WHO Situation Report

Health emergencies in the Eastern Mediterranean Region

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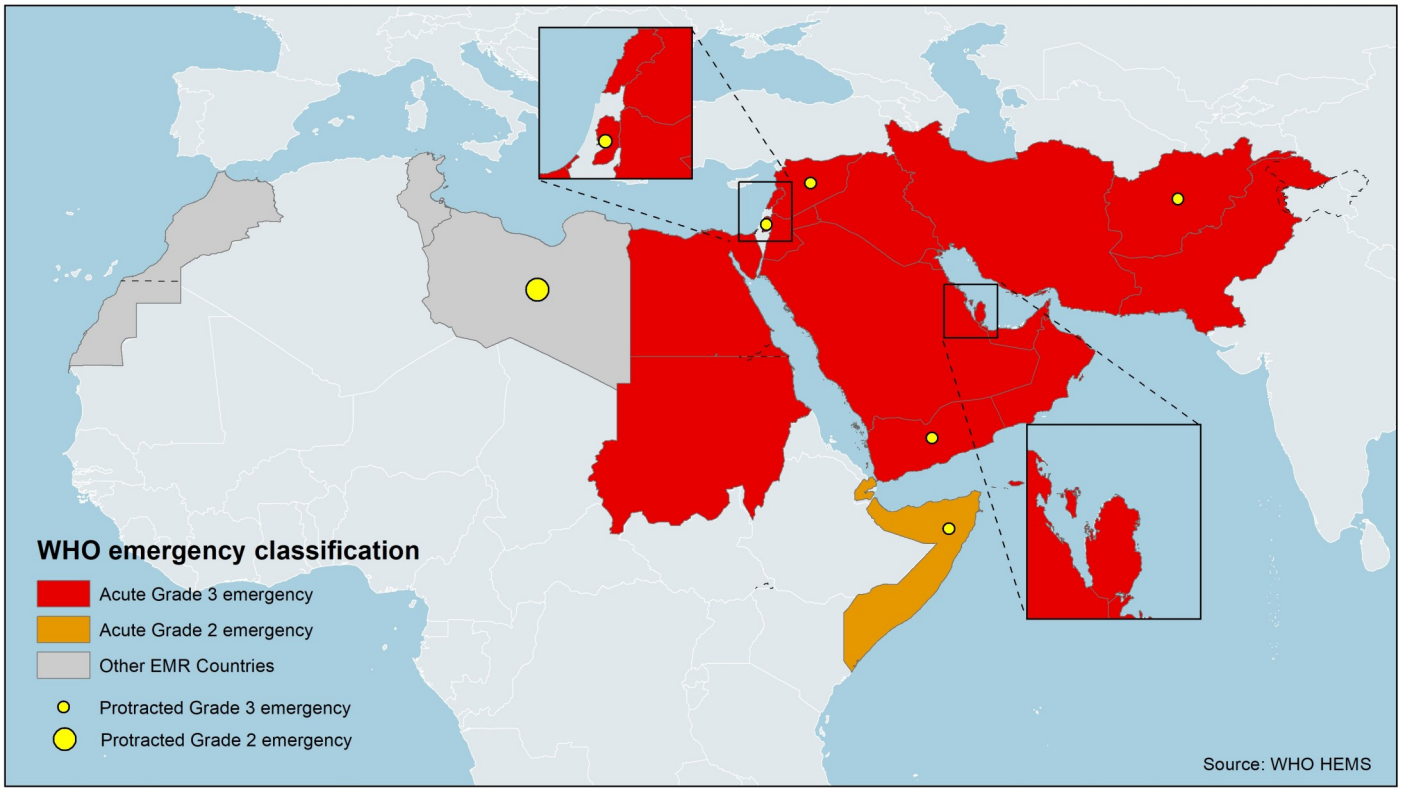
Eastern Mediterranean Region

Regional overview

117 million people in need of humanitarian aid	**80 million** people at crisis levels of acute food insecurity	**60.4 million** displaced persons of concern
14 acute and protracted health emergencies	**62** active disease outbreaks in 19/22 countries	**9/22** countries with violent conflict or social fragility
7,673 killed | **46,002** injured in the Middle East conflict 2026	**27** attacks on health care from 1 to 30 June 2026	**40%** funding gap for 2026 (US$ 633m total required)

WHO Eastern Mediterranean Region



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EXECUTIVE SUMMARY

- While the conflict in the Middle East showed signs of de-escalation at the end of the June reporting period, renewed hostilities in early July reversed this trend and significantly increased the risk of wider regional escalation. Renewed strikes in the **Islamic Republic of Iran** and several Gulf countries, together with attacks on commercial shipping and disruptions to navigation through the Strait of Hormuz, increased risks to civilians, medical and humanitarian supply chains, and continuity of essential health services.
- In the **Islamic Republic of Iran**, programme implementation and field support remained constrained by logistical and security challenges, while disruptions to domestic flights and high-risk areas continued to limit access for WHO teams. In **Lebanon**, insecurity, repeated population movements and damage to critical infrastructure, particularly in South Lebanon and Nabatiyeh, continued to constrain the humanitarian response.
- **Sudan** remained the Region's largest humanitarian emergency, with **30.4 million people** requiring humanitarian assistance, **13.5 million displaced**, multiple concurrent disease outbreaks and severe funding shortfalls threatening continuity of health services. Across other graded emergencies, humanitarian conditions continued to deteriorate in the **occupied Palestinian territory** and **Somalia**, while conflict, funding constraints, disease outbreaks and climate-related hazards continued to strain health systems in **Yemen** and the **Syrian Arab Republic**.
- The food insecurity and health crisis continued to deteriorate across the **Greater Horn of Africa**, driven by conflict, climate shocks, displacement, recurrent disease outbreaks and fragile health systems. More than **37.8 million people** are experiencing, or are projected to experience, acute food insecurity across the six affected countries, including nearly **26 million** in **Sudan, Somalia and Djibouti**. Children under five, pregnant and lactating women, displaced populations, refugees and communities in hard-to-reach areas remain among the most vulnerable.
- WHO's Regional Office for the Eastern Mediterranean is appealing for **US$6.42 million** to sustain critical health and nutrition interventions in **Sudan, Somalia and Djibouti**. The funding will help sustain primary health care and lifesaving nutrition services, strengthen surveillance and early warning, maintain outbreak detection and response capacities, expand nutrition screening and referral pathways, strengthen community engagement, and pre-position essential medicines, diagnostics and therapeutic supplies.
- WHO accelerated regional preparedness for **Bundibugyo virus disease** through strengthened surveillance, rapid response capacity, contact tracing, infection prevention and control, water, sanitation and hygiene, laboratory preparedness, community engagement and contingency planning. In **Somalia**, WHO supported national preparedness planning, readiness assessments and pre-positioning of viral haemorrhagic fever and laboratory supplies. A multidisciplinary mission to **Sudan** identified preparedness strengths and critical operational gaps, while additional technical support missions to **Somalia** and **Djibouti** are planned for July.
- WHO sustained emergency health operations across the Region through country-specific support. In the **occupied Palestinian territory**, partners delivered 708,600 health consultations during the first two weeks of June. In **Sudan**, WHO supported 13 hospitals, four primary health care facilities and 35 stabilization centres, while strengthening cholera preparedness and response. In **Somalia**, WHO trained 144 health workers and 73 community leaders to strengthen surveillance across 50 health facilities, distributed 6 tonnes of essential medicines and supplies, and pre-positioned 400 pallets of emergency medical commodities. In **Yemen**, Health Cluster partners supported 809 health facilities and 116 mobile medical teams, reaching approximately 690,000 people. In the **Syrian Arab Republic**, WHO expanded EWARS, active case finding and community-based surveillance in flood-affected areas while supporting restoration of essential health services. In **Lebanon**, WHO continued supporting hospitals, primary health care centres, emergency referral services and health services for displaced and conflict-affected communities.
- At regional level, WHO strengthened emergency preparedness and operational readiness through technical support for chemical, biological, radiological and nuclear emergencies, national **Emergency Medical Team** development, and a global simulation exercise involving more than **600 health emergency experts from 26 countries**. Targeted technical missions to **Bahrain, Kuwait, Oman, Qatar** and the **Kingdom of Saudi Arabia** strengthened all-hazards preparedness, public health intelligence, emergency operations centres, health security, emergency logistics and continuity of essential health services across the **Gulf Cooperation Council**.

REGIONAL PRIORITIES FOR THE COMING PERIOD

01 Strengthen emergency preparedness and operational readiness
Enhance preparedness for Ebola disease caused by Bundibugyo virus and chemical, biological, radiological and nuclear hazards, while protecting medical supply chains and mobilizing flexible, predictable funding to sustain emergency operations.

02 Scale up integrated health and nutrition action
Expand integrated health and nutrition services in food-insecure and drought-affected areas, including nutrition screening and treatment, mobile health services, and the pre-positioning of essential medicines, diagnostics and therapeutic supplies.

03 Strengthen disease surveillance and outbreak response
Enhance disease surveillance, early warning and outbreak response, with priority attention to cholera and acute watery diarrhoea, measles, dengue and other epidemic-prone diseases, alongside strengthened laboratory capacity, rapid response and community-based surveillance.

04 Sustain essential health services
Maintain primary and emergency care, trauma services, maternal and child health, nutrition, mental health, and care for noncommunicable diseases, while restoring and maintaining the functionality of disrupted health facilities.

FUNDING AND RESOURCE MOBILIZATION

- WHO's **2026 Health Emergencies Appeal for the Eastern Mediterranean Region requires US$633 million**, of which **40% remains unfunded**, to sustain lifesaving health interventions across acute and protracted emergencies.
- Funding shortfalls are already reducing operational capacity across multiple emergency settings. In Somalia, more than **260 health facilities** have closed or severely reduced operations, jeopardizing access to health care for **1.62 million people** and disrupting nutrition, immunization and outbreak response.
    - In Yemen, severe funding constraints have forced Health Cluster partners to reduce operations, leaving an estimated **8.4 million people** across **141 districts** with reduced access to health services.
    - In the occupied Palestinian territory, a **US$227.4 million funding gap** continues to limit the health response amid escalating humanitarian needs.
    - Syria's Flash Emergency Appeal remains **96.8% unfunded**, constraining recovery of essential health services and emergency response.
- **WHO has launched a US$6.42 million regional appeal to sustain critical health and nutrition interventions in Somalia, Sudan and Djibouti** over the next six months (July–December 2026), as part of WHO's US$25.4 million Greater Horn of Africa response. The appeal will support primary health care, nutrition services, disease surveillance, outbreak response and the pre-positioning of essential medicines and supplies in the countries most affected by the regional food insecurity and health crisis.

ATTACKS ON HEALTH CARE

- **27 attacks on health care were documented across Member States of the Region from 1-30 June 2026**, representing approximately one third of the 85 incidents reported globally during the month. **These attacks caused 10 deaths and 75 injuries**, accounting for one-third of all reported fatalities and more than 70% of injuries reported globally during the month. Additionally in June, Markada Primary Health Care Centre in southern Al-Hasakah Governorate, north-east Syria, was looted, disrupting service delivery.

  Lebanon
  21 attacks | 9 deaths | 75 injuries
  ———————————————————

  occupied Palestinian territory

  5 attacks | 0 deaths | 0 injuries
  ———————————————————

  Sudan
  1 attack | 1 death | 0 injuries
  ———————————————————

  TOTAL
  27 attacks | 10 deaths | 75 injuries

- Attacks on health care deprive entire communities of essential health, putting lives at immediate risk and weakening health systems over the long term. Health workers everywhere must be able to deliver health care in a safe and protected environment without disruption from acts or threats of violence.

- As mandated by Member States, following the adoption of the WHA Resolution 65.20, WHO continues to monitor and verify attacks through its Surveillance System for Attacks on Health Care (SSA), advocate for the protection of health care under International Human Rights Law, International Humanitarian Law (IHL) and the Geneva Conventions, and support Member States with evidence generation, to inform evidence-based recommendations and coordination and operational measures needed to safeguard health services and maintain continuity of care.

Mid-year overview: Attacks on health care in the Eastern Mediterranean Region *January-June 2026*

During the first six months of 2026, WHO documents 369 attacks on health care in the Region's Member States accounted, representing nearly half of all reported incidents globally (47%). These attacks resulted in 761 deaths and 1,084 injuries, accounting for 85% of reported fatalities and 77% of injuries worldwide, highlighting the disproportionate human toll borne by the Region.

The pattern of attacks remains uneven across countries but demonstrates the widespread impact of conflict on health systems. Lebanon recorded the highest number of incidents (212 attacks), while Afghanistan experienced the highest mortality, with 408 deaths associated with attacks on the Omid Addiction Treatment Hospital, a 2,000-bed drug rehabilitation center in Kabul, which was struck by a devastating airstrike. Sudan continued to experience particularly severe consequences, with 21 attacks resulting in 195 deaths and 326 injuries, reflecting the intensity of violence affecting health workers, patients and facilities. The occupied Palestinian territory, the Syrian Arab Republic and the Islamic Republic of Iran also reported continued incidents affecting health service delivery.

The number and severity of attacks on health care in the Eastern Mediterranean Region fluctuated considerably during the first half of 2026. Following 31 reported incidents in January and 29 in February, attacks surged sharply in March to 148 incidents, accompanied by 558 deaths and 598 injuries, making it the deadliest month of the year. Thereafter, reported incidents declined progressively to 83 in April, 50 in May and 27 in June. Despite this downward trend in the number of recorded attacks, violence against health care continued to result in casualties and disruption of essential services.

MIDDLE EAST ESCALATION OF VIOLENCE (ACUTE GRADE 3 EMERGENCY)

- Since the beginning of the hostilities on 28 February, national authorities reported 3,375 deaths and 33,806 injuries in the **Islamic Republic of Iran**, including 15 injuries following strikes on 7 June. In **Lebanon**, 4,298 people were killed (including 253 children and 391 women) and 12,196 injured between 2 March and 2 July, including 1,792 deaths and 4,279 injuries since the 17 April ceasefire.
- As of 29 June, 704,445 people remained internally displaced in **Lebanon**, representing a 17% decrease since 17 June. Around 91% originated from Nabatieh, Bent Jbeil, Marjaayoun, Sour and Baabda, while 44,638 people remained in 402 collective shelters. Returns continued but remained constrained by insecurity and extensive damage to housing and critical infrastructure. 53 epidemiological signals were investigated during 1–29 June, including rabies exposure, food poisoning, acute diarrhoeal disease, measles, brucellosis, malaria, meningitis and environmental health events, with no clustering identified.
- Health systems in the **Islamic Republic of Iran** maintained full operational readiness despite logistical and security constraints. In Lebanon, three hospitals remained fully non-operational and 35 primary health care centres remained closed. Demand for trauma supplies, essential medicines, blood products and medical consumables continued to exceed routine replenishment, while insecurity and movement restrictions delayed humanitarian deliveries.
- WHO verified 26 attacks on health care in the **Islamic Republic of Iran** between 28 February and 9 June, resulting in 11 health worker deaths. Since 2 March, WHO recorded more than 190 attacks on health care in **Lebanon**, resulting in 135 health worker and paramedic deaths and 406 injuries.
- Spillover effects continued across the Region. On 3 June, strikes in **Kuwait** resulted in 1 death and 63 injuries. Since 2 March, 441,453 movements from Lebanon into the **Syrian Arab Republic** have been recorded.

WHO response

- In the **Islamic Republic of Iran**, WHO launched a risk communication and community engagement programme for vector-borne disease preparedness and response, and supported procurement of UPS units and generators to strengthen operational continuity. WHO strengthened mental health and psychosocial support in the Islamic Republic of Iran. By 23 June, more than 5,900 participations were recorded through in-person training and peer support sessions, over 3,000 participations through webinars, 594 health-care workers received individual psychosocial support, and 94 were referred for specialized care.
- In **Lebanon**, WHO supported continuity of essential health services in Lebanon by providing noncommunicable disease medicines for approximately 140,000 beneficiaries, reaching around 60,000 internally displaced people living with noncommunicable diseases, distributing 20 intensive care ventilators to 14 hospitals, and 30 trauma emergency surgery and burn kits to 15 hospitals, supporting care for more than 1,500 trauma patients.
- WHO supported re-establishment of the Central Public Health Laboratory in **Lebanon**, operationalization of the National Reference Laboratory for Emerging and Re-emerging Diseases, and strengthened environmental health surveillance, water quality monitoring, infection prevention and control, and preparedness for Ebola and radionuclear emergencies.
- From April to June 2026, WHO supported **Gulf Cooperation Council (GCC) Member States** to strengthen emergency preparedness and health security through targeted technical missions to Bahrain, Kuwait, Oman, Qatar and the Kingdom of Saudi Arabia. The initiative focused on strengthening all-hazards emergency preparedness and response capacities, including public health intelligence, early warning systems, public health emergency operations centres, CBRN preparedness, emergency logistics, medical countermeasures, mass-casualty management, risk communication and community engagement, and continuity of essential health services. Country-specific missions supported national priorities while promoting greater regional collaboration. Technical support included strengthening **Bahrain's** emergency preparedness framework, supporting **Kuwait's** emergency preparedness and humanitarian coordination capacities, enhancing **Oman's** Early Warning Centre and public health intelligence functions, advancing **Qatar's** integrated emergency preparedness and response architecture, and supporting regional collaboration through the **Kingdom of Saudi Arabia's** emergency operations, simulation and rapid response capacities to strengthen regional collaboration and preparedness.

Greater Horn of Africa Food Insecurity and Health Crisis (acute Grade 2 emergency)

- More than 37.8 million people are facing, or are projected to face, acute food insecurity across the six affected countries, including nearly 26 million people in **Sudan**, **Somalia** and **Djibouti** in WHO's Eastern Mediterranean Region. Conflict, climate shocks, displacement, disease outbreaks and fragile health systems continued to drive worsening health and nutrition needs.
- **Sudan** remains the epicentre of the crisis, with nearly 19.5 million people experiencing acute food insecurity. In **Somalia**, 6 million people (31%) faced IPC Phase 3 or worse between April and June 2026, including 1.9 million at Emergency levels, an increase of more than 500,000 compared with February projections. In **Djibouti**, up to 230,000 people (22%) are projected to face Crisis or Emergency levels of food insecurity.
- In **Somalia**, 1.88 million children are projected to require treatment for severe acute malnutrition during 2026, including 64,719 admitted between January and May, of whom 5,443 required inpatient stabilization. Buurhakaba District recorded 37.1% global acute malnutrition and remains at credible risk of famine.
- In **Sudan**, more than 825,000 children are expected to suffer severe acute malnutrition during 2026. In **Djibouti**, more than 34,300 children under five, including 7,700 with severe acute malnutrition, and more than 2,000 pregnant and breastfeeding women are acutely malnourished or projected to become so.
- **Somalia** operates 90 stabilization centres and 1,175 outpatient therapeutic programmes, but 11 districts reporting severe acute malnutrition had no functional stabilization centre and three districts reported neither admissions nor services. In **Sudan**, funding shortfalls have placed around 160 health facilities at risk of closure. In Djibouti, funding reductions are affecting immunization, nutrition and other lifesaving services.
- Disease risks continued to increase in parallel. During the first 24 epidemiological weeks of 2026, **Somalia** reported 15,249 suspected acute watery diarrhoea and cholera cases, including 18 deaths, with children under five accounting for 88% of cases. **Djibouti** reported increasing acute watery diarrhoea, malaria and dengue, while **Sudan** reported 1,332 suspected cholera cases and 141 deaths as of 4 July.

WHO response

- In **Sudan**, WHO supported 156 functional stabilization centres treating children with severe acute malnutrition and continued operational support to 13 hospitals, 35 stabilization centres and 4 primary health care facilities.
- WHO strengthened cholera preparedness and response in **Sudan** through laboratory support, rapid response teams, cholera treatment centres, 15 oral rehydration points in Al Nuhud, and pre-positioning of cholera and laboratory supplies.
- WHO strengthened disease surveillance in **Somalia** by training 144 health workers from 10 districts and 73 female community leaders, improving early detection across 50 health facilities. WHO also trained 56 health workers on the Integrated Management of Acute Malnutrition guidelines and distributed paediatric severe acute malnutrition kits to 13 stabilization centres.
- WHO strengthened emergency logistics in **Somalia** by distributing one cholera kit, 6 tonnes of essential medicines and medical supplies, and dispatching paediatric severe acute malnutrition medicines, emergency and primary health care kits, and cholera laboratory and diagnostic supplies. WHO also received 400 pallets of essential medicines, diagnostics and medical kits for pre-positioning in drought- and flood-affected areas.
- In **Djibouti**, WHO supported mobile health teams, nutrition screening and referrals, treatment of acute malnutrition, weekly disease surveillance, emergency health kits, forecasting and pre-positioning of medicines, and integration of mental health and risk communication into primary health care.

REGIONAL READINESS FOR EBOLA DISEASE OUTBREAK CAUSED BY BUNDIBUGYO VIRUS

- No suspected or confirmed cases of Ebola disease caused by Bundibugyo virus (BVD) have been reported in the Eastern Mediterranean Region. However, population movements, fragile health systems and gaps in surveillance and laboratory capacity increase the risk of importation. Sudan, Somalia and Djibouti were identified as the highest-priority countries for intensified preparedness based on the risk of cross-border spread, geographical proximity and population movements. The United Arab Emirates, Qatar, Kingdom of Saudi Arabia, Libya, Egypt and Morocco were also prioritized because of their roles as major travel and transit hubs connecting Africa with the Region and the world.
- Surveillance, including laboratory readiness and diagnostic capacity, remain among the most urgent gaps, alongside shortages of testing supplies and personal protective equipment and constraints in specimen transport. Surveillance gaps persist in high-risk and hard-to-reach areas. Further training, simulation exercises and refresher training are needed for frontline health workers and points-of-entry staff, while limited operational funding continues to constrain preparedness activities.
- WHO activated regional preparedness and readiness activities and established a multidisciplinary technical working group to coordinate action across key preparedness pillars. A regional readiness checklist and contingency plan template were disseminated to support national capacity assessments, identify gaps and strengthen planning. A scenario-based operational matrix and web-based platform were developed to guide country preparedness and response activities.
- WHO and the Ministry of Health of Somalia developed a national Ebola preparedness and response plan and completed a national readiness assessment. In the Syrian Arab Republic, WHO supported Ebola preparedness through development of a national contingency plan, training of community health volunteers in eight governorates, and operational support to rapid response teams. Preparedness and response plans and readiness assessments were also completed by Libya, Djibouti, Sudan, Qatar and the Kingdom of Saudi Arabia.
- Laboratory preparedness is being strengthened in high-priority countries through diagnostics, equipment, training and surveillance support. WHO facilitated the participation of national laboratory focal points in coordination meetings with WHO, the Africa Centres for Disease Control and Prevention and partners to strengthen national capacity to safely detect and confirm suspected cases. WHO delivered to Somalia one viral haemorrhagic fever kit sufficient to manage 100 cases for 10 days, together with laboratory supplies, primers and reagents to test 50 samples. Preparations are under way to train health workers on Ebola detection, reporting, referral and case management. Shipments of viral haemorrhagic fever kits and laboratory supplies are also planned for delivery to Sudan, Djibouti and Libya.
- A multidisciplinary Ebola preparedness support mission to Somalia and Djibouti is underway in July.

Multidisciplinary Ebola preparedness support mission to Sudan

From 23 to 29 June, WHO deployed a multidisciplinary Ebola preparedness support mission to Sudan to assess national readiness across coordination, surveillance, laboratory capacity, points of entry, risk communication and community engagement, case management, infection prevention and control, and water, sanitation and hygiene.

The mission visited Red Sea and Khartoum states and remotely engaged teams and health partners in Darfur and the Central Zone. The mission found important preparedness foundations, including an operational Emergency Operations Centre, an approved national contingency plan and designated emergency response leadership. However, significant operational and technical gaps remain in surveillance integration, Ebola diagnostic capacity, points-of-entry readiness, isolation and treatment facilities, risk communication and operational financing.

Immediate priorities include strengthening national and state-level coordination; entry screening, isolation and referral at points of entry; community- and event-based surveillance; laboratory testing capacity; and the readiness of isolation and case management facilities in Port Sudan and Khartoum.

POPULATION DISPLACEMENT AND POPULATION MOVEMENTS

- **Sudan** remained the Region's largest displacement crisis. As of 25 May, 8 805 506 internally displaced persons (IDPs) were recorded across 185 localities in all 18 states, while 4 441 570 returnees had returned to 74 localities in nine states. Returnees increased by 6% compared with the previous month, while IDPs declined by less than 1%.
- **Lebanon** continued to experience large-scale displacement despite reduced hostilities. As of 29 June, 704 445 people remained internally displaced, a 17% decrease since 17 June. Of these, 44 638 people remained in 402 collective shelters, with 91% originating from Nabatieh, Bent Jbeil, Marjaayoun, Sour and Baabda. Returns continued but remained constrained by insecurity and damaged infrastructure. In the **Syrian Arab Republic**, approximately 441 453 cross-border movements from Lebanon were recorded from 2 March-15 June, while 1 700 families returned to Afrin during June, increasing pressure on health services and basic infrastructure.
- In the **occupied Palestinian territory**, repeated displacement continued across Gaza, while more than 33 000 Palestine refugees remained displaced from Jenin, Tulkarm and Nur Shams refugee camps in the West Bank. Movement restrictions and insecurity continued to disrupt access to health care and other essential services.
- Climate- and conflict-related population movements persisted elsewhere in the Region. **Yemen** hosts 5.2 million IDPs, 329 000 migrants and 63 000 refugees and asylum seekers, with 1 114 newly displaced households (6 684 people) recorded since 1 January 2026. **Djibouti** continued to host more than 33 000 refugees and asylum seekers and 400-600 migrants transiting daily.

WHO response

- WHO and partners continued to monitor population movements, support health services at border crossings and areas of return, strengthen disease surveillance, and provide essential health, mental health and psychosocial support services for refugees, internally displaced populations, returnees and host communities.
- In **Lebanon**, WHO continued supporting health services for internally displaced people and returnees through hospitals, primary health care centres, emergency referral services, mobile medical teams and health services in collective shelters and conflict-affected communities.
- In the **Syrian Arab Republic**, WHO continued supporting health services in areas receiving returnees from Lebanon, maintained operational support to rapid response teams, and strengthened health system readiness in areas affected by returns and displacement.
- In **Yemen**, Health Cluster partners supported 809 health facilities and 116 mobile medical teams across 48 districts in 12 governorates, reaching approximately 690 000 people with primary and secondary health care, communicable disease surveillance, reproductive health, MHPSS, noncommunicable disease services and referrals despite severe funding constraints. In **Djibouti**, refugees and migrants continued accessing free health services through Ministry of Health facilities supported by humanitarian partners.

DISEASE OUTBREAKS

- Outbreak risks remained high across the Region as conflict, displacement, climate shocks and disrupted public health services continued to drive disease transmission and weaken surveillance.
- *Waterborne diseases*: **Somalia** reported over 15 000 suspected acute watery diarrhoea and cholera cases, while **Yemen** remained among the countries reporting the highest cholera burden globally. **Sudan** reported 1 332 suspected cholera cases, including 141 deaths, with transmission concentrated in West Kordofan and increasing in North Kordofan. **Djibouti** reported increasing acute watery diarrhoea linked to prolonged drought, The **Syrian Arab Republic** continued to face elevated cholera risks following flooding, and Lebanon investigated recurrent foodborne disease events and acute diarrhoeal disease.
- *Vector-borne and zoonotic diseases*: **Iran** reported 860 dengue cases between March and June while maintaining entomological surveillance at international points of entry. Sustained dengue transmission

continued in **Somalia**, **Sudan** and **Yemen**, while **Djibouti** reported increasing malaria and dengue trends. In **Iraq**, Crimean-Congo haemorrhagic fever (CCHF) remained the primary outbreak of concern, with 183 laboratory-confirmed cases and 13 deaths (CFR 7.1%) across 14 governorates. Thi-Qar accounted for 44% of cases, with transmission peaking in June (82 cases). Most cases occurred among males (73%) and adults aged 25–44 years (42%). Limited adherence to safe livestock handling and gaps in One Health surveillance persisted.

- *Other epidemic-prone diseases*: The **Syrian Arab Republic** continued to report increasing measles transmission, while Somalia reported ongoing measles and diphtheria outbreaks. **Sudan** continued responding to hepatitis E, measles and meningitis outbreaks alongside preparedness for Ebola disease and mpox. **Lebanon** strengthened rabies surveillance following continued animal exposure events.

WHO response

- WHO strengthened outbreak preparedness through surveillance, laboratory support and rapid response capacity. In **Lebanon**, physicians and nurses in approximately 120 hospitals received training on standardized rabies case management and DHIS2 surveillance. In **Iraq**, WHO supported CCHF preparedness through an online workshop involving more than 50 public health and emergency focal points from all governorates.

- In **Somalia**, 144 health workers from 10 districts, 73 community leaders and 56 health workers were trained on outbreak detection, community-based surveillance and integrated management of acute malnutrition. In **Sudan**, WHO supported cholera treatment centres, 15 oral rehydration points, rapid response teams, pre-positioning of cholera and laboratory kits, and measles catch-up vaccination in Darfur.

HEALTH SYSTEM FUNCTIONALITY

- Health systems remained under severe strain across conflict- and crisis-affected countries. In the **occupied Palestinian territory**, only 44% of Gaza health service points were operational as of 26 June, while 98% of health service points in the West Bank remained fully or partially functional. More than 11 000 surgeries have been postponed and one third of essential medicines are at zero stock.

- **Lebanon** continued restoring health services, although three hospitals and 35 primary health care centres remained closed. Maternity services resumed in three hospitals, while four hospitals in Bent Jbeil and Nabatieh continued providing emergency care only. In the **Syrian Arab Republic**, only 39% of public health centres and 59% of public hospitals were fully functional. Shortages of health workers, medicines and medical equipment continued to constrain service delivery.

- Funding reductions continued to undermine service delivery. In **Yemen**, only 17.1% of Health Cluster funding has been secured, forcing 24 partners to reduce or suspend activities, reducing access to health care for 8.4 million people across 141 districts and affecting more than 460 health facilities. In **Somalia**, more than 260 health facilities have closed or severely reduced operations, affecting 1.62 million people.

- **Djibouti** reported shortages of skilled health workers, medicines, laboratory supplies and equipment despite 78 operational health facilities. **Iran** reported that the health system remained fully operational following the cessation of hostilities, while **Iraq** and **Jordan** reported no major disruption to health services during June.

WHO response

- In the **occupied Palestinian territory**, Health Cluster partners, coordinated by WHO, established or restored 119 health service points following the October 2025 ceasefire, including 58 in Gaza City and 15 in North Gaza. In the **Syrian Arab Republic**, WHO supported rapid health facility assessments across five governorates.

- During June, one medical evacuation mission transferred 21 patients, primarily children, from Gaza through **Jordan** to Spain and Türkiye, supporting access to specialized care unavailable in Gaza.

- In **Sudan**, WHO supported 13 hospitals, 4 primary health care facilities and 35 stabilization centres, while selecting an additional 20 hospitals and 25 primary health care facilities under the African Development Bank project. In **Yemen**, health partners supported 809 health facilities, reaching approximately 690 000 people with essential health services. In **Djibouti**, WHO supported mobile health teams, disease surveillance, nutrition services, immunization and health workforce capacity.

Medical supplies and logistics

- Medical supply chains remained under pressure across multiple emergencies. In the occupied **Palestinian territory,** one third of essential medicines were at zero stock, while humanitarian access restrictions continued to delay delivery of medicines, trauma supplies, fuel and medical equipment. In **Lebanon**, damaged infrastructure and insecurity continued to delay delivery of medical supplies to conflict-affected areas.
- In **Sudan**, insecurity, access restrictions, fuel and electricity shortages, banking constraints and disrupted transport continued to affect emergency health operations and medical supply pipelines, particularly in Darfur, Kordofan and Blue Nile. In **Somalia**, disruptions to therapeutic feeding supplies threatened nutrition services despite continued pre-positioning of emergency health and nutrition commodities ahead of drought and flooding. In **Yemen**, funding shortages continued to disrupt procurement and distribution of medicines, contributing to reduced health services across 141 districts.

WHO response

- In **Somalia**, WHO distributed cholera supplies, as well as 6 tonnes of essential medicines and medical supplies, paediatric severe acute malnutrition medicines, and cholera laboratory supplies, while receiving 400 pallets of essential medicines and diagnostics for pre-positioning. In **Sudan**, WHO distributed emergency health kits valued at US$146 751 and pre-positioned cholera and laboratory supplies.
- In the **occupied Palestinian territory**, WHO continued coordinating delivery of essential medicines, trauma supplies, fuel and medical equipment despite severe access constraints. In **Yemen**, Health Cluster partners maintained medicine and emergency health supply pipelines, while in the **Syrian Arab Republic**, WHO supplied essential medicines, emergency medical supplies and laboratory commodities to affected areas.
- **WHO's Global logistics hub in Dubai** airlifted two shipments of supplies to support the Ebola response in the Democratic Republic of Congo. As part of regional preparedness measures, WHO delivered to **Somalia** one viral haemorrhagic fever kit sufficient to manage 100 cases for 10 days, together with laboratory supplies, primers and reagents to test 50 samples. Shipments of viral haemorrhagic fever kits and laboratory supplies are also planned for delivery to Sudan, Djibouti and Libya.

Climate change and environmental health risks

- Climate-related hazards continued to increase public health risks across the Region. In **Iraq**, preparedness was intensified for extreme heat and the Arbaeen mass gathering, while **Somalia** forecast temperatures exceeding 35°C during the Hagaa dry season, increasing risks of dehydration, heat-related illness and livestock disease.
- In the **Syrian Arab Republic**, flooding along the Euphrates River affected Deir ez-Zor, Ar-Raqqa and Aleppo, resulting in 11 drowning deaths, disruption of referral pathways and health services, damage to water infrastructure, and increased waterborne disease risks. In the **occupied Palestinian territory**, inadequate water, sanitation and hygiene conditions, repeated displacement and shortages of essential supplies continued to increase communicable disease risks.
- In **Yemen**, rising temperatures, recurrent drought, erratic rainfall, flash floods, dust storms and environmental degradation are increasing the risks of heat-related illness, water-borne, and vector-borne diseases. Heat exposure is a growing concern, particularly in coastal, lowland, urban and displacement-hosting areas. Flash floods continue to damage health facilities, roads, water and sanitation systems and supply chains.

WHO response

- In the **Syrian Arab Republic**, WHO expanded the Early Warning, Alert and Response System, active case finding and community-based surveillance in flood-affected areas while supporting restoration of essential health services., while in **Iraq**, WHO supported preparedness for extreme heat and the Arbaeen mass gathering through enhanced surveillance and risk communication.
- In **Yemen**, climate resilience work included technical assessments, tendering and the start of solar power installation in 6 hospitals, 3 therapeutic feeding centres and 2 central public health laboratories. The intervention is expected to benefit vulnerable populations across 10 governorates while reducing dependence on diesel and protecting medical equipment from unstable electricity supplies.
- At **Regional level**, WHO delivered the first Regional Workshop on Health Vulnerability and Adaptation

Assessments (H-VAAs) and Health National Adaptation Plans (H-NAPs), on 15 June 2026. The workshop brought together around 36 participants from 18 countries, including ministry of health focal points and WHO country office staff, with contributing experts from the International Organization for Migration (IOM). Country teams were oriented on the H-VAA methodology, including approaches adapted for conflict-affected and fragile settings where routine health data, environmental monitoring and governance capacity are disrupted, drawing on recent assessments completed in the Region.

- Sessions addressed health facility climate resilience assessment, governance and adaptive capacity, and climate finance entry points for health, including the Green Climate Fund, the Adaptation Fund and the Fund for responding to Loss and Damage, to sustain adaptation in resource-constrained and crisis-affected settings. Participating countries developed preliminary 12-month H-VAA/H-NAP roadmaps, and a draft regional implementation framework was initiated to guide WHO support to Member States during the 2026-2027 biennium, with priority follow-up for countries affected by acute and protracted emergencies.

Protection from Sexual Exploitation, Abuse and Harassment (PSEAH)

- Humanitarian emergencies, displacement and weakened health systems continued to increase risks of sexual exploitation, abuse and harassment across the Region. In the **occupied Palestinian territory**, overcrowding, repeated displacement and limited survivor-centred services continued to heighten risks for women, girls, children, persons with disabilities and other vulnerable groups.

- In the **Islamic Republic of Iran**, WHO assessed the operational risk of sexual misconduct as *medium*. The risk remains significant and may be further heightened by the ongoing regional instability. The assessment also identified gaps in mainstreaming PSEAH across programmes and workplans. In the **Syrian Arab Republic**, expanding humanitarian operations, population movements and increased engagement with government institutions and partners reinforced the need to strengthen institutional safeguarding and integration of PSEAH across health programmes.

- In **Yemen**, conflict, displacement and weakened institutions continued to increase vulnerabilities, requiring strengthened prevention, accountability and survivor-centred approaches. In **Djibouti**, drought, food insecurity and displacement continued to increase risks of sexual exploitation, abuse, harassment and gender-based violence, particularly among refugees, asylum seekers, migrants, internally displaced persons, women and girls.

WHO response

- In the **occupied Palestinian territory**, WHO trained 40 WHO staff, 32 third-party contractor personnel, 38 Emergency Medical Team members, 10 Ministry of Health Prevention of Sexual Exploitation and Abuse focal points and 48 health-care providers on prevention of sexual exploitation, abuse and harassment, gender-based violence and the Clinical Management of Rape. An additional 15 certified gender-based violence and Clinical Management of Rape trainers completed refresher training, 60 Health Cluster partners signed the Prevention of Sexual Exploitation and Abuse Network Standard Operating Procedures, and eight partner organizations completed United Nations Partner Portal Prevention of Sexual Exploitation and Abuse assessments.

- In the **Islamic Republic of Iran**, WHO integrated ethical principles into mental health and psychosocial support training, assessed prevention of sexual exploitation, abuse and harassment capacity with two implementing partners, supported United Nations Partner Portal registration, and developed a country prevention of sexual exploitation, abuse and harassment proposal. In the **Syrian Arab Republic**, WHO implemented the Prevention of Sexual Exploitation and Abuse Annual Workplan, supported development of a Health Workforce Code of Conduct, strengthened partner capacity, and supported implementation of recommendations from the Inter-Agency Sexual Exploitation and Abuse Risk Assessment.

- In **Yemen**, WHO developed the Sexual Exploitation, Abuse and Harassment Action Plan for the World Bank-funded Yemen Health and Nutrition Water, Sanitation and Hygiene Project, expanded community engagement through 26 civil society organizations, integrated prevention of sexual exploitation, abuse and harassment into the Mental Health and Psychosocial Support Technical Working Group, and participated in Prevention of Sexual Exploitation and Abuse focal point training. In **Djibouti**, WHO and partners continued prevention of sexual exploitation, abuse and harassment training and awareness-raising activities.

- At **regional level**, WHO convened the 4th Annual Regional PRS Workshop in Cairo over two streams (23–25 June and 29 June–1 July 2026), bringing together participants from all three levels of the Organization,

including PRS champions and focal points. The workshop covered three thematic areas: risk management, compliance, and systems strengthening for PRS reporting and documentation. The 3-day workshop covered topics including victim/survivor-centred assistance, gender-based violence, institutional culture, and country collaboration across the Region; as well as the Government Accountability Framework, emergency response, community protection, and humanitarian coordination.

- Key gaps remain, including limited funding and human resources, weak referral pathways, limited community awareness of reporting mechanisms, uneven partner capacity, and insufficient institutionalized PSEAH systems across government institutions and implementing partners. Priority actions include expanding PSEAH capacity-building, strengthening reporting and referral mechanisms, supporting partner risk assessments and UNPP assessments, increasing community awareness of survivor services and reporting channels, and mainstreaming PSEAH across WHO-supported health programmes, partner agreements, and monitoring systems.

Mental health and psychosocial support

- Mental health and psychosocial needs continued to increase across emergencies due to conflict, displacement, food insecurity and uncertainty. In the **occupied Palestinian territory**, nearly one million children in Gaza are estimated to require MHPSS, while repeated displacement, insecurity and damaged infrastructure continued to disrupt continuity of care.

- In **Somalia**, protracted displacement, food insecurity and conflict continued to increase psychological distress, gender-based violence and unmet MHPSS needs. In **Djibouti**, drought, displacement and economic hardship contributed to stress, anxiety and depression, particularly among women and children.

- Service delivery remained constrained by damaged infrastructure, shortages of psychotropic medicines, limited numbers of trained mental health professionals, staff burnout, funding gaps and weak integration of MHPSS into emergency response. These challenges were reported in the **occupied Palestinian territory**, **Djibouti** and other countries facing acute and protracted emergencies.

WHO response

- In the **occupied Palestinian territory**, WHO strengthened the MHPSS system through rehabilitation of Ministry of Health mental health facilities, implementation of mhGAP-IG and Problem Management Plus (PM+), support for psychotropic medicines and coordination of 37 partners through the MHPSS Technical Working Group. WHO also supported establishment of a 17-bed inpatient mental health unit and seven outpatient consultation rooms at the Ophthalmic Hospital, rehabilitation of Berka Health Centre for outpatient and partial inpatient care, and planned training for 80 Palestine Red Crescent Society staff on self-care and stress management.

- In the **Islamic Republic of Iran**, WHO established an inter-agency referral pathway for specialized MHPSS services and supported capacity-building, with more than 5 900 participations in face-to-face activities, 3 000 participations in webinars, psychosocial support provided to 594 health workers, 94 referrals for specialized care and 463 hotline calls following training. In **Djibouti**, WHO supported integration of MHPSS into primary health care and community-based psychosocial support.

- At **Regional level**, WHO continues supporting implementation of the Regional Action Plan for Mental Health and Psychosocial Support (2024–2030), including strengthening preparedness, response, recovery and resilience, and integrating MHPSS into emergency preparedness and response planning across Member States. An orientation session on the regional MHPSS Dashboard for WHO country office focal points was conducted on 17 June to strengthen country capacity for mapping MHPSS resources and capacities. Preparations also continued for a dedicated MHPSS session during the pre-Regional Committee virtual week.

Risk Communication, Community Engagement & Infodemic Management (RCCE-IM)

- RCCE-IM remained central to emergency preparedness and response across emergencies, supporting outbreak response, vaccination, flood response, community-based surveillance and public health preparedness in the **occupied Palestinian territory**, **Somalia**, the **Syrian Arab Republic**, **Yemen** and the **Islamic Republic of Iran**.

- In the **Syrian Arab Republic**, RCCE focused on flooding and increased risks of waterborne diseases, leishmaniasis and scabies, while **Yemen** prioritized malaria and cholera prevention. In the **Islamic Republic of Iran**, RCCE supported preparedness for vector-borne diseases following damage to environmental health infrastructure and seasonal increases in vector activity. In the **Islamic Republic of Iran**, RCCE remains a non-

priority area within the Ministry of Health and no national RCCE focal point has been designated. In **Lebanon**, misinformation, population movements and access constraints continued to require adaptive communication approaches and strengthened community feedback mechanisms.

WHO response

- In the **Islamic Republic of Iran**, WHO launched RCCE activities under a CERF-supported vector-borne disease preparedness programme and developed a draft RCCE action plan. In **Somalia**, WHO reached approximately 1.5 million people through nationwide radio broadcasts and trained 73 female community leaders to strengthen community-based surveillance. In **Yemen**, WHO worked with 26 civil society organizations to strengthen community awareness, feedback and referral mechanisms while advancing malaria and cholera RCCE activities.
- In the **Syrian Arab Republic**, WHO trained 800 community health workers to reach approximately 35 000 households, 280 health directorate staff across all governorates on risk communication, rumour management and community engagement, and 40 Ministry of Health staff through a training-of-trainers programme. In **Lebanon**, WHO strengthened RCCE through community health education, digital communication, community volunteers and integration of health promotion into mobile medical teams.
- At **regional level**, WHO co-developed Qatar's National RCCE-IM Strategic Action Plan (2026–2030) with the Ministry of Public Health and facilitated a multisectoral stakeholder consultation to define operational roles. The strategy has been submitted for institutional endorsement.
- WHO also finalized a cross-departmental strategic package with contributions from more than 50 experts across the three levels of the Organization, providing actionable guidance for multiple audiences on intersecting public health and climate risks. The Regional Office also initiated the revitalization of the regional RCCE-IM interagency working group with UNICEF and IFRC by updating the terms of reference and mapping active partners ahead of upcoming technical sessions.

Regional emergency preparedness and operational readiness

- At regional level, WHO continued to provide technical support to Ministries of Health in priority countries to strengthen preparedness for **chemical, biological, radiological and nuclear (CBRN) incidents and emergencies**. Support focused on strengthening public health risk assessment, risk communication and community engagement, implementation of public health measures, protection of personnel and their dependents, and coordination of health sector preparedness and response, including for potential radiological and nuclear emergencies.
- WHO conducted a three-day regional workshop in Cairo to strengthen the development of national **Emergency Medical Teams (EMTs)** and their integration into national emergency preparedness and health systems. The workshop brought together 30 participants from the health, humanitarian, academic and civil society sectors to support the development of national EMT roadmaps aligned with the Emergency Medical Teams 2030 Strategy and the regional action plan.
- **Exercise Polaris II**, conducted during the second quarter of 2026 as part of WHO's HorizonX simulation programme, advanced regional and global health emergency preparedness by testing the operational application of the Global **Health Emergency Corps (GHEC)** and **National Health Emergency Alert and Response Frameworks.** The exercise engaged more than 600 health emergency experts across 26 countries and 14 time zones, demonstrating coordinated approaches to early event detection, rapid risk assessment and incident management. The exercise also tested the Quick and Immediate Risk Assessment (QIRA) algorithm and the draft GHEC AI platform, strengthening situational awareness and emergency workforce planning under simulated emergency conditions.
- Following recent Public Health Emergency Operations Centre training in Egypt, Sudan and Yemen, rollout of the **electronic Public Health Emergency Management Suite** is advancing to strengthen digital emergency management capacity across the Region. The platform has also been updated with new features for operational planning and response reporting, drawing on lessons from its use during the Ebola response in Uganda and the Marburg virus disease response in Ethiopia.

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