nearly 2000 WHO-supported health facilities and suspended operations in more than half – has demonstrated that the gap between health needs and health financing in this Region is not simply a question of resources, but of political choices as well. Sustaining WHO's ability to operate in the most fragile and conflict-affected settings, protecting health workers' safety and ensuring continuity across the humanitarian–development–peace nexus must remain non-negotiable priorities regardless of the financing environment.

252. WHO enters GPW 14 as a more disciplined, results-oriented and structurally coherent Organization than at the start of the preceding biennium. The strengthened accountability frameworks, the expanded Country Cooperation Strategies aligned with the Regional Strategic Operational Plan, and the maturation of the governance and assurance environment position the Organization to deliver on its renewed mandate with greater transparency and impact. The path ahead is not without risk. Geopolitical instability, financing uncertainty and the breadth of unmet health need in this Region are structural features, not passing conditions. But the work of this past year has demonstrated that WHO, working in partnership with Member States and the broader health community, can advance health equity and save lives even in the most demanding environments. That is the foundation on which the work ahead will be built.

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