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Progress report on health issues facing populations affected by disasters and emergencies, including implementation of the International Health Regulations (2005)

Introduction

1. This report provides an update on WHO's work in health emergencies in the Eastern Mediterranean Region, pursuant to resolution EBSS3.R1 of the WHO Executive Board (2015) and decision WHA68(10) of the Sixty-eighth World Health Assembly (2015).

2. Additionally, the report provides an update on progress in implementing the International Health Regulations (IHR) (2005) in the Region in the context of resolution EM/RC64/R.1 (2017), which deals with the monitoring and evaluation of IHR implementation, and of resolution WHA61.2 (2008), which deals with annual reporting on the implementation of the Regulations by States Parties, under paragraph 1 of Article 54 of the IHR.

3. Finally, the report provides an update on progress in implementing resolution EM/RC68/R.2 on accelerating health emergency preparedness and response – a plan of action, which was endorsed by the Regional Committee at its 68th session in October 2021.

WHO's work in health emergencies in the Eastern Mediterranean Region

Introduction

4. The Eastern Mediterranean Region continues to bear the brunt of complex and protracted health emergencies resulting from multiple hazards – prominently outbreaks, epidemics, conflicts and climate change – leading to increasing vulnerabilities, risks and enormous needs. As of 30 June 2025, WHO was actively responding to 16 graded emergencies across the Region (one third of the WHO global graded emergency burden), including seven complex humanitarian crises, while also monitoring over 53 other public health events. This included six emergencies classified as Grade 3 (the most acute crisis level, requiring a major WHO response), including the conflicts in Palestine and Sudan, the global cholera and mpox outbreaks and the escalation of hostilities in Lebanon and the Syrian Arab Republic.

5. The Region is also home to three of the world's largest displacement crises. Sudan now represents the largest forced displacement situation globally, with 14.3 million refugees and internally displaced persons (IDPs), surpassing the Syrian Arab Republic (13.5 million) and followed by Afghanistan (10.3 million). It hosts 46% of the global IDP burden, with 31.4 million of the world's 67.7 million IDPs residing in the Region. It is also the source of 57% of the world's refugees, with 21.6 million refugees originating from the Region.

6. Fortunately, no major natural disasters were recorded in 2024 or in the first half of 2025. However, the Region was still significantly impacted by extreme weather events: three of the 10 deadliest climate-induced disasters in 2024 occurred in the Region, including heatwaves in Saudi Arabia and Pakistan and severe winter conditions in Afghanistan. These intersecting crises continue to threaten health and livelihoods across multiple countries, making a coordinated response essential.

7. In 2024, WHO responded to 80 disease outbreaks in the Region, more than double the 31 outbreaks reported in 2021. As of 30 June 2025, there were 50 active outbreaks.

8. Conflicts and other crises have left an estimated 115 million people – 15% of the Region's population – in urgent need of assistance, accounting for about one third of the global humanitarian burden. The ongoing

crises in Lebanon, Palestine and Sudan have stretched response capacities to their limits, highlighting the need for stronger support.

9. In this time of overwhelming need, WHO has ensured the continued delivery of life-saving health care in some of the most dangerous and underserved areas of the Region. The Organization continues to adopt an all-hazards approach to managing emergencies. Despite the multiple demands and acute funding constraints, efforts have continued to strengthen both WHO's own capacity and that of its Member States to prevent, prepare for, detect, respond to and recover from health crises. WHO adopts a humanitarian–development–peace nexus approach to emergency response as it works to strengthen long-term emergency management capacities while addressing immediate humanitarian needs. The Region is at a critical juncture, as several of its Member States – such as Iraq, Libya and the Syrian Arab Republic – are embarking on recovery journeys, navigating the complex path from crisis to stability and resilience. In view of this transition, WHO has developed a technical paper to support health system recovery in countries recovering from conflict and fragility, which will be presented to the 72nd session of the WHO Regional Committee for the Eastern Mediterranean. In January 2025, WHO appealed for US$ 856 million to respond to health emergencies and provide life-saving health care to millions of people in need in the Eastern Mediterranean Region. This funding will allow WHO to continue to deliver life-saving medical supplies, keep hospitals running by providing fuel and ensure that communities in crisis receive the health care they need. However, the majority of the appeals in the Region remain critically underfunded, threatening WHO's ability to sustain these vital operations.

10. In 2024, attacks on health care in conflict zones remained a massive problem in the Region, and 2025 has so far been no different. Such attacks are among the most concerning features of modern-day conflicts and remain prevalent despite advocacy efforts by WHO and its partners. During 2024, according to WHO's Surveillance System for Attacks on Health Care (SSA), close to two thirds (1039) of all attacks documented globally (1646) were recorded in the Eastern Mediterranean Region. Attacks were recorded in six countries and territories of the Region, including Palestine (729), Lebanon (149), the Syrian Arab Republic (84), Sudan (72), Somalia (3) and Afghanistan (2), with over half of all global attacks documented in Palestine and Lebanon alone. Globally, attacks on health care led to 750 deaths and nearly 1249 injuries, with the Region accounting for 63% of attacks, 79% of deaths and 70% of injuries documented by the SSA.[1]

11. WHO's Contingency Fund for Emergencies has played a key role in supporting the initial phase of emergency responses in the Region. In 2024, five new awards were issued, in addition to eight carried over from 2023. These funds helped respond to humanitarian crises in Palestine, Lebanon, the Syrian Arab Republic and Sudan and to outbreaks of cholera and dengue. Over the year, US$ 5.8 million was spent from the Fund, primarily on life-saving medical supplies, equipment and technical support, including logistics support and the deployment of personnel to emergency-affected countries.

Preparing for health emergencies

12. Strengthening Member States' capacities to prepare for health emergencies caused by all potential hazards and risks is pivotal to reducing morbidity and mortality. Therefore, supporting national capacities to prevent, detect and prepare for emergencies has been a major priority for WHO across the Region. The COVID-19 pandemic highlighted the critical need to expand efforts to enhance preparedness for all hazards and build resilience against future shocks. The IHR (2005) continue to serve as the legal framework guiding Member States in the Region to develop core capacities for preventing, detecting, investigating and responding to public health events and emergencies. Progress on the implementation of the Regulations is covered in paragraphs 74–87 below.

13. WHO applies the Incident Management System, recognized as a global best practice for emergency response, which is being adopted by some Member States in the Region. The Organization also supports countries to assess their emergency management structures and enhance their preparedness to respond to emergencies caused by high-risk hazards, particularly in countries where health capacities are minimal.

[1] Surveillance System for Attacks on Health Care (SSA) [online database]. Geneva: World Health Organization; 2025 (https://extranet.who.int/ssa/Index.aspx, accessed on 22 May 2025).

14. Regularly updating multi-hazard risk profiles is essential for effective evidence-based planning, prioritization and resource allocation in health emergency and disaster management. For the last few years, WHO has been supporting countries to develop and update their risk profiles and in using them to inform the development of national multi-hazard preparedness and response plans. During 2024, risk profiling workshops were facilitated in Iraq, Jordan, Libya and Qatar, and conducted virtually for the whole of the Syrian Arab Republic. A virtual training course on using the Strategic Tool for Assessing Risks (STAR) was organized for Somalia. Preparations for updating risk profiles are underway in Egypt, Kuwait, Morocco and Tunisia, with plans for implementation in the remainder of 2025. The Syrian Arab Republic developed an all-hazards preparedness and response plan based on the updated risk profile, while the process to update risk profiles was initiated in Qatar and Yemen.

15. WHO continues to place high strategic importance on strengthening Public Health Emergency Operations Centres (PHEOCs) across the Eastern Mediterranean Region, recognizing them as hubs for effective emergency coordination. Having previously supported most Member States in establishing PHEOCs, the current priority has shifted to enhancing their functionality and operational readiness. Both the Global Emergency Operations Centre Functional Simulation Exercise (GEOCX) in November 2024 and the Global Health Emergency Corps (GHEC) Polaris Simulation Exercise in April 2025 tested the activation and coordination capacities of PHEOCs in the Region, with further exercises planned for the remainder of 2025. In parallel, WHO has continued its capacity-building efforts to ensure the effective operation of PHEOCs and has conducted a fourth bi-regional training of trainers in December 2024. A key component of this strengthening agenda is the digitalization of emergency management processes through the continued development and roll-out of the electronic Public Health Emergency Management (ePHEM) software tool. Developed within WHO's Regional Office for the Eastern Mediterranean, ePHEM has emerged as a leading digital solution for public health emergency management – designed to be open-source, highly adaptable and easily scalable to meet diverse country needs. In 2025, ePHEM roll-out continued in Morocco, Yemen, the Africa Centres for Disease Control (Africa CDC) headquarters and more than a dozen Member States beyond the Eastern Mediterranean Region, reflecting its growing global demand and impact. Despite the notable progress achieved by Member States, most PHEOCs continue to face significant challenges. Many centres operate with limited legal authority, restricted access to critical information and a shortage of dedicated personnel. In several contexts, PHEOCs are anchored within specific units or programmes with limited scope or mandates, which hampers their ability to engage the full range of emergency functions and coordinate a comprehensive, all hazards, multisectoral response.

16. To ensure continuity of care during emergencies, WHO supported capacity development for emergency, critical and operative services, including system assessments, workforce training and hospital safety evaluations. As of December 2024, WHO had rolled out emergency, critical and operative care strategic planning and capacity-building initiatives to ensure a continuum of care during emergency situations in Egypt, Iran (Islamic Republic of), Libya and Yemen.

17. Strengthening hospital resilience remains a key focus in the Region. WHO continued to support countries in identifying and addressing vulnerabilities that may disrupt health facility operations during emergencies. A hospital resilience framework and operational guide were developed by WHO to support hospital resilience efforts in the Region. In 2024, the roll-out of the guide was supported in an additional six countries/territories, including Egypt, Oman, Palestine, the Syrian Arab Republic, Pakistan and Yemen, through hospital resilience pilot projects to enhance the capacities of selected hospitals to manage emergencies and disasters. Training was provided to multidisciplinary teams of evaluators from Egypt, Libya, Pakistan, the Syrian Arab Republic and Yemen on the use of the Hospital Safety Index tool to grade hospital safety levels and develop capacities to manage emergencies and disasters, while continuing to provide health services to the affected population.

18. To support research on health emergency and disaster management, WHO is preparing a paper for publication on urban preparedness capacities in selected cities in the Region, with a focus on health capacities and infrastructure alignment, in the context of World Health Assembly resolution WHA75.7 (2022) on strengthening health emergency preparedness and response in cities and urban settings.

19. In response to rising health risks from zoonoses and environmental threats, countries are advancing the One Health approach. A One Health regional taskforce is coordinating all One Health-related WHO activities. Collaboration between Quadripartite organizations at global, regional, subregional and country levels was notably strengthened during 2024, and a regional Quadripartite action plan was developed and endorsed in June 2025, with its implementation currently underway.

20. Capacity-building sessions for One Health professional staff from human–animal–environmental health authorities in the Region were carried out, including a One Health online bilingual course for the Near East and North Africa, in collaboration with the FAO Regional Office for the Near East. In Egypt, a One Health field epidemiology programme was developed and piloted, and professional capacities for prioritizing health threats at the human–animal–environment interface were increased through a training-of-trainers course held in May 2025, facilitated by WHO experts. Two Global Laboratory Leadership Programme (GLLP) webinars and a GLLP regional workshop were held in Muscat, Oman, to support the development of national capacity to respond to outbreaks and health emergencies and sustain national laboratory systems in line with the One Health approach. In Yemen, guidance and tools to establish a One Health coordination mechanism for all relevant national human–animal–environment health authorities were provided, along with the capacity-building of professionals.

21. Continued investments to institutionalize risk communication and community engagement (RCCE) and infodemic management (IM) as an integral component of community protection to reinforce the overall aims of the global architecture for health emergency preparedness, response and resilience continued in 2025. Positioned as a cross-cutting pillar of health emergency management, RCCE-IM has been operationalized through strategic investments in the development of national community protection strategies in the Islamic Republic of Iran and Jordan. Efforts have also focused on integrating RCCE-IM into response plans for crises in Lebanon and Palestine, as well as national strategies in Iraq, Iran (Islamic Republic of), Jordan, Pakistan, Qatar, Somalia, Sudan, Tunisia and Yemen. This was reinforced through regional and national training courses and simulation exercises to test and strengthen capacities, including social listening, and enhance RCCE-IM coordination structures, and through community mapping, context assessments and rapid behavioural research to inform real-time risk communication and targeted community engagement in Iraq, Pakistan, Sudan, the United Arab Emirates and Yemen. Additionally, a regional all-hazards RCCE-IM repository has been developed, housing adaptable messages, tools and guidance on subjects such as cholera, dengue, mental health and psychosocial support, mpox and water, sanitation and hygiene. To enhance behavioural and social intelligence, WHO has expanded Arabic-language social listening training packages and digital monitoring tools, improving real-time community feedback mechanisms. Interagency coordination has been reinforced through the Region's RCCE-IM Interagency Working Group, which co-develops RCCE-IM products and training materials with the United Nations Children's Fund (UNICEF) and the International Federation of Red Cross and Red Crescent Societies (IFRC). The Joint Emergency Action Plan (JEAP), which is a partnership between the Africa CDC and WHO, is yet another example of a shared platform enriching emergency response with direct collaboration with and feedback to communities. The RCCE-IM Technical Working Group within the JEAP is working to harmonize and streamline RCCE-IM activities within the African continent through a continental strategy centred around community engagement. By embedding RCCE-IM within national emergency preparedness and response plans, strengthening community-driven response strategies and advancing behavioural intelligence systems, WHO continues to position RCCE-IM as an essential pillar of resilient health systems across the Eastern Mediterranean Region.

22. Coordination and collaboration between the public health and law enforcement sectors is especially important for the management of intentional and malicious events. In collaboration with security partners (both inside and outside the United Nations), WHO has provided ongoing support to Iraq, Jordan, Lebanon, Qatar, Saudi Arabia, the Syrian Arab Republic, the United Arab Emirates and Yemen to enhance country capacities to prevent and manage events caused by chemical, biological and radio-nuclear agents.

23. WHO continues to encourage and support countries in conducting regular and event-specific risk assessments, contingency planning, simulation exercises and reviews of existing capacities in support of mass gatherings across the Region. A Technical Working Group on Mass Gatherings was established in July 2024, comprising 24 experts from relevant technical units of the WHO Regional Office, to provide holistic strategic and technical support to countries to ensure a cohesive all-hazards approach to mass gathering preparedness and

implementing the regional framework for strengthening public health readiness for mass gatherings in the Region.[2] The Working Group is helping countries to develop the capacities needed for implementation of the framework. To date, coordination meetings and bi-lateral discussions with each unit have been conducted to develop a regional workplan. Additionally, WHO conducted a mapping of planned mass gathering events in the Region to coordinate preparedness and response activities accordingly. During the reporting period, WHO organized technical webinars for countries on conducting risk assessments for mass gathering events, and risk assessments were updated for Arbaeen in 2024 and for Hajj and Umrah during 2024–2025. Mitigation measures and risk communication messages were developed as a result of the risk assessments. For the Hajj season in 2025, WHO developed targeted health messages for pilgrims – covering the periods before departure, during the pilgrimage and after return – to promote full compliance with health requirements and safeguard their well-being. Countries hosting mass gatherings also enhanced their early warning and surveillance systems to rapidly detect, investigate and provide a timely response to public health threats during the events. In addition to enhancing the routine national surveillance system in Iran (Islamic Republic of), Iraq and Saudi Arabia, WHO supported the development of standard operating procedures and the adoption of Epidemic Intelligence from Open Sources (EIOS) for real-time monitoring of health risks associated with these mass gathering events.

24. As developing IHR (2005) core capacity is fundamental to preventing the international spread of disease and achieving global health security, WHO has been closely working with Member States to develop, strengthen and maintain capacities, to respond to public health emergencies of international concern (PHEICs), institutionalize risk-based measures and foster seamless cross-border and regional collaboration. In an evolving situation, WHO provided technical support to Sudan to conduct a risk assessment for the re-designation of points-of-entry (PoEs) as previously designated ones were no longer operational due to conflict. WHO also provided technical support to the Syrian Arab Republic to develop contingency planning for ground crossings amid rising refugee flows from Lebanon. Subregional and country-specific capacity-building workshops were conducted for developing IHR (2005) core capacities at PoEs for Afghanistan, Iraq, Libya, Pakistan, Somalia, Sudan, the Syrian Arab Republic, Tunisia and Yemen. WHO launched Pakistan's first national PoE webinar series, laying the groundwork for a certified-trainer network and curriculum, and supported Iraq in conducting PoE assessments during Arbaeen. Along with the International Civil Aviation Organization (ICAO) and WHO Regional Office for Europe, the WHO Regional Office for the Eastern Mediterranean organized the Joint Meeting of the ICAO Europe and North Atlantic Regional Office together with the ICAO Middle East Regional Office for the Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation (CAPSCA EUR/MID) in 2024 and 2025, to strengthen aviation–health coordination. WHO also supported providing hands-on ship-inspection training for Moroccan port officers. In response to mpox, WHO closely worked with countries to update risk assessments to inform travel measures, monitor travel measures and conduct capacity-building webinars. Moreover, a cross-border collaboration workshop was organized between Algeria, Libya and Tunisia to foster collaboration for the prompt detection, assessment and response to public health threats and meeting their IHR (2005) obligations.

25. Work to establish and strengthen emergency medical teams (EMTs) continued across the Region. In March 2025, the Saudi Disaster Medical Assistance Team (SDMAT) reached the significant milestone of classification by WHO as an EMT Type 2, the first in the Region and the 53rd globally. This recognition marks a pivotal moment for EMTs in the Region. Work to establish and strengthen EMTs is continuing across the Region through mentorship support to Jordan, Libya, Pakistan, Tunisia and the United Arab Emirates. The EMT initiative is playing an increasing role in enhancing preparedness and response in the Region, catalysing a shift towards proactive emergency response strategies. The regional contribution to global efforts was also exemplified by the United Arab Emirates, which hosted the sixth EMT global meeting in November 2024. A regional governance structure with 12 Member State focal points is continuing to standardize emergency medical response systems. During 2024, EMTs were mobilized to support response efforts to crises, including the conflict in the Gaza Strip and Sudan. The EMT coordination cells established in response to the conflicts in the Gaza Strip and Sudan have played an active role in facilitating the deployment of international EMTs and coordination of the emergency response through international and national teams.

[2] Framework for strengthening public health readiness for mass gatherings in the Eastern Mediterranean Region, 2023–2028. Cairo: WHO Regional Office for the Eastern Mediterranean; 2023 (https://applications.emro.who.int/docs/WHOEMIHR020E-eng.pdf, accessed on 22 May 2025).

26. WHO continued to advance efforts to strengthen the capacity of IHR national focal points (NFPs). As part of the IHR NFP community of practice, a series of virtual meetings and webinars were organized to enhance preparedness, operational readiness and response capabilities. During the reporting period, 14 sessions were conducted, covering topics such as the proposed amendments to the IHR, the WHO Pandemic Agreement and other technical areas. In addition, a subregional workshop brought together IHR NFPs to focus specifically on the IHR amendments. This workshop served as a platform to discuss key endorsed changes, including the designation of a national IHR authority, the management of PoEs and the implementation of public health and social measures and communication protocols with WHO. Participants also worked on outlining the structure, roles and responsibilities of both the IHR NFPs and the proposed national IHR authority.

27. The WHO Director-General launched the Universal Health and Preparedness Review in 2020 to assess health security preparedness through the lens of health systems strengthening. Iraq was the first country in the Region, and the second globally, to have completed the first two phases of the review (the pre-review and high-level review missions). In 2024, the first global peer review took place in Geneva; the report for Iraq is expected to be reviewed during the second global peer review in the third quarter of 2025. Negotiations are underway to include more countries from the Region in the Review.

28. The Emergency Health Workforce Initiative bolstered global health emergency preparedness and response through a trifecta of interconnected projects: an intensive regional leadership in emergencies training programme cultivating skilled middle management and visionary health emergency leaders via a blended learning approach; the Joint Action Emergency Plan (JEAP) partnership between the WHO African and Eastern Mediterranean regional offices, to enhance surge capacity, deployment efficacy and robust emergency leadership through a regional network of leaders; and the strengthening of emergency workforce capacities through the GHEC, which concentrates on developing resilient national multidisciplinary teams and establishing a cohesive regional and multiregional network of emergency leaders. In collaboration with prestigious institutions, including Johns Hopkins University, Harvard University, the WHO Collaborating Centre at Imperial College London, the Learning Capacity Development Department at WHO headquarters, the WHO Academy, and the Gates Foundation, the Initiative had successfully trained 596 WHO and ministry of health professionals across five regions as of June 2025. Notably, ministry of health engagement has significantly increased, with 40% of participants now representing national ministries, demonstrating a growing commitment to collaborative preparedness. Furthermore, the initiative has fostered a new generation of leaders through impactful initiatives, such as the multiregional interdisciplinary humanitarian response simulation exercise, conducted in partnership with the Harvard Humanitarian Initiative.

Detecting public health events

29. The world is facing multiple health challenges, including the emergence and re-emergence of infectious diseases, vaccine-preventable diseases, antimicrobial resistance, noncommunicable diseases, the effects of climate change, weak health systems, and conflict, famine and displacement that renders populations vulnerable. The early detection and assessment of acute public health events and emergencies is crucial for informed and effective decision-making to protect and preserve health security. WHO has invested substantial resources in strengthening this core public health function and continues to provide technical support to countries to strengthen epidemiological surveillance, information management and IHR notification and information sharing. This has included the development and customizing of tools to collect, manage and analyse data on public health events and communicate the results of the analysis, while providing support to countries to strengthen their information management capacities and guide their response.

30. As part of this support, WHO detects and assesses potential acute public health events and emergencies for the attention of decision-makers to enable rapid follow-up and response. Between 1 July 2024 and 30 April 2025, 2500 signals were captured, 160 of which warranted verification; 24 of these were new public health events that were monitored, while 15 led to rapid risk assessments and the development and dissemination of public health situation analyses. Public health situation analyses were carried out for the emergency situations in Afghanistan, Libya, Palestine, Somalia, Syrian Arab Republic and Sudan, as well as for the Lebanon hostilities. Rapid risk assessments were conducted for cholera in Palestine and spillover countries (Jordan, Lebanon, the Syrian Arab Republic), measles in Morocco and invasive meningococcal disease in Saudi Arabia. The Regional Office also contributed to the drafting of global rapid risk assessments on cholera and mpox.

31. IHR notification is an important source of the acute public health events recorded by WHO. Between 1 July 2024 and 30 June 2025, 46% (13 of 28) of all acute public health events were notified by Member State IHR NFPs to WHO through the Regional Office for the Eastern Mediterranean. Nine Event Information Site (EIS) posts were published through the EIS confidential platforms for IHR NFPs and seven Disease Outbreak News posts were published on the WHO public website. Additionally, 239 daily bulletins of signals and events were produced and 35 weekly summaries of events disseminated.

32. A joint project of WHO and the United States of America's Centers for Disease Control and Prevention (US CDC) to enhance notification and information sharing for acute public health events by IHR NFPs concluded in October 2024. The project resulted in an increase in the notification rate from 28% in 2022 to 43% in 2024 (a 54% increase), with 55% of Member States responding to verification requests within 48 hours.

33. Following the endorsement of a regional strategy for integrated disease surveillance (IDS) by the Regional Committee for the Eastern Mediterranean in October 2021 and the adoption of the associated resolution (EM/RC68/R.3), WHO intensified its work with countries to improve national surveillance systems in the Region. To support implementation of the IDS strategy, the WHO Regional Office is assisting Member States through a cross-departmental technical working group. This provides strategic guidance and practical tools for national health ministries, offering specialized support in areas such as governance and advocacy, technical guidance, digital platforms and laboratory services.

34. Governance is a cornerstone of IDS. To ensure long-term sustainability, multistakeholder national governance bodies for surveillance have been established in 14 countries, including Afghanistan, Bahrain, Iraq, Jordan, Kuwait, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Tunisia and the United Arab Emirates. These governance structures serve as essential platforms for coordinating surveillance activities, streamlining information flow and ensuring a unified approach to national and regional IDS implementation. Twelve countries, including Afghanistan, Iraq, Kuwait, Lebanon, Libya, Morocco, Pakistan, Qatar, Somalia, Sudan, Syrian Arab Republic and Tunisia, have successfully developed national IDS roadmaps and identified surveillance priorities, creating the foundation for an effective IDS system. Libya and Tunisia have established national IDS coordination bodies, reinforcing their commitment to an integrated, sustainable disease surveillance system. WHO continues to provide tools, training and technical support to enhance national surveillance governance, facilitate IDS implementation and improve reporting systems.

35. WHO continues to advance the collaborative surveillance agenda in the Eastern Mediterranean Region, in collaboration with the Robert Koch Institute (RKI) and the WHO Berlin Hub for Pandemic and Epidemic Intelligence. A public health intelligence initiative (PHI) was piloted in 2024 in Djibouti, Egypt, Jordan and Lebanon, to support countries in establishing and strengthening event-based surveillance (EBS) systems. The project builds on earlier efforts to institutionalize EBS as a core component of national surveillance systems by supporting the integration of data from multiple sources, enhancing analytical capacities and fostering multisectoral coordination for timely detection and response to public health threats. WHO continues to engage with countries that initiated EBS implementation in previous years, who have made good progress in operationalizing EBS as a key element of the IDS approach. Several have developed national guidelines and standard operating procedures to institutionalize EBS, with technical support, training and capacity-building from WHO. These ongoing activities aim to ensure the sustainability and effectiveness of EBS and PHI systems, ultimately contributing to the Region's ability to rapidly detect, assess and respond to public health threats in a timely and coordinated manner.

36. A key advance in early warning and event detection in the Region has been the expansion of the EIOS platform. Two additional countries – Kuwait and Pakistan – and three new entities – the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), the Gulf Centre for Disease Prevention and Control (Gulf CDC) and the Eastern Mediterranean Public Health Network (EMPHNET) – received EIOS training and have integrated the platform into their routine surveillance activities as a result. This expansion reflects WHO's continued commitment to strengthening EBS capacities at national and regional levels. Regular follow-up and technical support have also been provided to the 14 previously-trained EIOS countries and territories – Afghanistan, Bahrain, Egypt, Iraq, Lebanon, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Tunisia and the Syrian Arab Republic – to reinforce effective platform utilization. These follow-up activities include troubleshooting, refresher training, responding to user queries and providing

ongoing feedback to enhance operational use of the platform. In addition, WHO provided targeted support to Member States hosting mass gatherings, such as Saudi Arabia during Hajj, to optimize the use of EIOS for real-time signal detection and risk assessment during high-risk events. Early warning, alert, and response systems have been integrated into existing surveillance systems in Afghanistan, Iraq, Lebanon, the Syrian Arab Republic, Sudan and Yemen to strengthen early detection. WHO also supported Libya and Somalia in incorporating early warning capabilities into national IDS platforms, improving real-time event detection and response mechanisms. WHO conducted regional training in November 2024 on integration of the District Health Information System version 2 (DHIS2)-based early warning, alert and response network (EWARN) to strengthen digital early warning capacities. In Libya, a comprehensive national digital early warning system has been expanded, ensuring nationwide coverage for 47 diseases and conditions, and in April 2024, WHO facilitated a training of trainers course on the system with the National Centre for Disease Control.

37. In fragile and conflict-affected countries, WHO continued to execute a reinforcement strategy for EWARN that included expansion, maintenance, staff capacity-building and rapid response team training. Technical support was provided for integrating an EWARN module into DHIS2 to strengthen real-time surveillance in nine countries/territories implementing EWARN in the Region, namely Afghanistan, Iraq, Lebanon, Pakistan, Palestine, Somalia, Sudan, the Syrian Arab Republic and Yemen. The effectiveness of its implementation is evident in the notably high rates of reporting completeness, even in extremely challenging conditions such as those in Palestine, where the completeness and timeliness of the implementation reached 100% and 90%, respectively. WHO support to strengthen the early warning system in the Region included the development of a comprehensive technical package on prioritizing communicable diseases, including a multicriteria decision analysis tool and a three-day workshop. Piloted in the Syrian Arab Republic (both in the north-west and in other areas), the workshops engaged 60 participants from diverse surveillance and disease programmes, including laboratory and local and international nongovernmental stakeholders.

38. Digitalization plays a crucial role in improving disease surveillance and outbreak detection. A regional assessment confirmed that all countries utilize electronic surveillance platforms, but challenges remain regarding integration and interoperability. WHO has been supporting Member States in transitioning towards digitalized, integrated and interoperable surveillance systems. Somalia and Syrian Arab Republic have now joined Afghanistan, Iraq, Lebanon, Pakistan, Sudan and Yemen in adopting DHIS2 as a national surveillance platform, enabling real-time data collection, standardization and enhanced data sharing across health systems. Iraq recently implemented DHIS2 for EBS, enhancing early outbreak detection and response. Afghanistan and Iraq have developed a DHIS2 training module to strengthen national capacities in communicable disease surveillance, while Yemen has adapted DHIS2 for its immunization programme, demonstrating its potential for expanding digital health solutions beyond outbreak surveillance. To further optimize real-time detection and response, WHO has developed a regional digital adaptation kit to standardize reporting, improve data sharing and automate early warning and alert systems.

39. Recognizing the importance of a well-trained workforce in ensuring efficient and timely public health event detection, WHO has supported field epidemiology training and surveillance capacity-building initiatives across the Region. More than 200 professionals from nine countries have been trained in data visualization and outbreak analytics using Power BI, R and advanced Excel software tools. WHO has supported GIS-based surveillance enhancements, with Somalia launching the GIS Centre for Health and Yemen developing a GIS roadmap for surveillance monitoring. WHO is also working to enhance the use of geospatial and predictive analytics, enabling surveillance officers to assess risk factors and trends more effectively.

40. Data-driven decision-making is a key component of the IDS strategy. WHO is working to enhance the quality, accessibility and use of surveillance data for real-time outbreak detection, and has developed five interactive dashboards and seven automated information products to strengthen regional outbreak monitoring and response. This has improved real-time data visualization and analysis, enabling public health officials to track emerging threats more effectively. Egypt and the Syrian Arab Republic received technical support in setting thresholds for public health interventions, ensuring that response actions are based on surveillance data. WHO collaborated with US CDC, EMPHNET, University of California San Francisco (UCSF) and Applied Epi to develop a regional epidemiological data analysis and dissemination approach.

41. In 2024, the Response Monitoring Initiative was rolled out in Libya, Palestine, Somalia, the Syrian Arab Republic and Yemen to enhance the monitoring of humanitarian health responses in fragile, conflict-affected and vulnerable (FCV) settings. It integrates standardized indicators, tracks health hazards and strengthens digital health systems to improve response effectiveness, accountability and decision-making. The initiative has been expanded to include Sudan and to integrate response monitoring into key frameworks such as WHO's Regional Trauma Initiative and WHO's Fourteenth General Programme of Work (GPW 14). WHO is developing a unified data platform and coordinating with the Global Health Cluster for global adoption. Complementing this, the Health Resources and Services Availability Monitoring System (HeRAMS) operates in nine countries, tracking over 23 000 health service delivery units and guiding resource allocation. Additionally, an Incident Management Support Team (IMST) health information management toolkit, integrating AI-driven analysis to support emergency information management, has been developed and deployed in 2025.

42. Despite progress, several challenges remain in strengthening public health event detection. Limited governance and policy frameworks continue to affect the integration of surveillance efforts at national and subnational levels. Insufficient workforce capacity remains a key challenge, particularly in event verification, rapid response and data analytics. Many countries continue to face fragmented digital surveillance platforms, necessitating enhanced interoperability measures. Political instability and fragile health systems in conflict-affected areas pose additional barriers to the full-scale implementation of IDS components.

43. To address these gaps, WHO will continue supporting Member States by strengthening governance mechanisms for integrated surveillance coordination, expanding EBS and digital surveillance tools, including AI-driven analytics, enhancing workforce training and capacity-building programmes, and increasing investment in IDS expansion and resource mobilization, leveraging existing funding opportunities. WHO is committed to improving the use of emerging technologies such as AI, machine learning and predictive analytics to improve the timeliness and accuracy of surveillance activities. The integration of IDS governance structures into broader health security policies is needed, ensuring sustainability and institutionalization within national health systems. Efforts will also focus on mobilizing resources through mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Pandemic Fund, to sustain long-term surveillance efforts.

44. Through strategic partnerships, digital innovation and robust governance structures, WHO aims to further strengthen disease surveillance in the Eastern Mediterranean Region, ensuring early detection, rapid response and effective outbreak management. The integration of EBS, indicator-based surveillance and digital platforms will remain central to achieving a more resilient, data-driven and coordinated surveillance infrastructure, ultimately enhancing global and regional health security.

Preventing and controlling epidemics and pandemics

45. The Eastern Mediterranean Region continues to face significant public health threats due to outbreaks of emerging and re-emerging infectious diseases and other public health emergencies. The Region's health systems, already fragile, are further weakened by prolonged humanitarian crises and persistent armed conflicts in nine countries and territories. These conditions create substantial barriers to effectively preventing, detecting and responding to infectious diseases, making all countries in the Region extremely vulnerable to epidemics and pandemics.

46. Throughout 2024, COVID-19 continued to negatively impact all 22 countries and territories of the Region, severely taxing health resources, diverting attention from other urgent health priorities and challenging national capacities. WHO actively supported regional responses to COVID-19, while simultaneously assisting 21 countries in managing and responding to 79 additional outbreaks of infectious diseases, including measles (12 outbreaks), mpox (12), dengue fever (11), acute watery diarrhoea or cholera (9), poliomyelitis caused by circulating vaccine-derived polioviruses (6), malaria (5), Crimean-Congo haemorrhagic fever (CCHF) (4), diphtheria (3), West Nile fever (3), Middle East respiratory syndrome (MERS-CoV) (2), travel-associated Legionnaires' disease (2), botulism (2), poliomyelitis caused by wild polioviruses (2), acute gastroenteritis caused by *Escherichia coli* (1), brucellosis (1), meningococcal disease (1), HIV (1), tuberculosis (1) and rabies (1). In 2025, COVID-19 was downgraded to a level 2 protracted crisis. In addition, WHO proactively responded to recent Ebola and Marburg virus disease outbreaks in Africa by supporting seven potentially at-risk countries in the Region, significantly mitigating the risk of international disease transmission.

47. The factors driving these infectious disease outbreaks are numerous and interlinked, including climate change, recurrent natural disasters (floods and earthquakes), weakened public health infrastructure, prolonged conflicts, state fragility, weakened health care systems and large-scale population displacements and migrations. WHO actively responded by providing comprehensive technical and logistic assistance, strengthening surveillance systems, supporting disease investigation, promoting evidence-based public health interventions and limiting the geographical spread of outbreaks, thus effectively reducing their health, social and economic impact.

48. Implementation of the strategic framework for the prevention and control of emerging and epidemic-prone infectious diseases in the Region (2020–2024) has resulted in significant progress in building national capacities for outbreak prevention, preparedness, rapid detection, timely response and effective containment. These efforts markedly decreased the adverse effects associated with infectious diseases throughout the Region. The implementation of the framework has helped contain cholera outbreaks in Lebanon and the Syrian Arab Republic and reduce disease transmission in five other countries. Among seven out of nine outbreaks, case fatality rates remained below 1%, aligning with international standards. Moreover, WHO-supported response efforts, including early diagnosis, treatment protocols and enhanced surveillance, have helped reduce CCHF-related fatalities. Iraq recorded the most notable improvement, with case fatality rates dropping from 18% in 2023 to around 5% in 2024, demonstrating the impact of targeted interventions and improved case management.

49. In 2024, dengue outbreaks emerged as a major public health concern in 11 of the Region's countries. Historically concentrated in fragile and conflict-affected states, such as Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen, dengue has increasingly appeared in middle- and high-income countries, notably Egypt, Oman, Qatar and Saudi Arabia. Unusual rainfall patterns driven by climate change, combined with extensive population movements, have significantly contributed to the expanded geographical spread of dengue. The regional response has been complicated by inadequate surveillance systems, limited diagnostic capacities, delayed and incomplete data sharing, and ongoing armed conflicts, which together heighten concerns about undetected cases and strained public health resources.

50. Responding promptly to its global Grade 3 dengue emergency declaration in December 2023, WHO swiftly developed a comprehensive regional dengue response plan in January 2024. Supported by an allocation of US$ 1 million from the WHO Contingency Fund for Emergencies, targeted response activities were implemented between January to December 2024 in 10 critically-affected countries: Afghanistan, Djibouti, Egypt, Iran (Islamic Republic of), Oman, Pakistan, Qatar, Somalia, Sudan and Yemen. This initiative led to strengthened multisectoral coordination, centralized procurement and distribution of dengue response supplies through a logistics hub in Dubai, significantly improved disease surveillance and laboratory diagnostic capabilities, enhanced case management capacities and adherence to clinical guidelines, comprehensive vector control interventions and intensified RCCE.

51. One of the deadliest diseases in the Region, CCHF, persistently affects four countries: Afghanistan, Iran (Islamic Republic of), Iraq and Pakistan. Efforts have been strengthened in these countries to improve disease surveillance, laboratory-based early confirmation, rapid screening, triage and treatment, as well as RCCE, all within the context of a One Health approach. Currently, clinical research is ongoing in Iraq to establish a gold-standard treatment protocol for CCHF, which does not yet exist globally. This research builds upon a joint WHO–Iraqi government study on the 2022–2023 CCHF outbreaks.[3]

52. Acute watery diarrhoea and cholera remained a significant public health issue in 2024, with nine countries in the Region affected (Afghanistan, Djibouti, Iraq, Lebanon, Pakistan, Somalia, Sudan, the Syrian Arab Republic and Yemen) together reporting 643 080 suspected cases, including 2354 deaths. WHO led a comprehensive multisectoral response, identification of priority areas for multisectoral interventions, oral cholera vaccination campaigns, technical missions and training workshops, and established a regional cholera data hub for improved monitoring. WHO also developed a regional cholera preparedness and response strategy (2025–2028), emphasizing early outbreak detection and rapid response, improved water, sanitation

[3] Kodama C, Alhilfi RA, Aakef I, Khamasi A, Mahdi S, Hasan HM et al. Epidemiological analysis and potential factors affecting the 2022–23 Crimean-Congo hemorrhagic fever outbreak in Iraq. Eur J Public Health. 2025;35(S_1):i6-i13. doi:10.1093/eurpub/ckae147.

and hygiene (WASH) infrastructure particularly at health facilities, enhanced multisectoral collaboration and optimized case management.

53. WHO has continued to assist countries in the Region in establishing, maintaining and improving surveillance systems for influenza and other emerging respiratory diseases. Currently, 21 of 22 countries and territories have developed functional sentinel surveillance systems for influenza-like illnesses and/or severe acute respiratory infections. To optimize resource utilization and enhance the monitoring of respiratory pathogens with epidemic and pandemic potential, SARS-CoV-2 has been integrated into influenza surveillance in 19 countries across the Region. Additionally, 13 countries have successfully implemented the EMFLU 2.0 platform, which introduces advanced data entry features for multipathogen laboratory data and coinfections, along with new analytical tools. This upgrade improves the quality of data shared with WHO, thereby strengthening the overall understanding of the influenza situation in the Region. Building on these efforts, WHO consolidates and analyses country-reported data and has been publishing a weekly bulletin, the Regional Respiratory Virus Activity Weekly Update, since week 36 of 2024, providing insights into the regional trends of both influenza and SARS-CoV-2.

54. WHO has continued to support Member States in generating evidence to support decision-makers in making informed choices regarding vaccine prioritization and resource allocation for influenza. Currently, burden of disease estimates for influenza have been finalized and published in Afghanistan, Lebanon and Saudi Arabia and have been finalized in Jordan and Oman. Additionally, assessments of the burden averted through vaccination have been conducted in Lebanon and Oman.

55. Robust early warning systems and continuous epidemiological surveillance must be underpinned by accurate laboratory diagnostics, as well as prompt and coordinated outbreak investigation and response. During the COVID-19 pandemic, WHO made substantial investments in laboratory infrastructure and capacity-building, which have been strategically leveraged to broaden diagnostic capabilities across a spectrum of high-priority pathogens. This includes the expansion of testing for pathogens that cause arboviral diseases in Afghanistan and Somalia; CCHF in Iraq; cholera in Lebanon, Sudan and the Syrian Arab Republic; and mpox in Egypt, Lebanon and Sudan. However, due to persistent challenges such as high workforce turnover and the protracted nature of complex emergencies in the Region, there is a critical need for sustained support from WHO to preserve and advance laboratory capacity for the detection of epidemic- and pandemic-prone pathogens. In response, WHO continues to provide targeted technical training and capacity-development initiatives tailored to country-specific needs, with a focus on priority diseases, including seasonal and avian influenza, CCHF, MERS-CoV, dengue fever and cholera.

56. As of 2024, COVID-19 sequencing had been maintained in 21 out of 22 countries and territories of the Region, with varying throughput and capacity. Three regional reference laboratories continue to function for genomic sequencing in Morocco, Oman and the United Arab Emirates.

57. Rapid response teams across the Region received comprehensive WHO support through targeted training and technical support. All 22 countries and territories have established functional national and subnational rapid response teams. Effective pilots in Egypt and Saudi Arabia contributed to developing standardized operational procedures and enhanced management structures. Extensive regional training included an Arabic-language rapid response team training programme for 190 participants and specialized outbreak management training for 120 frontline health workers in Kuwait, Lebanon and Oman.

58. Twelve countries – Afghanistan, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Pakistan, Somalia, Sudan, Syrian Arab Republic and Yemen – were assisted by WHO with clinical training, guideline development and integrating priority respiratory diseases into national protocols. Specialized support was provided in conflict-affected areas, notably multidisciplinary clinical services in Sudan, and developing syndromic and antimicrobial treatment protocols for 32 priority diseases in the Gaza Strip. Oxygen scale-up initiatives were supported in 16 countries, with six establishing robust oxygen production capabilities.

59. Despite significant regional progress, substantial challenges remain. Insufficient governmental investment, delays in data sharing, inconsistent reporting and ongoing conflicts continue to hinder effective disease responses. Ongoing WHO support remains essential to strengthen regional preparedness and resilience against epidemic and pandemic threats.

Responding to humanitarian emergencies

60. The Eastern Mediterranean Region continues to bear an enormous burden of humanitarian needs owing to the increasing complexities of conflicts, the impact of climate change, natural disasters, recurrent disease outbreaks and economic crises. In 2025, 115 million people were estimated to need urgent humanitarian assistance, representing an increase from the 107 million people in need in 2024. The Region is home to 9% of the world's population and bears 37% of its humanitarian burden. It is also the source of more than half (58%) of the world's refugees and hosts 40% of global IDPs. The Region continues to see the convergence of crises in many countries with protracted humanitarian needs. In places such as Afghanistan, Lebanon, Palestine, Sudan, the Syrian Arab Republic and Yemen, crises and conflicts continue to hamper population access to essential health services.

61. The scale and complexity of the conflict in the Gaza Strip and the West Bank have resulted in widespread devastation and a surge in humanitarian needs. Between October 2023 and June 2025, the Ministry of Health reported over 55 000 deaths and over 127 000 injuries. The health system in the Gaza Strip is on the brink of collapse, with more than 1500 incidents of attacks on health care, including the destruction of health infrastructure, injuries and deaths of patients and personnel, restrictions on access to care and obstruction of delivery of health services. As of June 2025, only half of the hospitals in the Gaza Strip (17 of the 36) were partially functional, and only 61 of 160 primary health care facilities were functional. The water and sanitation infrastructure had been severely damaged leading to critical water shortage and increased risk for outbreak-prone diseases. Between 12 000 and 14 000 critically ill patients – including 2500 children – still required immediate evacuation, and cases of acute respiratory infections and acute watery diarrhoea had skyrocketed. On 23 August 2025, the Integrated Food Security Phase Classification (IPC) Famine Review Committee (FRC) declared a famine in Gaza Governorate, confirming that three critical thresholds – extreme food deprivation, acute malnutrition and starvation-related deaths – had been breached. The first phase of the WHO 2025 operational response plan included a 60-day ceasefire plan to guide the health sector in meeting the most immediate humanitarian needs integrated with early recovery efforts. Following the breakdown of the ceasefire and resumption of hostilities in March 2025, attacks on health care have intensified, entry of medical supplies and fuel to keep health facilities operational was suspended and EMT deployment denial rate to the Gaza Strip neared 50%. Temporary resumption of limited aid entry was announced by Israeli authorities after 80 days of total aid blockade. Since the beginning of 2024 to June 2025, WHO helped restore hospitals and primary health care facilities and delivered more than 11.9 million litres of fuel and 3000 metric tonnes of WHO-procured medical supplies to health facilities and partners. The medical supplies supported over 6.3 million treatments and surgeries; however, due to the blockade of humanitarian aid, the last shipments reached Gaza at the end of February 2025, resulting in severe shortages of essential medicines. WHO conducted 178 out of 379 initiated missions (while the rest were either denied, cancelled or impeded) to deliver critical medical supplies and transport critical patients on referral and health care personnel. WHO also supported evacuations for more than 5300 critically ill patients for life-saving care abroad. In addition, WHO supported the establishment and operations of six malnutrition treatment centres in the Gaza Strip. EMTs are crucial in enhancing access to essential health services. From January 2024 to May 2025, over 49 EMTs deployed across the Gaza Strip provided over 2.7 million consultations. In response to a polio outbreak, vaccination campaigns were successfully conducted despite unparalleled operational and security challenges, reaching 556 774 children under 10 with type 2 novel oral polio (nOPV2) vaccine. Following the 19 January 2025 ceasefire, WHO maintained its dual focus on evolving humanitarian needs and health systems recovery.

62. The ongoing conflict in Sudan and the resultant acute humanitarian emergency remains the world's largest displacement crisis with over 12. 5 million people forcibly displaced, including 8 million internally. Over 40 000 deaths due to the conflict had been reported as of June 2025. The breakdown of public services, sanitation systems and the scarcity of clean water have created an environment conducive to the spread of infectious diseases. The latest cholera outbreak started in July 2024 and has spread to 92 localities in 13 states, with over 70 000 suspected cases and over 1700 associated deaths. Less than 30% of health facilities are functional in states with active conflict. In August 2025, the IPC warned of Phase 5 (famine) conditions emerging in Al-Fasher, where over half a million civilians remain trapped, with markets destroyed, supply routes cut, and aid deliveries blocked. Moreover, half the population – an estimated 24.6 million people – were reported to be experiencing high levels of acute food insecurity as of June 2025. Over two years of conflict have left the health system in ruins and millions are at acute risk of life-threatening illnesses. Between

mid-2024 and mid-2025, WHO verified more than 104 incidents of attacks on health care, including 1091 deaths and 79 impacts on health care infrastructure. The delivery of humanitarian aid has been severely hampered by widespread violence, looting of aid supplies and access restrictions imposed by conflicting parties. Under the leadership of the federal and state ministries of health, WHO is coordinating the health response to improve access to essential health services, including case management for cholera and other outbreak-prone diseases and severe acute malnutrition with complications. WHO led the establishment of a cross-border operation from Chad in 2023, and in 2024 installed 640 m^2 temperature controlled and cold-chain storage facilities in Abeche. By the end of 2024, US$ 17.7 million worth of medical supplies had been distributed from Port Sudan and US$ 4.7 million worth had been delivered through the cross-border operation. As of June 2025, WHO was supporting 138 operational nutrition stabilization centres with severe acute malnutrition kits and technical support, including operational costs for 47 centres, addressing the high burden of malnutrition across the country. Over 9.9 million oral cholera vaccine doses were administered across eight states between August 2024 and mid-2025. In 2024, 1500 metric tonnes of medicines and medical supplies were delivered to 28 health partners and health authorities in 18 states.

63. The multilayered crisis in Lebanon has left an estimated 3.7 million people in need of humanitarian assistance. A surge in hostilities in October 2024 exacerbated the situation, triggering the displacement of over 800 000 people across the country. By June 2025, over 4300 deaths and 17 741 injuries had been reported across the country. In response to the October escalation, WHO immediately facilitated the shipment of over 116 metric tonnes of critical supplies, including 40 trauma and emergency surgery kits and additional supplies for partners that were distributed to eight frontline hospitals. WHO also supported evaluation of the readiness of the referral hospitals, including audits, technically supported mass casualty management drills for more than 118 hospitals and supported advanced trauma management training for mass casualty incidents, including through training of trainers. WHO further supported a pre-emptive oral cholera vaccination campaign, targeting 350 000 people in the high-risk areas of five governorates, and distributed cholera supplies. Between the start of the escalation of hostilities and the de-escalation, following the November ceasefire agreement between Israel and Lebanon, WHO delivered and supported the distribution of US$ 4.4 million worth of medical supplies to 112 hospitals and health facilities.

64. The health sector in the Syrian Arab Republic has welcomed the recent lifting of sanctions imposed by the United States of America on the country, where 14 years of conflict have devastated the health system, leaving millions without essential medical care and 90% of the population living in extreme poverty. Forced to flee their homes, millions of Syrians have sought refuge in camps and makeshift shelters where food, clean water and health care are scarce. The country is still confronted by unprecedented levels of humanitarian need compounded by still-ongoing hostilities, population displacement, economic decline, disrupted public services, persistent insecurity and an unpredictable political future following the transition of authorities on 8 December 2024. Around 15.8 million people (almost 65% of the population) are in dire need of life-saving essential primary and secondary health assistance in 2025, an increase of 6% from 2024. Overall, 264 out of 270 sub-districts are classified as being under severe or extreme conditions according to the health sector severity scale. As of May 2025, only 57% of hospitals and 37% of primary health care centres in the country are fully functional. Over 30 health facilities in former frontline areas such as Idleb and western Aleppo require urgent rehabilitation. Across north-west Syrian Arab Republic, 172 health facilities are at risk of closure due to abrupt funding cuts, potentially leaving 4.24 million people without reliable access to trauma care, maternal and child health services and chronic disease treatment. In north-east Syrian Arab Republic, 23 facilities have already been suspended, and another 68 are at risk of shutting down. Mental health needs have also surged, especially in conflict-affected areas such as the coast and the south. The population in need of humanitarian assistance in 2025 remained at over 16.5 million. Despite the change in authorities, hostilities have persisted in the north-east and south of the country, particularly in the city of Suwayda and its surrounding villages, causing mainly civilian casualties. WHO has provided medical equipment and supplies to support the health system from Damascus and, in a cross-border approach, to the north-west of the country. WHO has also developed a trauma emergency response and preparedness plan for the north-west of the country to strengthen the capacity of health care facilities to manage trauma cases and mass casualty incidents effectively amid the escalating conflict. Since July 2024, WHO and partners have trained over 2000 people, including 500 health workers and 500 teachers, in suicide prevention and has distributed psychological first aid materials to 1200 humanitarian workers. As part of a cholera vaccination campaign launched on 28 December 2024 in partnership with UNICEF, Gavi, the Vaccine Alliance, and local health authorities, WHO vaccinated over 25 000 people in Al-Hol Camp.

65. The humanitarian crisis in Afghanistan remains one of the world's largest and most severe. In 2025, 22.9 million people need comprehensive humanitarian support, of whom 52% are children and 24% are women. Afghanistan has some of the highest levels of food insecurity in the world, with 14.8 million people experiencing crisis levels of food insecurity and 3.1 million of these, 7% of the population, experiencing emergency levels of food insecurity. While this represents a marginal improvement from 15.8 million people in 2024, any cuts in assistance are likely to result in a sharp rise in admissions to nutrition centres as children slide deeper into hunger. The fourth consecutive year of drought-like conditions has left 20 out of 34 provinces with severe or extremely poor water quality and increased the number of people impacted by drought from 10% in 2020 to 41% in 2024. Today, 21 million people require WASH services, a stark increase from just 2.4 million a decade ago. According to the Humanitarian Needs Overview 2025, needs related to gender-based violence have risen – from 13.3 million people in 2024 to 14.2 million in 2025, and 7.8 million children and women need emergency nutrition assistance to avoid death and disease. Resources are further strained by the influx of returnees from neighbouring countries where more than 8 million Afghan refugees had been hosted. Access constraints, including incidents of interference in implementing activities, restriction on women humanitarian workers, requests for sensitive data and sporadic detention of staff from health partner organizations, challenge the delivery of humanitarian assistance. In 2024, WHO and health cluster partners reached more than 8 million people (representing 66% of those people-in-need targeted) with essential services, including primary health care, secondary care, reproductive, maternal, newborn and child health services, mental health and psychosocial support, trauma care and health promotion. In 2024, 54 623 children under 5 years of age with medical complications were admitted and treated in 141 WHO-supported inpatient centres for the management of severe acute malnutrition across Afghanistan. This represents an 8% increase from the 50 588 children treated in 2023, reflecting the positive impact of expanded coverage and improved health care delivery.

66. Afghanistan has made significant progress against poliovirus in recent years. Following the political transition in 2021, the eradication programme gained access to all areas of the country, enabling a series of vaccination campaigns and reducing the geographical reach of the virus. In 2024, WHO purchased 6241 metric tonnes of essential medicines, diagnostics and medical supplies for around US$ 14 million and services for around US$ 13.4 million, including the rehabilitation of health facilities, benefiting around 14 238 100 people. Reducing funding will impact WHO's ability to sustain health services nationwide. WHO, in collaboration with the Ministry for Public Health, the Health Cluster and the Afghanistan Protection of Sexual Exploitation and Abuse Network, implements a zero-tolerance policy for sexual misconduct in all its programmes.

67. In Somalia, the Humanitarian Needs and Response Plan (HNRN 2025) launched in January 2025 estimates that 5.98 million people need humanitarian assistance, of which 5.4 million (90%) need health assistance, and 2.4 million people have been internally displaced. A total of 3.4 million people are targeted for health assistance. Somalia is grappling with a high burden of infectious diseases, including malaria, respiratory illnesses and ongoing outbreaks of cholera, measles, diphtheria and dengue fever. Limited access to health care services exacerbates these health issues, particularly in rural areas where infrastructure is weak, health care personnel are scarce and health facility density is at an extreme low of 1.69 per 10 000 population. Somalia is still one of the most dangerous places for women to give birth, with a maternal mortality ratio of 621 deaths per 100 000 live births, which is among the highest in the world. The child mortality rate (deaths < 5 years per 1000 births) is 106.

68. According to recent estimates, less than 50% of children in Somalia receive the full schedule of vaccinations, leaving them vulnerable to outbreaks of diseases such as measles, polio and diphtheria. About one in three children (34%) of vaccination age (aged under six) from new IDP households have reportedly never received any vaccination (compared with 24% for both host community and protracted IDP households).

69. In late March, the IPC Technical Working Group in Somalia conducted an update of their analysis released in February 2025. There were 21 areas analysed in the acute food insecurity projection update based on changes to humanitarian assistance and other aggravating factors, reflecting the likely impact of the major reduction in humanitarian assistance funding announced and a likely further increase in population displacement due to drought and conflict. For the 21 areas, 36% of the population is now projected to face high levels of acute food insecurity (IPC Phase 3 or above), with 9% in emergency (IPC Phase 4) and 28% in crisis (IPC Phase 3), compared to the 6% and 22%, respectively, projected in the January 2025 analysis. The revised number of people in IPC Phase 3 or above between April and June 2025 is 713 000 people compared to the 553 000 people

estimated in the January 2025 analysis, or a net increase of nearly 160 000 people (29%). The projected total acute malnutrition burden in children aged 6–59 months for January to December 2025 has also increased to 1.8 million children, including 479 000 children likely to be severely malnourished. Compared to the January 2025 analysis, with a total burden estimate of 1.7 million for the same period, the revised estimate reflects an increase of nearly 47 000 children facing severe acute malnutrition.

70. WHO is making a tangible impact on Somalia's health landscape, significantly bolstering its fragile health system and leading critical emergency responses. It actively supports 11 hospitals for acute trauma management, including training staff in mass casualty response, while enhancing 30 primary health care facilities to expand essential service access. As a pivotal first responder to outbreaks such as cholera and measles, WHO supported 56 active partners (as of June 2025) to ensure rapid, effective interventions and precise risk analysis. Despite ongoing operational and funding challenges, health partners in Somalia continue to deliver vital, life-saving basic health services to those in need. Between January and June 2025, partners provided 2 million medical consultations through the support of 590 health facilities and mobile teams across 71 districts in Somalia. Crucially, WHO is dedicated to championing equitable and safe access to life-saving health services for vulnerable populations, including those in IDP camps, providing direct and substantial support to the facilities that serve them.

71. In Yemen, after decades of conflict, political and socioeconomic fragility, natural hazards and multiple recurrent disease outbreaks, more than 19.6 million people were in need as of 2025 January. The impact of climate change has become increasingly severe, and the country experienced unprecedented flooding in 2024, impacting over 1 million people and severely damaging critical infrastructure, including health care facilities and stockpiles of essential medical supplies. Less than 40% of Yemenis can access safe drinking-water and basic sanitation, which makes the overall population highly vulnerable to preventable diseases. Yemen currently accounts for 13% of all cholera cases reported worldwide. Half of all children under the age of five are acutely malnourished and 70% of 3- and 4-year-olds have not received a full course of vaccinations. The regional escalation of hostilities involving the Houthi movement in Yemen, Israel and international forces disproportionately affected civilian populations in Al Hudaydah, Hajjah, Amanat Al Asimah, Ta'izz and Ma'rib, with considerable infrastructural damage. WHO supported the deployment of essential supplies and a surgical team to Al Thawara Hospital, the largest referral hospital in Hudaydah, to deliver life-saving surgical and trauma care and train local health workers. For the year 2024, Yemen reported over 250 000 suspected cholera cases and 861 associated deaths, the highest burden of the disease globally. In response to the outbreak, WHO supported more than 25 000 rapid response team missions to investigate alerts and initiate control measures, provided laboratory supplies for 12 central public health laboratories, continued to support 16 diarrhoea treatment centres (94% of all operational centres) and built capacities in case management for more than 800 health workers. WHO also established over 96 therapeutic feeding centres in high-malnutrition areas, covering the costs of laboratory tests, severe acute malnutrition medication kits and support for the meals of caregivers, reaching over 31 220 children in 2024.

72. In 2024, serving as the backbone of emergency supply chain operations, the WHO Hub for Global Health Emergencies Logistics in Dubai, United Arab Emirates, delivered 592 emergency orders to 75 countries across all six WHO geographical regions valued at over US$ 34 million. It responded to health emergencies arising from outbreaks of infectious disease such as cholera and Ebola virus disease, natural disasters, including floods and earthquakes and escalations in conflict. In 2024, 70% of the essential medicines and health supplies delivered globally supported the Eastern Mediterranean Region. The capacity for rapid response is illustrated by the 46 emergency charter flights that took place in 2024 to the Gaza Strip, Sudan, Yemen, Lebanon and Ukraine, the top five recipients of emergency health supplies by value. Providing over 50% of the health supplies delivered to the Gaza Strip, Lebanon and Sudan in 2024, the Hub served as a lifeline for countries in crisis, improving the accountability, agility and responsiveness of emergency supply chain operations. Throughout 2024, the Hub managed an average of over 100 metric tonnes, valued at US$ 1.3 million, per week, to ensure the uninterrupted supply of high-quality life-saving medicines, supplies and equipment. Thanks to the generous support of in-kind emergency charter flights from the Government of the United Arab Emirates, Dubai Humanitarian and donors such as ECHO, the per-kilogram rate of transportation from the Hub to recipients was less than US$ 2, representing a substantial return on investment for WHO and enabling it to deliver more supplies to more people faster than ever before. In 2024, WHO and the United Arab Emirates

signed a host country agreement to scale up the capabilities of the Hub to ensure that it continues to deliver vital supplies and services to meet the growing humanitarian needs around the world.

73. WHO and partners continue to face multiple operational constraints including overwhelmed health systems, limited health workforce access, declining emergency funding and increasing safety and security risks for humanitarian actors and assets.

Progress of States Parties in implementing the IHR (2005), including the report of the Regional Assessment Commission

IHR monitoring and evaluation framework

74. The IHR Monitoring and Evaluation Framework, with its four components of State Party Self-Assessment Annual Reporting (SPAR), joint external evaluation (JEE), intra/after-action reviews and simulation exercises, continues to be widely accepted and used by countries in the Eastern Mediterranean Region.

75. The SPAR tool allows States Parties to report online and WHO to provide real-time monitoring of submitted reports and quality checks of the data provided. All the 22 countries and territories in the Region completed the 2024 SPAR on the achievement of IHR-related core capacities, in accordance with Article 54 of the IHR (2005). During the reporting period, Qatar successfully completed the second round of JEE and Libya and Afghanistan completed the self-assessment phase of the second round in both countries. Discussions and preparations started with Libya, Jordan and Tunisia for the conduction of the second round in 2025.

76. During the reporting period, eight simulation exercises were successfully developed and conducted on the IHR, cholera, MERS-CoV and radionuclear emergencies for Iran (Islamic Republic of), Iraq, Jordan, Libya, Saudi Arabia, Sudan, Syrian Arab Republic and Yemen. Ongoing follow-up to the SimEx recommendations is being undertaken to ensure that corrective measures are implemented.

IHR core capacities

77. Analysis of the 2024 SPAR data indicates an overall regional average IHR capacity score of 66%, the same as reported in 2023 (capacity scores are shown in Annex 1). SPAR capacity scores have remained essentially unchanged in the Region since 2018, ranging between 63% and 66%; this is largely due to inadequate investments in the national action plans for health security (NAPHS).

78. The highest average implementation scores were for capacities related to surveillance (80%), health service provision (75%) and laboratory (71%). Less well-performing areas include capacities related to chemical events (55%), human resources (61%) and RCCE (60%). The scores for the 15 IHR capacities in countries and territories of the Region are provided in Annex 1.

79. NAPHS had previously been developed in all countries and territories, except in the Islamic Republic of Iran. These plans are currently being updated in several countries, building on the lessons learned from the COVID-19 pandemic and on revised JEEs. As of January 2025, five countries have finalized their NAPHS: two (Syrian Arab Republic and Yemen) as a first round following JEE, and three (Pakistan, Sudan and Tunisia) as a second round. The countries are prioritizing actions through a two-year operational NAPHS. Iraq and Yemen have already initiated the process.

80. Data from the JEE and NAPHS was used to develop proposals to the Pandemic Fund, which is an initiative put in place by the World Bank and WHO to coordinate the mobilization of resources for building country capacity for pandemic prevention, preparedness and response. Thirteen countries/territories in the Region submitted proposals for the second round of the Call for Proposals, with five countries, namely Egypt, Jordan, Lebanon, Pakistan and Tunisia, succeeding in securing funding from single-country proposals and three countries, namely Djibouti, Somalia and Sudan, from the regional mpox proposal. The third Call for Proposals was announced in December 2024 and officially launched in March 2025. Eight countries and territories from the Region are working to submit single-country proposals. These proposals generated more demands for JEEs and NAPHS updates and many countries will be supported to meet these requests before the end of 2025.

Procedures under the Regulations

IHR committees and the Intergovernmental Negotiating Body

81. The IHR Emergency Committee concerning the ongoing transmission and international spread of poliovirus has met 40 times since its establishment in April 2014. The 40th meeting of the Emergency Committee was convened by the WHO Director-General on 6 November 2024. The Committee unanimously agreed that the risk of international spread of poliovirus remains a public health emergency of international concern and recommended the extension of temporary recommendations for a further three months.

82. The Intergovernmental Negotiating Body (INB) was established in 2021 by decision WHA SS2(5) to draft and negotiate a convention, agreement or other international instrument on pandemic preparedness and response. After three years of negotiations, Member States reached consensus on all provisions of the accord. The pandemic agreement was subsequently finalized and formally endorsed under Article 19 of the WHO Constitution at the Seventy-eighth World Health Assembly in 2025.

IHR NFPs and event-related information

83. Support continued to be provided to IHR NFPs to enhance their knowledge and capacities in the implementation of the IHR (2005), as described in above (see paragraph 26).

84. IHR NFPs in the Region accessed the EIS 1358 times from 1 July 2024 to 30 March 2025, with the IHR NFPs of Kuwait (245), Egypt (230), Morocco (169) and Qatar (106) being the most frequent users of the site. In April, a new EIS website was launched and between 14 April 2025 and 22 June 2025, IHR NFPs in the Region accessed the EIS 1431 times, with the IHR NFPs of Egypt (354), Kuwait (310) and Saudi Arabia (173) being the most frequent users of the site.

Travel and additional health measures

85. According to the 2024 SPAR, the countries of the Eastern Mediterranean Region have designated 112 ports, 100 airports and 92 ground crossings for IHR core capacities (2005) implementation. Seventeen countries reported having authorized ports to issue ship sanitation certificates in accordance with Annex 3 of the IHR (2005). The Region's capacity for IHR (2005) implementation at PoE has slightly increased from 62% in 2023 to 63% in 2024. The specific core capacity for routine operation is 68% for routine public-health capacities, 57% for rapid response to a potential public health emergency of international concern, while the capacity to underpin risk-based travel measures is 65%.

86. After the acute phase of the COVID-19 pandemic, countries adopted and promoted a risk-based approach to travel measures. Some countries such as Saudi Arabia conducted risk assessment to inform travel measures and required and recommended vaccinations for Hajj and Umrah. No major travel restrictions have been adopted for mpox, which was redeclared a PHEIC in 2024. During Arbaeen, another major mass gathering organized during the mpox PHEIC, Iran (Islamic Republic of), Iraq and Pakistan enhanced entry and exit screening for mpox symptoms at PoEs. Travel advice and recommendations in relation to respiratory diseases and other public health threats, including mpox, cholera, Ebola virus disease, dengue and other haemorrhagic fevers, have been consistently provided to countries, including the recommendations of the IHR Emergency Committee for performing risk assessment to inform travel-related mitigation measures.

Yellow fever

87. As of December 2024, all 22 countries and territories of the Region had responded to the annual questionnaire on requirements for yellow fever vaccination for international travellers. Nine of them, including Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Oman, Pakistan, Saudi Arabia and the United Arab Emirates, request a certificate of vaccination against yellow fever for incoming travellers from all countries and territories at risk of yellow fever transmission as determined by WHO. These countries confirmed that the international certificates of vaccination against yellow fever, using WHO-approved vaccines, are now accepted as valid for the life of the vaccinated person, in accordance with Annex 7 of the Regulations, as amended by World Health Assembly resolution WHA67.13 (2014).

Accelerating health emergency preparedness and response – a plan of action

Introduction

88. At its 68th session in 2021, the Regional Committee adopted resolution EM/RC68/R.2, which endorsed a plan of action for strengthening efforts towards ending the COVID-19 pandemic and preventing and controlling future health emergencies in the Eastern Mediterranean Region. The resolution requested WHO to provide the needed support to Member States to implement the plan of action and report on progress annually to the Regional Committee.

89. Progress made by WHO and countries in many of the activities outlined in the action plan have been described in previous sections of this report, including: developing or updating all-hazard risk profiles;, institutionalizing RCCE capacities; building capacities for outbreak detection and response; establishing/strengthening PHEOCs; implementing the EMT initiative; strengthening travel-related measures and public health and social measures; building IHR NFP capacities; updating NAPHS; advancing research and innovation; enhancing the implementation of One Health approach; and strengthening emergency, critical and operative care services at prehospital and facility levels.

Progress made by countries and the Secretariat on ending the COVID-19 pandemic and preventing and controlling future pandemics and health emergencies

90. In line with the evolving global context, countries across the Region continue to communicate COVID-19 situation updates and reduce control measures. Following the declaration of the end of COVID-19 as a PHEIC, many countries scaled back or phased out their dedicated COVID-19 high-level and technical coordination structures, which are now embedded within routine systems. In several instances, these have been replaced by standing committees on emergency preparedness, reflecting a broader focus on health security and resilience. While response measures are increasingly integrated into routine public health frameworks, authorities continue to monitor disease trends and maintain readiness for potential surges or the emergence of new variants. Efforts to strengthen the governance of essential public health functions as a basis for health systems transformation and resilience remains ongoing, as well as enhancing the capacity of legislators to strengthen health systems governance for universal health coverage and health security. WHO is working with conflict-affected countries to apply the humanitarian–development–peace nexus approach to ensure an effective humanitarian response while addressing health system strengthening whenever possible. Examples of this include WHO support to Lebanon, Libya and Yemen.

91. WHO and partners have led and coordinated efforts to prioritize access to COVID-19 vaccines and reduce vaccine inequity, while the monitoring of vaccine supply, use and coverage remains ongoing. The COVID-19 vaccine is now completely or partially integrated within the Essential Programme on Immunization in the Region's countries. Gavi is supporting eligible countries with the vaccine based on annual forecasting. Countries are now focusing on high-risk groups, such as the elderly, especially those with co-morbidity, others with co-morbidity, health workers and pregnant women. The uptake of the vaccine is low, as is the reporting of the doses given.

92. Genome sequencing capacity continues to be available in all countries in the Region, with data shared through platforms such as EMFLU, GISAID and the National Center for Biotechnology Information's (NCBI's) Sequence Read Archive, and efforts are being made to develop national policies for genomic surveillance. While COVID-19 surveillance efforts are being scaled down, many national laboratories remain prepared for future pandemics and epidemics.

93. All national public health laboratories and national influenza centres continue to participate in WHO's external quality assurance programmes, with some subnational laboratories also taking part – all passing WHO assessments. Progress has been made in strengthening both infrastructure and workforce capacity for molecular testing, as well as in developing national policies to ensure biosafety and biosecurity standards remain high beyond the COVID-19 pandemic.

94. WHO continues to support laboratory operations and logistics, ensuring stable supply chains for both routine tests (culture and rapid testing) and more complex molecular and genomic testing across the Region.

Challenges

95. Existing structures for health emergency management continue to be fragmented in most countries of the Region, which impedes efforts to strengthen governance and leadership for managing health emergencies. Several capacity-building efforts for the workforce and surge capacity-building for emergency response are underway. However, strategies to generate and sustain a skilled multidisciplinary health workforce are still lacking in most countries of the Region. During the COVID-19 response, most countries managed to allocate resources and fast-track mobilization to different administrative levels, and domestic resources were allocated for preparedness. However, lack of resources continues to limit efforts to enhance health emergency preparedness, especially in lower-middle-income and low-income countries. Sustainability of efforts is a key challenge in the context of FCV settings. This leads to low effectiveness and low efficiency.

96. While RCCE capacities were strengthened in most countries during the COVID-19 pandemic – with several ministries of health establishing new RCCE technical units or teams – more work is required in this increasingly important area.

97. Efforts to advocate for a risk-based approach to travel measures and enhancing PoE capacities for routine operations and in response to public health emergencies are ongoing. Since WHO declared the end of COVID-19 as a PHEIC, investments and efforts to maintain and strengthen these core capacities have decreased, especially at ground crossings, which remain a major weak point for national and global health security.

98. The prevalence of health threats at the human–animal–environment interface in the Region continues to rise. Although efforts have been made to address these through applying the concept of One Health and enhancing the preparedness and response capacities of the relevant authorities in countries, challenges persist, including competing priorities, the absence of supportive policies and an unwillingness to share resources and information across sectors and unify efforts and vision.

The way forward

99. Building on the progress made, countries should deepen engagement between health ministries and ministries of finance to secure sustainable domestic funding for health emergency preparedness. This includes prioritizing public investments in common goods for health that benefit all hazards, not just individual threats.

100. Countries should scale up involvement in global initiatives to address inequities in access to medicines, vaccines and medical devices. This involves reinforcing national regulatory authorities, expanding local and regional manufacturing capacity, strengthening supply chains and actively contributing to the Pandemic Agreement and the Pathogen Access and Benefit-Sharing (PABS) process to promote technology transfer and equitable distribution.

101. Recognizing the unique challenges in FCV settings, countries and partners should integrate the humanitarian–development–peace (triple nexus) approach into health emergency planning. This means tackling the root causes of vulnerability, while ensuring continuity of essential health services during crises. Countries should finalize and operationalize standard operating procedures for procurement and supply to guarantee timely delivery of emergency health supplies. WHO will continue to provide targeted technical support to strengthen procurement planning and last-mile distribution. Countries should continue to roll out collaborative surveillance, enhance genomic sequencing capabilities and commit to timely sharing of data through regional and global platforms, reinforcing collective regional readiness. Additionally, countries should routinely evaluate the impact of public health and social measures, ensuring decisions are evidence-informed and balance health benefits with socioeconomic impacts. Multisectoral coordination, behavioural insights and community engagement should be institutionalized for better crisis management. Countries should also maintain and expand IHR (2005) core capacities at points of entry and for international travel and invest in workforce development and cross-border cooperation to prevent, prepare for, detect and respond to cross-border threats. WHO will support risk assessments, dialogue between neighbours and the development of travel-related public health measures.

Conclusion

102. The Eastern Mediterranean Region remains at the epicentre of multiple, intersecting crises – conflict, disease outbreaks, forced displacement, climate shocks and under-resourced health systems – all of which continue to threaten the health and survival of millions. Against this backdrop, WHO's work in 2024–2025 has been defined by agility, scale and innovation. From leading responses to complex emergencies in the Gaza Strip and Sudan, to supporting countries with real-time surveillance, outbreak detection, building hospital resilience and emergency medical deployments, WHO has proven indispensable. It has consistently demonstrated that, when provided with access to populations affected by emergencies, good health outcomes can be achieved, and international standards can be met. Its all-hazards approach, integration of the humanitarian–development–peace nexus, and expansion of digital tools such as ePHEM and EIOS have strengthened both emergency response and health system recovery. However, the scale of need continues to outpace resources. With rising attacks on health care and persistent funding gaps, the sustainability of life-saving operations is at risk. As the Region stands at a crossroads between escalating emergencies and emerging opportunities for recovery, continued investment, political will and solidarity are urgently needed. WHO remains committed to working with Member States and partners to protect health, build resilience and drive recovery, ensuring no one is left behind in the Region's most fragile and vulnerable settings.

Action by the Regional Committee

103. The Regional Committee is invited to note this report and encourage investment in preparedness and response systems in view of the persistent threat posed by emergencies from all hazards.

Annex 1

International Health Regulations (2005) national capacity monitoring: capacity scores (%) for all reporting States Parties for 2024

Member State	Legal instruments	IHR coordination	Financing	Laboratory	Surveillance	Human resources	Health emergency management	Health service provision	Infection prevention and control	Risk communication & community engagement	Points of entry	Zoonosis	Food safety	Chemical	Radiation
Afghanistan	20	33	30	56	80	20	27	60	27	33	20	60	20	20	20
Bahrain	100	93	100	96	100	100	100	100	93	93	100	100	100	40	60
Djibouti	30	27	20	32	50	40	20	47	20	20	27	40	40	20	20
Egypt	90	87	100	80	100	100	100	100	80	80	100	80	80	100	80
Iran, Islamic Republic of	80	93	70	88	80	70	80	87	73	80	80	60	80	60	60
Iraq	60	73	60	68	80	50	60	80	53	47	47	40	40	60	60
Jordan	70	87	60	80	80	80	80	73	67	60	80	80	80	40	80
Kuwait	100	93	100	88	100	100	100	87	100	100	100	100	80	100	100
Lebanon	80	73	20	84	100	60	67	67	60	80	60	80	40	80	100
Libya	20	60	60	56	50	30	20	53	27	27	33	40	40	20	40
Morocco	60	60	80	84	80	70	73	80	53	87	73	80	80	80	80
Oman	40	73	70	80	80	50	87	100	93	93	80	80	80	60	80
Pakistan	40	43	60	64	80	40	53	67	40	40	33	60	20	40	100
Palestine	70	53	30	56	70	50	27	53	47	67	20	80	0	20	20
Qatar	80	80	100	92	90	70	87	100	93	80	80	80	100	100	100
Saudi Arabia	100	87	100	96	100	100	100	93	100	100	87	80	100	80	100
Somalia	20	47	20	36	70	30	40	47	33	20	27	40	20	20	20
Sudan	40	73	60	40	80	50	87	60	67	33	53	80	40	20	40
Syrian Arab Republic	60	20	30	40	50	40	53	40	40	33	33	40	60	40	40
Tunisia	70	80	80	88	100	60	73	93	53	53	73	100	100	60	80
United Arab Emirates	100	100	100	100	100	80	100	100	93	100	100	100	80	100	100
Yemen	30	33	50	36	40	30	47	33	40	27	27	40	40	20	20