

From Resolution to Resilience

Making One Health work in the conflict-affected Eastern Mediterranean

The global architecture of One Health has never been more fully articulated, yet the Region that most needs it is losing the systems that carry it. A regional framework for fragile and conflict-affected settings must now convert commitments into functions that can survive war, displacement and the contraction of aid.

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KEY MESSAGES

- 1 An architecture strengthened but unfinished.** The amended International Health Regulations have been in force since 19 September 2025 and the Quadripartite One Health Joint Plan of Action now runs to 2029, but the WHO Pandemic Agreement cannot open for signature until its pathogen access and benefit-sharing annex is adopted.
- 2 A Region carrying a distinctive burden.** Almost one in three laboratory-confirmed bacterial infections in the Eastern Mediterranean is resistant to antibiotics — twice the global proportion — and the Region concentrates nearly half of global humanitarian need.
- 3 Institutionalisation advancing, but unevenly.** By 2024, ten of the Region's 22 countries and territories had developed a One Health strategy or operational framework and five had a formal governance structure; political instability and armed conflict head the list of obstacles.
- 4 A framework built around functions.** The regional initiative's six functions — Understand, Protect, Connect, Detect, Adapt, Recover — suit fragile settings, provided they are anchored in resolutions EM/RC69/R.5 and EM/RC72/R.3, use antimicrobial resistance as a sentinel indicator, and treat trade incentives and domestic financing as core.
- 5 Three priorities for the next 24 months:** protect and bundle an essential One Health package; build trade-safe, community-anchored detection; and finance One Health as a common good, domestically and counter-cyclically.

THE REGION AT A GLANCE

1 in 3

Bacterial infections resistant to antibiotics in the Region, against 1 in 6 globally (2023 data)

117 million

People in need of humanitarian assistance across the Region (July 2026)

41%

Share of attacks on health care reported worldwide in 2025 that occurred in the Region

10 of 22

Countries and territories with a One Health strategy or operational framework (2024)

Sources: WHO GLASS report 2025; WHO EMRO health emergencies situation report, July 2026; statement of the WHO Regional Director, January 2026; document EM/RC71/INF.DOC.8 (2024).

01 A region where the interfaces are the emergency

One Health rests on a simple proposition with demanding consequences: the health of people, animals and ecosystems is interdependent and must therefore be governed together. The definition advanced by the One Health High-Level Expert Panel, and adopted by the Quadripartite organisations — the Food and Agriculture Organization of the United Nations (FAO), the United Nations Environment Programme (UNEP), the World Health Organization (WHO) and the World Organisation for Animal Health (WOAH) — describes an “integrated, unifying approach” that seeks to “sustainably balance and optimize” the health of all three.^{1,2} Nowhere is that proposition tested more severely than in the WHO Eastern Mediterranean Region.

Across much of the Region, the human–animal–environment interface is not an abstraction at the margins of the health system. It is the shared borehole at which displaced families water their herds; the informal market in which antibiotics are sold without prescription for people and livestock alike; the field hospital whose untreated effluent reaches the same water; and the export quay on which entire pastoral economies depend. Conflict does not merely interrupt One Health programmes. It multiplies the interfaces through which pathogens and resistance travel, while dismantling the institutions designed to watch them.

It is against this background that an emerging regional initiative — *One Health in Conflict-Affected Settings: Documenting Experiences, Lessons and Priorities in the Eastern Mediterranean Region* — has set out to capture what practitioners have learned about sustaining One Health through protracted crises. Its premise is one I share from experience, including as Incident Manager for Somalia’s COVID-19 response: the conventional assumptions of One Health — stable governance, coordinated ministerial budgets, functioning laboratories and enforceable regulation — rarely hold where they are needed most. This essay is offered as a practitioner’s contribution to that initiative. It assesses where One Health stands in October 2026, explains why the Region represents its hardest test, and proposes how the initiative’s six-function framework can be translated into priorities on which governments, humanitarian actors and partners can act.

02 The state of One Health in 2026: a stronger architecture, an unfinished settlement

At the global level, the institutional scaffolding of One Health is more complete than at any point in its history. The Quadripartite’s One Health Joint Plan of Action (OH JPA), launched for 2022–2026 around six action tracks — from health-system capacities and zoonotic spill-over to food safety, antimicrobial resistance (AMR) and the environment — has been extended to 2029 under a renewed Memorandum of Understanding (2025–2030), with a structured review that will inform its next phase.^{2,3} The amended International Health Regulations (IHR), which introduce a “pandemic emergency” alert level and require States to designate National IHR Authorities, entered into force on 19 September 2025, although eleven of the 196 States Parties rejected them.⁴

The WHO Pandemic Agreement, adopted by the World Health Assembly on 20 May 2025, gives One Health its most explicit footing yet in international health law. Article 4 commits Parties to address the “drivers of infectious disease at the human-animal-environment interface” and to undertake “coordinated multisectoral surveillance”, while Article 5 requires them to “promote a One Health approach for pandemic prevention, preparedness and response”.⁵ The settlement nevertheless remains unfinished. The Agreement can open for signature only once the Health Assembly adopts its Pathogen Access and Benefit-Sharing (PABS) annex, and in May 2026 Member States agreed to continue negotiating that annex for consideration by the Eightieth

World Health Assembly in May 2027 or at a special session in 2026.⁶ No State — in the Region or elsewhere — has yet been in a position to sign.

On AMR, the 2024 political declaration of the United Nations General Assembly committed countries to reduce the estimated 4.95 million annual deaths associated with bacterial AMR by 10% by 2030, and to ensure that at least 60% of countries have funded national action plans.⁷ Without stronger action, some 39 million deaths directly attributable to AMR are forecast worldwide between 2025 and 2050.⁸ The Region has been central to this agenda. The Jeddah Commitments, adopted at the Fourth Global High-Level Ministerial Conference on AMR in November 2024, provided for an AMR One Health Learning Hub and a regional AMR access and logistics hub, both based in Saudi Arabia; the Fifth Conference, in Abuja on 6–8 December 2026, is expected to launch the Independent Panel on Evidence for Action against AMR.^{9–11}

Regionally, the decisive instrument remains resolution EM/RC69/R.5 of 2022, which urges Member States to “institutionalize the One Health approach” through a system of governance that includes “a legislative framework and adequate budgetary allocations”, to prioritise zoonoses, AMR and food safety, and to drive action through timely information-sharing among sectors.¹² It has since been complemented by resolution EM/RC72/R.3 of 2025 on health systems recovery in fragile and conflict-affected situations, which records that nine of the Region’s 22 countries and territories are classified by the World Bank as fragile and conflict-affected, and asks WHO to develop a regional coordination platform for health systems recovery.¹³

The first progress report on the One Health resolution is instructive. By 2024, ten countries had developed a One Health strategy or operational framework, five had established a formal governance structure, eight had held national joint risk assessment workshops and four had completed a prioritisation exercise. Political instability and armed conflict head the list of obstacles, alongside sectoral silos, funding gaps and insufficient or non-existent legal frameworks.¹⁴ The second progress report is due at the Regional Committee’s 73rd session in 2026. The conclusion is clear: in the Region, the binding constraint on One Health is no longer the absence of a mandate. It is the capacity to implement that mandate where the State is contested, budgets are fragmented and the institutions of all three sectors have been hollowed out by war.

Table 1. Milestones in the One Health policy landscape, 2021–2026

2021	▶ One Health High-Level Expert Panel publishes the operational definition of One Health
2022	▶ Quadripartite collaboration formalised with UNEP; One Health Joint Plan of Action 2022–2026 launched ▶ Regional Committee adopts resolution EM/RC69/R.5 on advancing One Health in the Region
2024	▶ IHR amendments adopted (June); UN General Assembly political declaration on AMR (September) ▶ First regional One Health progress report (EM/RC71/INF.DOC.8); Jeddah Commitments on AMR (November)
2025	▶ WHO Pandemic Agreement adopted (20 May); amended IHR enter into force (19 September) ▶ Resolution EM/RC72/R.3 on health systems recovery in fragile and conflict-affected situations (October)
2026	▶ PABS annex negotiations extended (May); OH JPA extended to 2029 and Quadripartite MoU renewed for 2025–2030 (August) ▶ Second regional One Health progress report due (RC73); Fifth Ministerial Conference on AMR, Abuja (6–8 December)

Sources: references 1–7, 9, 10, 12–14; author’s compilation.

03 Why the Eastern Mediterranean is One Health's hardest test

Four features distinguish the Region's One Health risk profile. Each is intensified by conflict.

Resistance at the highest recorded levels. WHO's 2025 global surveillance report found that one in six laboratory-confirmed bacterial infections worldwide in 2023 was resistant to antibiotic treatment; in the Eastern Mediterranean and South-East Asia Regions, the proportion was one in three.¹⁵ Conflict compounds the problem. A 2025 systematic review of conflict-associated wounds and burns in the Region — drawing on studies from Iraq, Libya, Lebanon, Yemen, Gaza and refugee settings in Jordan — found high rates of WHO priority pathogens among wounded civilians, while cautioning that the evidence is heterogeneous and of low quality and calling for stronger laboratory capacity and surveillance in conflict settings.¹⁶

Zoonoses embedded in livelihoods. The Region is the epicentre of Middle East respiratory syndrome (MERS). Of the 2,649 cases and 960 deaths reported worldwide since 2012, the great majority have been reported by Saudi Arabia — 2,218 of the 2,627 cases recorded by WHO to August 2025 — where dromedary camels are the major animal reservoir.^{17,18} Brucellosis, Rift Valley fever, anthrax and Crimean–Congo haemorrhagic fever remain persistent threats across pastoral and agricultural systems. Somalia's 2023 multisectoral prioritisation exercise, for example, selected seven priority zoonoses — Rift Valley fever, MERS, anthrax, trypanosomiasis, brucellosis, zoonotic enteric parasites and zoonotic influenza viruses — from an initial list of thirty-three.¹⁹

A concentration of humanitarian crises. In January 2026, WHO was responding to 15 graded health emergencies in the Region — one-third of all graded emergencies worldwide — and the Regional Director observed that nearly half of global humanitarian needs are concentrated there. In 2025, the Region accounted for 41% of all attacks on health care reported globally and more than 90% of the deaths linked to them.²⁰ By July 2026, 117 million people in the Region needed humanitarian assistance, 60.4 million were displaced persons of concern, and 48 disease outbreaks were active.²¹ Displacement concentrates people, livestock and vectors around scarce water and shelter, interrupts the vaccination of children and herds alike, and pushes care-seeking into informal markets where antimicrobials circulate unregulated.

Climate stress and the political economy of trade. Much of the Region is arid, and some 60% of the water of the Middle East and North Africa flows across international borders.²² Recurrent drought punctuated by flash floods drives herds and households into ever closer contact around shrinking water points and peri-urban displacement sites. At the same time, the livestock trade across the Red Sea binds the Horn of Africa to the Arabian Peninsula: in 2024, livestock accounted for an estimated 66% of Somalia's goods exports, worth about US\$1.03 billion.²³ History shows what is at stake when disease and trade collide. After the Rift Valley fever outbreaks of 1998–2000 in East Africa, Saudi Arabia and other Gulf countries banned imports of livestock and livestock products from Ethiopia for several years; one analysis estimated that it reduced the GDP of Ethiopia's Somali Region by 36%.²⁴ The lesson is uncomfortable but essential:

Where transparency is punished by embargo, silence becomes economically rational — and surveillance fails not for want of technology, but for want of incentives.

04 What conflict does to One Health

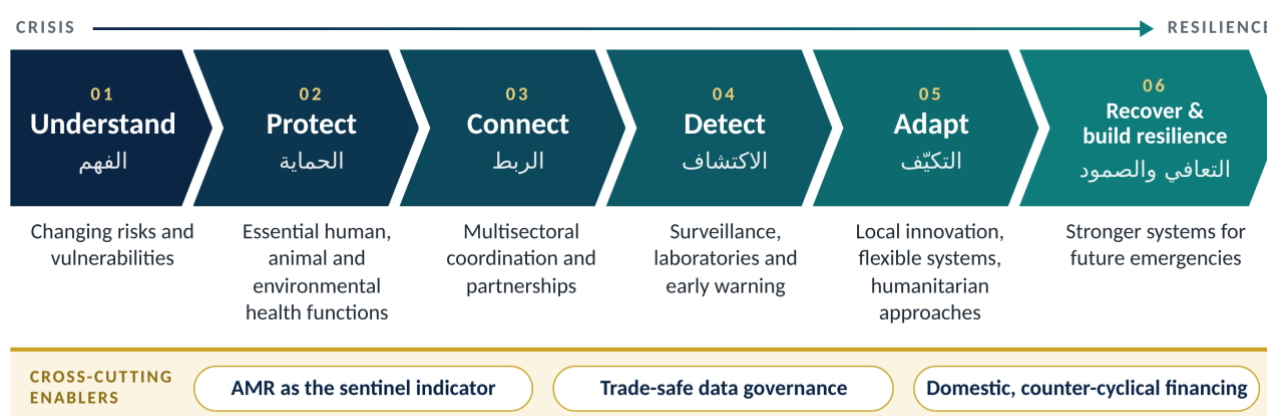
Practitioners across the Region describe a recognisable sequence, which the initiative's seven thematic axes capture well. Four mechanisms stand out.

- **Risks shift faster than systems adapt.** Displacement, environmental degradation and the collapse of water and sanitation remove the barriers that ordinarily separate people, animals and pathogens, so that zoonotic, vector-borne and resistance risks rise together.
- **Systems fragment.** Laboratories lose reagents, power and cold chains; veterinary services, rarely prioritised even in peacetime, are among the first to disappear; and skilled staff in all three sectors leave. The 2025 contraction of aid accelerated the erosion: more than 450 clinics closed in Afghanistan, Sudan and Syria alone, leaving 2.5 million people in need of treatment at risk.²⁵
- **Coordination fractures.** Ministries of health, livestock and environment may sit on different sides of a line of control, answer to different authorities, or compete for the same donor budget lines, while tensions between levels of government can paralyse joint outbreak investigation.
- **Financing shortens.** One Health activity in fragile settings is financed largely through humanitarian project cycles of 12 to 24 months, which end before institutions can form. The multilateral system is itself contracting: WHO's budget for the Region in 2026–2027 was reduced from US\$743 million to US\$534 million, and staff positions from 2,253 to 1,432, primarily through the abolition of vacant posts.²⁶ Globally, the 2026 Global Humanitarian Overview has had to prioritise US\$23 billion for 87 million people out of 239 million in need.²⁷ In Somalia, the health-sector humanitarian appeal was only 21% funded in July 2026.²¹

05 A six-function agenda for the Region

The initiative proposes a framework of six functions: **Understand**, **Protect**, **Connect**, **Detect**, **Adapt**, and **Recover and build resilience** (Figure 1). Its principal strength is that it is organised around what a One Health system must *do* in a crisis, rather than around the ministries that would ordinarily do it. That is the right unit of analysis for settings in which institutions are contested, displaced or absent. Table 2 sets out how each function can be anchored in instruments that already bind or guide the Region's Member States, so that the framework reinforces existing commitments rather than competing with them.

Figure 1. The six-function framework of the regional initiative, with three cross-cutting enablers proposed in this essay



Source: author, adapted from the concept note of the regional initiative; Arabic labels follow the initiative's original terminology.

Table 2. Translating the six functions into priority actions for fragile and conflict-affected settings

Function	What conflict changes	Priority actions	Anchoring instruments
01 Understand	Risk profiles shift with displacement, climate shocks and market disruption	Rapid joint risk assessment using the Tripartite Zoonoses Guide tools; periodic updating of priority-zoonosis lists; AMR tracked as a sentinel indicator	EM/RC69/R.5; Pandemic Agreement, Art. 4; OH JPA tracks 2 and 5
02 Protect	Essential human, animal and environmental services collapse first at the margins	A costed minimum One Health package: joint human–animal vaccination, WASH and infection prevention, basic veterinary care, antimicrobial stewardship	EM/RC72/R.3; OH JPA tracks 1, 3 and 6
03 Connect	Ministries and authorities are divided across lines of control	Coordination platforms with legal mandates and budget lines, linked to the regional recovery platform and to humanitarian clusters	EM/RC69/R.5; EM/RC72/R.3; National IHR Authorities
04 Detect	Facility-based surveillance and laboratories fail	Joint community event-based surveillance by community health and animal health workers; tiered laboratory networks; trade-safe data-sharing protocols	Amended IHR; Pandemic Agreement, Art. 4; WOA standards
05 Adapt	Static, facility-based models cannot reach mobile and displaced populations	Mobile One Health units; task-sharing between cadres; partnership with customary institutions such as Somali <i>xeer</i>	Pandemic Agreement, Art. 5; OH JPA track 1
06 Recover and build resilience	Short project cycles end before institutions form	Domestic, earmarked and counter-cyclical financing; One Health embedded in recovery and UHC strategies; access to climate finance	EM/RC72/R.3; Pandemic Fund; climate adaptation funds

Abbreviations: AMR, antimicrobial resistance; IHR, International Health Regulations; OH JPA, One Health Joint Plan of Action; UHC, universal health coverage; WASH, water, sanitation and hygiene; WOA, World Organisation for Animal Health.

Three design choices will determine whether the framework works in practice.

- **Make AMR the sentinel indicator.** Resistance integrates prescribing, infection prevention, veterinary use, sanitation and environmental contamination. A rising resistance rate is therefore the most sensitive signal that the One Health system as a whole is failing, and routine resistance data reported to global surveillance offer a metric that is already partly in place.
- **Design detection to be trade-safe.** Surveillance must be paired with prior agreement between exporting and importing States on risk-based, time-limited trade measures — drawing on WOA standards for zoning and compartmentalisation — so that early reporting earns a dividend rather than a penalty.
- **Treat financing as a function, not an input.** Surveillance, laboratory networks and outbreak investigation are common goods for health: they benefit whole populations, cannot be charged to individuals, and will not be financed by premiums or out-of-pocket payments.²⁸ They require explicit public financing. The World Bank has estimated that One Health prevention would cost US\$10.3–11.5 billion a year globally — less than 1% of the cost of COVID-19 in 2020 — with an annual rate of return of up to 86%.²⁹ Even if such estimates are treated with caution, the asymmetry between the cost of prevention and the cost of crisis is unmistakable.

As countries in the Region build social health insurance and design UHC benefit packages, One Health functions should be financed alongside, not inside, insurance pools: through earmarked general revenue; levies on the value chains that benefit from animal health, such as fractional cesses on livestock export certificates or abattoir fees; and programme-based budget lines shared across health, livestock and environment ministries.

BOX 1 Somalia: a sentinel case for the Region

- **Risk.** A 2023 multisectoral exercise identified seven priority zoonoses, including Rift Valley fever, MERS, anthrax and brucellosis.¹⁹
- **Institutions.** Somalia is among the ten countries in the Region reported to have developed a One Health strategy or operational framework,¹⁴ yet One Health initiatives remain driven largely by external funding, with limited institutionalisation across government sectors.^{30,31}
- **Economy.** Livestock accounted for about 66% of goods exports in 2024 and about 10% of GDP,²³ making animal health a macroeconomic as well as a public-health concern.
- **Financing.** In February 2026 the Pandemic Fund awarded US\$24.98 million to build Somalia's pandemic prevention, preparedness and response capacities, with the World Bank, FAO and UNICEF as implementing entities.³² Debt relief at the HIPC Completion Point in December 2023, worth some US\$4.5 billion in debt-service savings, offers an opening to establish domestic budget lines for core One Health functions.³³
- **Framework.** In ongoing work on Somalia, I have proposed a five-pillar framework — institutionalised governance, financial resilience, integrated intelligence, human capital, and community empowerment through legitimate local institutions — that maps directly onto the regional functions and treats AMR as a cross-cutting indicator of system performance.

06 Three priorities for the next 24 months

The initiative asks practitioners to name their three most important priorities for strengthening One Health in conflict-affected countries. Mine are as follows.

1**Protect and bundle an essential One Health package**

Every humanitarian response plan in the Region should include a costed minimum package that keeps the three sectors working together: joint vaccination of children and livestock at seasonal water points; community animal health workers deployed alongside community health workers; water, sanitation and infection-prevention measures; and basic antimicrobial stewardship. Evidence from nomadic communities in Chad shows that joint human–animal vaccination rounds reached more people per day than human-only rounds, while shared transport and equipment reduced total costs.³⁴

2**Build trade-safe, community-anchored detection**

Event-based surveillance that links community health and animal health workers, supported by tiered laboratory networks and by the National IHR Authorities now required under the amended Regulations, should be coupled with a regional compact between exporting and importing States on risk-based trade measures. Early reporting must carry a dividend, not a penalty.

3**Finance One Health as a common good — domestically and counter-cyclically**

Governments should create explicit budget lines for One Health functions, complemented by earmarked value-chain levies and climate-adaptation finance, and protected from the volatility of humanitarian funding. External grants, including those of the Pandemic Fund, should build institutions that outlast the grant rather than parallel projects that end with it.

07 What partners should do differently

- **Governments** should legislate mandates and budget lines for One Health coordination, as resolution EM/RC69/R.5 requests, and embed One Health in national recovery strategies under EM/RC72/R.3.
- **Humanitarian actors** should integrate animal and environmental health into health, WASH and food-security cluster planning, and treat community animal health workers as part of the frontline workforce.
- **Donors** should replace 12- to 24-month project cycles with multi-year, pooled financing aligned with national plans, and protect a minimum “One Health floor” for surveillance and laboratories during the current contraction.
- **The Quadripartite and WHO** should use the structured review of the OH JPA, the Abuja Ministerial Conference and the new Independent Panel on Evidence for Action against AMR to bring evidence from fragile and conflict-affected settings into global norms, and should disaggregate the forthcoming regional progress report by fragility status.
- **Universities and research institutions in the Region** should co-produce the evidence base with practitioners — implementation research on bundled services, AMR in informal markets, trade-safe data governance and domestic financing — so that the regional framework rests on the Region’s own experience.

08 Conclusion: One Health is not a luxury of stable states

It is tempting to regard One Health as an aspiration for countries that have already secured peace, functioning ministries and predictable budgets. The Eastern Mediterranean shows why that would be a mistake. It is precisely where conflict collapses the boundaries between people, animals and their environment that an integrated approach is most needed — and most likely to repay investment.

The global architecture has largely been built, and the Region’s own resolutions are in place. What remains is to make One Health operational under the conditions in which much of the Region actually lives. By documenting what has worked in the hardest places and translating it into a framework built around functions rather than ministries, the initiative can give the Region something the global system still lacks: a model of One Health designed for conflict, not merely tolerant of it. That is the task of moving from resolution to resilience — and it is one in which the Eastern Mediterranean can lead.

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SUMMARY IN SOMALI AND ARABIC

SOO KOOBID · AF-SOOMAALI

Laga bilaabo go'aannada ilaa adkaysiga: One Health ee Gobolka Bariga Badda Dhexe

Qaab-dhismeedka caalamiga ah ee One Health (Hal Caafimaad) aad ayuu u xoogaystay: Xeerarka Caafimaadka Caalamiga ah (IHR) ee wax laga beddelay waxay dhaqan galeen 19 Sebtembar 2025, Qorshaha Wadajirka ah ee One Health waxaa la kordhiyey ilaa 2029, halka Heshiiska Safmarka ee Ururka Caafimaadka Adduunka uu weli sugayo ansixinta lifaaqa helitaanka jeermisyada iyo qaybsiga faa'iidooyinka. Hase yeeshee, Gobolka Bariga Badda Dhexe ayaa wajahaya imtixaanka ugu adag: ku dhawaad saddexdii caabuuq ee bakteeriya ahba mid ka mid ah ayaa iska caabiya daawooyinka antibiyootigga, gobolkuna wuxuu xambaarsan yahay ku dhawaad kala badh baahiyaha bini'aadannimo ee adduunka. Maqaalkani wuxuu soo jeedinayaa in lixda hawlood ee hindisaha gobolka — Fahmid, Ilaalin, Isku-xirid, Ogaansho, La-qabsi, iyo Soo-kabasho iyo dhisidda adkaysiga — loo beddelo saddex mudnaan: ilaalinta xirmo adeeg oo aasaasi ah oo isku-dhafan (dadka, xoolaha iyo deegaanka); dhisidda kormeer cudurro oo bulshada ku saleysan, kana ilaalisa dalalka si hore u soo sheega cudurrada ciqaab xagga ganacsiga xoolaha ah; iyo maalgelinta One Health sidii adeeg guud oo laga maalgeliyo ilo gudaha ah si joogto ah.

ملخص · العربية

الصحة الواحدة في البيئات المتأثرة بالنزاعات: توثيق الخبرات والدروس والأولويات في إقليم شرق المتوسط

اكتملت البنية العالمية لنهج الصحة الواحدة إلى حدٍ بعيد؛ إذ دخلت اللوائح الصحية الدولية المعدلة حيّز النفاذ في 19 سبتمبر 2025، ومُددت خطة العمل المشتركة للصحة الواحدة حتى عام 2029، بينما لا يزال اتفاق منظمة الصحة العالمية بشأن الجوائح ينتظر اعتماد ملحق إتاحة المُمرضات وتفاصيل المنافع. غير أن إقليم شرق المتوسط يواجه أشدّ اختبار لهذا النهج: فنحو عدوى بكتيرية واحدة من كل ثلاث مقاومةً للمضادات الحيوية، ويتركز في الإقليم قرابة نصف الاحتياجات الإنسانية في العالم. ويقترح هذا المقال ترجمة الإطار السداسي للمبادرة الإقليمية — الفهم، والحماية، والربط، والاكتشاف، والتكيف، والتعافي وبناء القدرة على الصمود — إلى ثلاث أولويات: حماية حزمة أساسية متكاملة لصحة الإنسان والحيوان والبيئة، وبناء ترصد مجتمعي لا يُعاقب فيه الإبلاغ المبكر تجارياً، وتمويل الصحة الواحدة بوصفها منفعة عامة تمويلاً محلياً مستداماً ومعاكساً للدورات الاقتصادية.

Disclaimer. The views expressed are the author's own and do not necessarily represent the positions of the Social Health Insurance Authority, the Federal Government of Somalia or any institution with which the author is affiliated. **Competing interests:** none declared. **Data currency:** figures are as reported by the cited sources and were verified on 7 October 2026.

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