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A multi-communicable disease elimination approach for the Eastern Mediterranean Region

Executive summary

Communicable diseases are a major preventable cause of morbidity and mortality in the WHO Eastern Mediterranean Region. Progress towards target 3.3 of the Sustainable Development Goals (SDGs) remains uneven and is further influenced by several critical factors, including population displacement, protracted emergencies, health system fragility, fragmented health services and surveillance systems, and regional environmental determinants and weather-related factors, particularly those affecting the transmission of vector-borne diseases. Several priority communicable diseases remain off track to meet the SDG target for 2030, with their burden unevenly distributed geographically, socially and across population groups.

Many communicable disease programmes in the Region depend on health system functions such as surveillance, laboratory systems, service delivery platforms, supply chains, workforce and community engagement. However, these functions are often organized through parallel, disease-specific silos, reducing efficiency, weakening sustainability and limiting opportunities to deliver timely, people-centred services. This underscores the need for a more integrated and efficient approach to accelerate progress towards elimination targets (see detailed elimination definitions in Annex 1).

The multi-communicable disease elimination (MCDE) approach envisions a Region free from eliminable priority communicable diseases, where integrated, people-centred action, equitable access to health promotion, prevention, diagnosis and treatment services, and collective commitment drive disease elimination and reduce the risk of re-establishment of transmission. Building on WHO's multi-disease elimination (MDE) approach and lessons learnt from other WHO regions, this paper presents the analytical rationale, proposed strategic approach and overall MCDE framework architecture for the Region, anchored in shared functions and outputs. It presents MCDE as a pragmatic, country-led approach that promotes epidemiological and operational synergies across disease programmes, from prevention and control to elimination, while allowing implementation to remain context-specific. This integrated approach is intended to complement and strengthen existing disease programmes by enhancing shared health system functions, while preserving disease-specific expertise, targets and accountability.

The paper emphasizes prioritizing integrated approaches where diseases are co-endemic, where services and interventions can be delivered through common platforms or where integration can improve programme efficiency and effectiveness. Cross-border collaboration will be a critical enabler of MCDE, as the Region is characterized by high population mobility and shared transmission dynamics. Primary health care will serve as the main delivery platform for MCDE, enabling integrated, people-centred prevention, diagnosis and treatment services across priority diseases. Recognizing that countries in the Region are at different stages of disease elimination, ranging from high-burden to near-elimination settings, differentiated approaches are required that combine elimination acceleration, integration and health system strengthening, while also supporting enhanced disease control where elimination is not yet feasible or is not the defined target.

The MCDE initiative for the Eastern Mediterranean Region will prioritize the elimination of 14 communicable diseases: hepatitis B, including mother-to-child transmission (MTCT); hepatitis C; HIV (MTCT); leishmaniasis (visceral); leprosy; lymphatic filariasis; malaria; onchocerciasis; rabies; schistosomiasis; soil-transmitted helminthiases; syphilis (MTCT); trachoma; and tuberculosis. Beyond

this proposed priority list, countries will have the freedom and authority to further define priority diseases and elimination plans according to their national epidemiological context, disease burden, health system capacity and operational feasibility.

The proposed MCDE approach is organized around four action lines and a set of cross-cutting interventions to support implementation across countries and contexts. The four action lines are:

- strengthening governance, financing and health system functions to integrate and sustain MCDE efforts;
- operationalizing integrated, people-centred service delivery for MCDE;
- tracking and monitoring progress through integrated disease surveillance and information systems; and
- addressing social and environmental determinants of health, as well as barriers to access, affecting the elimination of communicable diseases.

The proposed outline of the MCDE framework (see Annex 2) is intended to inform the development of a regional framework in consultation with Member States. It will serve as the programmatic lens for accelerating communicable disease elimination in the Region and support Member States to identify opportunities to integrate planning, implementation and accountability across programmes through shared health system functions. The proposed approach will help to reduce the burden of preventable communicable diseases, lower mortality, prevent disability and accelerate progress towards the elimination and prevention of re-establishment of transmission.

Introduction

1. Communicable diseases continue to represent a major public health burden in the Eastern Mediterranean Region, which remains off track to meet target 3.3 of the Sustainable Development Goals (SDGs) to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases (NTDs) and combat hepatitis, waterborne diseases and other communicable diseases by 2030. Although gains were made before 2019, progress has since slowed or even reversed due to the COVID-19 pandemic, and inequities persist in access to health promotion and disease prevention, diagnosis and treatment services. Furthermore, progress is uneven across countries and continues to be undermined by protracted emergencies, conflicts, population displacement, cross-border transmission, environmental shocks, including droughts and flooding, and fragmentation of health services, disease surveillance and broader health information systems.

2. Disease elimination refers to the reduction to zero of the incidence of a specified disease or infection in a defined geographical area as a result of deliberate public health efforts, with continued measures required to prevent the re-establishment of transmission *(1)*. Depending on the disease and the available interventions, elimination targets may refer to elimination of transmission, elimination as a public health problem or elimination of specific transmission pathways, as defined in WHO disease-specific strategies (see detailed definitions in Annex 1). Although elimination targets are defined for individual diseases, they can be achieved through integrated approaches that improve efficiency by reducing duplication, optimizing resources and leveraging shared platforms across programmes.

3. Recognizing the need to strengthen common health system functions across disease programmes, WHO policy discussions have increasingly focused on integrated approaches to eliminating communicable diseases. Importantly, such approaches are intended to complement, rather than replace, existing disease-specific programmes by improving coordination while preserving country ownership, disease-specific expertise and accountability.

4. In 2019, Member States of the Pan American Health Organization approved the Disease Elimination Initiative, a pioneering regional framework promoting an integrated and sustainable approach to eliminating more than 30 communicable diseases and related conditions, as well as a number of noncommunicable diseases, through strengthened health system functions and coordinated interventions *(2)*.

5. Country experiences from other WHO regions have also shown that integrating disease elimination efforts can successfully catalyse impact. For example, in 2023 the Philippines launched a national multi-disease elimination (MDE) plan targeting 13 diseases through coordinated interventions and integrated service delivery within primary health care systems *(3)*. Similar country-led approaches have also been adopted in the Region of the Americas, including Brazil's *Saudável* programme *(4)* and national MDE plans in Panama (2025) *(5)* and Colombia (2026) *(6)*.

6. Building on these experiences, WHO released a global consultation paper on the MDE approach to ending more diseases together in 2024 *(3)*. The paper defines MDE as a people-centred approach to delivering services and intervention packages towards elimination. It notes that, as of 2024, WHO is targeting 32 diseases or conditions for elimination or eradication by 2030. The MDE approach is understood as an application of the primary health care approach to disease elimination, leveraging common platforms within the health system, across sectors and among communities.

7. The global consultation paper, together with relevant regional documents and country experiences, provides the foundation for advancing a coordinated MCDE approach in the Eastern Mediterranean Region. This is particularly relevant in a region affected by protracted emergencies, fragile health systems, high population mobility across borders and recurrent environmental shocks, including droughts and flooding.

8. This technical paper presents the analytical rationale for MCDE in the Region, outlines the proposed conceptual and strategic approach and introduces the architecture of the regional MCDE framework (see Annex 2) to guide its subsequent development through consultation with Member States.

Situation analysis

9. Communicable diseases remain a major cause of preventable mortality and morbidity in the Eastern Mediterranean Region, accounting for more than 8 million disability-adjusted life years lost in 2023 due to diseases such as viral hepatitis, HIV, malaria, NTDs, tuberculosis and sexually transmitted infections, including syphilis *(7)*.

10. Although all countries in the Region remain vulnerable to disease outbreaks and transmission risks, the burden of priority communicable diseases and the associated elimination challenges are disproportionately concentrated in countries affected by fragility, conflict, population movement, low service coverage and recurrent shocks, including Afghanistan, Pakistan, Somalia, Sudan and Yemen *(8)*. Pakistan alone accounts for the largest hepatitis C burden in the world *(9)* and malaria resurged in the country following the floods in 2022. More broadly, the burden of communicable diseases is greatest in settings characterized by fragility, conflict, poverty, low service coverage and high population mobility. This distribution also reflects persistent and systemic inequities in access to prevention, diagnosis and treatment, as well as continuity of care.

11. HIV is a growing epidemic in the Region, with an estimated 610 000 people living with HIV in 2024, double the number reported in 2015; however, only 37% knew their HIV status and 28% were receiving treatment *(10)*. Efforts to eliminate mother-to-child transmission (MTCT) of HIV also remain slow, except in a few countries. In 2022, only 1500 (19%) of the 7800 women living with HIV in the Region were receiving the needed treatment *(11)*. Progress in reducing the tuberculosis burden is similarly limited in the Region. Although many countries report low incidence of tuberculosis (fewer than 50 cases per 100 000 population), the Region as a whole achieved only 5.9% and 3.8% reductions in incidence and mortality, respectively, between 2015 and 2024 – well below the 2030 targets of 80% and 90% *(12)*. Viral hepatitis is also a major threat, with nearly 28 million people living with chronic hepatitis B or C in the Region *(9)*. An estimated 78 million people in the Region still require interventions against NTDs *(13)*.

12. In recent years, population displacement, cross-border movement, disruption of prevention and control services, as well as regional environmental and weather-related events, have increasingly influenced the transmission of vector-borne diseases in the Region. These diseases include those targeted for elimination, such as malaria, as well as other diseases (dengue, chikungunya and other arboviruses) for which prevention and control remain the principal strategies. Malaria remains endemic in six countries. There were 11.1 million malaria cases in 2024, with regional incidence increasing from 9.0 per 1000 population in 2015 to 19.1 per 1000 population in 2024, far above the 2030 target of 0.9 per 1000 population *(14)*. Between 2015 and 2024, malaria case incidence and estimated malaria mortality increased by 112% and 154%, respectively, in the Region *(14)*. The Islamic Republic of Iran detected locally acquired cases in 2022 after reporting zero indigenous malaria cases during 2018–2022. The resurgence was associated with the flooding in Pakistan in 2022, which increased cross-border population movement with the Islamic Republic of Iran and heightened the risk of malaria importation and local transmission. Dengue transmission has also increased, with 96 884 cases reported in 2024 from seven countries (Afghanistan, Djibouti, Iran (Islamic Republic of), Pakistan, Somalia, Sudan and Yemen) *(15)*. Chikungunya outbreaks have also been reported from Djibouti, Pakistan, Somalia, Sudan and Yemen.

13. Despite the challenges, several countries in the Eastern Mediterranean Region have demonstrated that progress and elimination are feasible. Since 2007, the Region has recorded multiple national achievements towards disease elimination and control, including WHO-validated, verified or certified elimination achievements across a range of diseases, including elimination of transmission, for example of malaria and some NTDs, and elimination of a transmission pathway, for example MTCT of HIV and

syphilis. Oman was the first country in the Region to eliminate MTCT of both HIV and syphilis in 2022 *(16)*. Egypt was certified malaria-free by WHO in 2024 (*17)* and was the first country in the Region to achieve hepatitis B control status in 2025 *(18*). Elimination of leprosy as a public health problem was achieved globally in 2000 *(19)*; current efforts focus on interrupting transmission. In 2024, Jordan became the first country globally to receive WHO verification of interruption of leprosy transmission *(20)*. Egypt (2025), Iran (Islamic Republic of) (2018), Iraq (2023), Libya (2026), Morocco (2016), Oman (2012), Pakistan (2024), Saudi Arabia (2022) and Tunisia (2026) have also eliminated trachoma as a public health problem *(21)*.

14. Beyond these disease-specific successes, the Region has also demonstrated practical examples of integrated approaches to disease control and elimination. Oman's elimination of MTCT of HIV and syphilis was supported through integrated maternal and child health services, while Yemen has implemented integrated preventive chemotherapy campaigns to control and eliminate schistosomiasis and soil-transmitted helminthiases *(22, 23)*. These experiences show that countries can achieve significant progress when strong political commitment, clear elimination targets, community engagement, robust surveillance and management capacities, and sustained implementation are combined.

15. Progress towards the elimination of 14 priority communicable diseases in the Region – including disease-specific targets for hepatitis B and C, malaria, eight NTDs[1] and tuberculosis, and transmission-pathway targets such as those for MTCT of HIV, hepatitis B and syphilis – was assessed against WHO-defined targets, using the most recent available regional data (see Annex 4)[2]. The assessment revealed wide variation across diseases and among countries, as well as important gaps in programme performance, reporting and continuity of progress. For analytical purposes, countries and territories were grouped according to their elimination progress profile, reflecting the number of targets achieved, on track or off track.

16. A first group of countries (Bahrain, Egypt, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia and the United Arab Emirates) show the strongest overall progress towards disease elimination, with more than 50% of the assessed targets already achieved.

17. A second group of countries and territories (Iran (Islamic Republic of), Iraq, Jordan, Libya, Morocco, Palestine and Tunisia) show an intermediate level of progress in disease elimination, with 25–50% of the assessed targets achieved.

18. A third group of countries (Afghanistan, Djibouti, Pakistan, Somalia, Sudan, the Syrian Arab Republic and Yemen) present the weakest elimination profile, with less than 25% of the assessed targets achieved and the highest concentration of off-track indicators.

19. In addition, the Region includes distinct epidemiological and geographical areas where integrated approaches are particularly relevant. A number of subregions are characterized by co-endemicity, defined as the simultaneous presence of multiple communicable diseases within the same population. The Red Sea rim, which includes Djibouti, Somalia, Sudan and Yemen, represents one such complex co-endemic zone, where the burden of multiple communicable diseases, including malaria, several NTDs, tuberculosis, HIV and chronic viral hepatitis B and C, overlaps. This concentration of co-endemicity warrants integrated, geographically targeted approaches to elimination and strengthened cross-border collaboration to address shared transmission risks across the Region.

20. These epidemiological trends underscore the importance of addressing the structural and systemic barriers that continue to constrain progress across the Eastern Mediterranean Region, including programme fragmentation, weak health systems and the broader contextual factors associated with fragile and conflict-affected settings, all of which limit the effectiveness, scalability and sustainability

[1] Leishmaniasis (visceral), leprosy, lymphatic filariasis, onchocerciasis, rabies, schistosomiasis, soil-transmitted helminthiases and trachoma.
[2] Using country data available at the WHO Regional Office for the Eastern Mediterranean.

of elimination efforts. Some of these factors are uniquely complex and persistent within the operating environment of the Region, requiring tailored and context-specific elimination strategies in response.

Strategic gaps and challenges

Weak health systems and programme fragmentation

21. In many countries of the Region, communicable disease programmes are organized in disease-specific silos across governance, financing, surveillance and service delivery, although efforts have been made in some settings to improve integration and coordination. While these programmes have achieved important disease-specific gains within their mandates, they have also contributed to duplication, reduced efficiency and weakened sustainability. In addition, access to innovative health technologies remains uneven across the Region, particularly in fragile and high-burden settings. Significant gaps persist in the availability, affordability and uptake of diagnostics, screening tools, vector control interventions and digital technologies, all of which are needed to support disease elimination.

22. Parallel programmes and financing and reporting mechanisms, separate surveillance and monitoring systems, vertical supply chains and procurement pathways, and parallel implementation arrangements, often operating through the same service delivery platforms, limit opportunities to share resources, align investments, combine workforce and community engagement efforts, and strengthen shared health system functions. At the same time, there are missed opportunities to leverage health technologies, including point-of-care and multiplex diagnostics, digital tools, and data analytics and interventions supported by artificial intelligence (AI). These technologies could help to extend capacity, improve efficiency and support integrated detection, monitoring and response across diseases. These existing inefficiencies are further compounded by workforce shortages, insecure access to services, disrupted supply chains and inconsistent service quality.

Emergency, fragile and conflict-affected settings

23. The Region includes multiple countries affected by protracted crises, with more than 117 million people in need of humanitarian assistance – one third of the global humanitarian burden – and 14 WHO-graded health emergencies across the Region, as of 30 June 2026. In many countries, health systems are already operating at the limits of their capacity, while ongoing and escalating regional conflicts further intensify pressure on health systems. Protracted crises have disrupted essential health services, displaced populations and further weakened already fragile health systems across the Region.

24. Resilience during emergencies is central to communicable disease elimination in the Region. Strengthening the capacity of health systems to maintain essential services, ensure continuity of care and sustain surveillance during crises is critical to prevent the reversal of gains and achieve the elimination targets.

Population mobility and weak cross-border collaboration

25. Population mobility is a major determinant of disease transmission in the Eastern Mediterranean Region. The Region is home to three of the world's largest displacement crises, with 31.4 million of the world's 67.7 million internally displaced persons 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. Recent crises have further intensified displacement, including an estimated 14.3 million displaced people in Sudan *(24)* and near-total displacement of the population in the Gaza Strip *(25)*.

26. Displacement increases exposure to infection and disrupts access to diagnosis, treatment and continuity of care. Border areas often have weak surveillance and low service coverage, but nonetheless frequently report higher numbers of cases of communicable diseases than other geographical areas. Cross-border collaboration remains limited and largely disease-specific, with insufficient integration

across programmes and inadequate use of referral mechanisms to ensure continuity of care for mobile populations.

Regional environmental and weather-related events affecting communicable diseases

27. Environmental and weather-related events affect communicable diseases in the Region through multiple pathways, particularly by influencing the transmission of vector-borne diseases. For example, the catastrophic floods in Pakistan in 2022 contributed to an estimated 6.6 million additional malaria cases between 2022 and 2024, with cases peaking at 2.7 million in 2023 compared with 0.4 million in 2021 *(26)*. Environmental and weather-related events have also been associated with wider transmission of dengue. Since January 2023, 12 countries in the Region have reported dengue outbreaks, up from only three countries in 2017 *(27)*.

28. Rising temperatures, erratic rainfall, flooding, drought and water insecurity can alter vector density and behaviour, extend transmission seasons and expand vector receptivity into previously non-endemic areas *(28)*. These conditions also exacerbate broader social and environmental determinants of health, contributing to food insecurity, malnutrition and displacement, increasing susceptibility to infection, reducing access to services and disrupting continuity of care. Such risks are further compounded by biological threats, including drug resistance, insecticide resistance and parasite mutations that affect diagnostic performance *(14)*. In this context, integrated vector-borne disease surveillance, seasonal risk forecasting and mobility-informed risk assessment are essential to achieving and sustaining elimination gains.

Sustainability after elimination

29. Sustaining elimination is a major challenge. Some countries remain at risk of reintroduction of transmission and potential reversal of elimination status, particularly where cross-border population mobility, shared ecological conditions and ongoing transmission in neighbouring countries persist. Sustaining elimination requires long-term investment in surveillance, prevention and health system resilience to prevent the re-establishment of transmission.

The MCDE approach

30. WHO has initiated a regional initiative to accelerate the elimination of communicable diseases by integrating interventions across programmes, harmonizing service delivery and measuring progress nationally and subnationally through routine monitoring. The MCDE initiative will prioritize the elimination of 14 communicable diseases: hepatitis B, including MTCT; hepatitis C; HIV (MTCT); leishmaniasis (visceral); leprosy; lymphatic filariasis; malaria; onchocerciasis; rabies; schistosomiasis; soil-transmitted helminthiases; syphilis (MTCT); trachoma; and tuberculosis. Beyond this proposed priority list, countries will have the freedom and authority to further define priority diseases and elimination plans according to national priorities, epidemiological context and disease burden, health system capacity, available resources and implementation readiness.

31. The vision of the MCDE approach is a Region free from eliminable priority communicable diseases, where integrated, people-centred action, equity and collective commitment drive sustainable elimination, strengthen disease control where needed and reduce the risk of disease re-establishment. Its goal is to support countries in transitioning towards integrated, evidence-based, context-sensitive programme planning and service delivery, while preserving disease-specific goals, accountability and verifiable progress across countries and populations.

32. In a Region characterized by significant variations in disease patterns, health system capacity and country vulnerability, integration should be applied selectively on the basis of disease characteristics and national context. Implementation of the MCDE approach will build upon disease-specific technical expertise, and maintain programme accountability and existing financing arrangements, while strengthening coordination and integration across shared health system functions in accordance with

national priorities and country contexts, and exploring additional financing mechanisms. The MCDE approach is particularly relevant where there is geographical co-endemicity, shared tools or functions, common service delivery platforms, clinical overlap or opportunities for synergistic operational efficiency. Accordingly, the approach combines regional disease-specific priorities, for example, coordinated actions to eliminate leprosy across the Region, and country-tailored multi-disease plans for the elimination of priority communicable diseases, with implementation remaining country-led and context-specific, building on or strengthening existing national governance structures and capacities of disease-specific programmes. Furthermore, it supports both elimination and control efforts, recognizing that countries are at different stages of epidemiological transition and elimination readiness.

33. From an economic perspective, the MCDE approach is justified because integration offers important opportunities to reduce duplication, administrative burden and fragmented patient care. Multi-disease surveillance and integrated diagnostic platforms can also improve efficiency in resource allocation and strengthen service integration. The economic case is supported by WHO evidence that integrated NTD interventions, including preventive chemotherapy, can generate approximately US$ 25 in economic benefits for every US$ 1 invested *(29)*.

34. The MCDE approach is expected to generate a set of shared outputs across programmes as key deliverables, including acceleration scenarios and pathways for disease elimination; multi-programme elimination strategies and plans; consolidated guidelines; interoperable information systems; joint operational and implementation research; cross-programme evaluation and efficiency analyses; and harmonized standards for confirmation of elimination through standardized tools, surveys and documentation, where feasible.

35. WHO has developed the regional MCDE initiative through strategic discussions, the theory of change underpinning it (see Annex 3a and the visual representation in Annex 3b), disease mapping, situational analyses (see Annex 4) and the development of dashboards. The next steps will include the full development of the regional MCDE framework and its monitoring and evaluation mechanisms through consultation with Member States and experts; establishment of regional governance and advisory structures in consultation with Member States and, where appropriate, building on existing regional coordination mechanisms; and the engagement of partners. The framework will align with existing global, regional and national disease-specific strategies, targets and monitoring, evaluation and reporting mechanisms, using existing data flows, where feasible, to avoid parallel arrangements. An investment case will also be developed to support resource mobilization on a regional and/or country basis, as appropriate.[3]

36. Implementation of plans and activities across countries will take a phased approach, followed by regional scale-up informed by documented lessons and peer learning. Regional knowledge-sharing will draw, where relevant, on the experience of countries that have achieved or are approaching multiple disease elimination targets, to support the context-specific adaptation of effective approaches across Member States and eventual institutionalization within national health plans, financing mechanisms and governance systems. The Secretariat will support countries in developing integrated, costed MCDE plans and intervention packages and with related confirmation processes (validation, verification and certification, as applicable), while embedding post-elimination surveillance into national health systems to ensure sustainability.

37. In line with WHO's global MDE consultation paper *(3)*, the regional MCDE approach is anchored in six shared functions that constitute the core health system capacities required to sustain elimination: people-centred delivery of services and interventions; inclusive governance and stewardship; pooled financing and strategic purchasing mechanisms[4]; joint procurement and integrated supply chains;

[3] No regional financing arrangement is proposed or endorsed at this stage. Any subsequent consideration of financing arrangements will be conducted in consultation with Member States, on a voluntary basis and without creating any financing obligation for Member States.

[4] In this context, pooled financing and strategic purchasing refer to national health financing functions, namely the pooling of prepaid domestic funds and their allocation to services, and do not imply any regional or cross-country financing arrangement.

multidisciplinary workforce development approaches; and interoperable health information systems and integrated disease surveillance.

38. Four action lines are proposed to operationalize the shared functions across diseases and settings, translating system-level capacities into coordinated, country-led interventions. In practice, each action line draws on and reinforces multiple shared functions. Under each action line, a set of cross-cutting interventions has been identified for coordinated, country-led action and constitute the basis for the future MCDE regional framework (Annex 2). These are as follows:

a. Strengthening governance, financing and health system functions to integrate and sustain MCDE efforts through:
   - Establishing or strengthening inclusive cross-sectoral governance and coordination mechanisms, including national MCDE committees, working groups and focal points.
   - Promoting sustainable financing through domestic resource allocation and integration of MCDE costing into national health strategies, while safeguarding adequate financing for essential disease-specific functions and interventions that require continued programme-specific capacity.
   - Deploying pooled or blended financing for integrated elimination packages at country level, where appropriate and in accordance with national circumstances, and leveraging partners and donors working with the country.
   - Promoting joint forecasting, integrated supply chain management and pooled procurement for diagnostics, medicines and other essential commodities.
   - Strengthening a multidisciplinary workforce, including by building the capacity of primary health care and community-based providers, and providing supervision, leveraging, as appropriate, regional training institutions and WHO collaborating centres to support joint training, implementation research and capacity-building across Member States, in accordance with their agreed terms of reference.

b. Operationalizing integrated, people-centred service delivery for MCDE through:
   - Progressively ensuring that promotive and preventive interventions, including immunization, services for the triple elimination of MTCT of HIV, hepatitis B and syphilis as well as other essential public health measures, are delivered through integrated service delivery platforms throughout the life course, with particular attention to maternal and child health.
   - Integrating health promotion and disease prevention, diagnosis, treatment and care through primary health care, where appropriate, with public, private and community providers aligned with national quality and notification requirements, and supported by outreach and community-based services.
   - Developing practical toolkits for the delivery of integrated service packages through primary health care platforms at both community and facility levels.
   - Prioritizing high-burden settings and vulnerable populations through targeted, context-specific intervention packages and subnational approaches.
   - Strengthening integrated vector management for malaria, dengue and other vector-borne diseases.
   - Improving access to appropriate health technologies, such as point-of-care and multiplex diagnostics, and multipurpose medicines, including antiparasitics, antibiotics and antivirals, as well as innovations for prevention, screening, diagnosis and treatment, including digital health and AI-enabled solutions, where appropriate and in accordance with national policies and applicable ethical and regulatory safeguards.

c. Tracking and monitoring progress through integrated disease surveillance and information systems through:
   - Progressively integrating national information systems by linking routine, event-based, laboratory, environmental and community data across diseases and sectors.

- Strengthening and investing in interoperable digital surveillance and information systems, including case-based surveillance, and establishing timely or near-real-time monitoring dashboards to enable integrated analysis of multiple data sources for identifying hotspots, co-endemic areas and populations at risk, and tracking progress towards national and subnational elimination milestones.
- Strengthening laboratory capacities in data management and quality assurance, implementing standardized protocols for priority diseases, investing in interoperable laboratory information systems, and strengthening national and regional reference laboratory networks.
- Promoting cross-border collaboration and data sharing, including the use of geographic information systems (GIS), in areas affected by population mobility and shared transmission risks, and incorporating equity indicators to monitor reach for mobile and other vulnerable populations, as well as coverage for communicable disease prevention, detection and treatment.
- Developing and launching real-time platforms to track national and subnational elimination milestones across priority communicable diseases.
- Maintaining post-elimination surveillance for a defined minimum period and establishing clear criteria for reversal of elimination status, where needed and feasible.

d. Addressing social and environmental determinants of health, as well as barriers to access, affecting the elimination of communicable diseases, through:
   - Leveraging the Early Warning and Response System (EWARS), supported by integrated vector and epidemiological surveillance, GIS-based risk mapping and population, environmental, meteorological and seasonal data, to strengthen integrated responses.
   - Incorporating environmental risk layers into MCDE planning, including flood-prone areas, drought-affected districts, vector expansion zones, water insecurity hotspots and high-mobility border corridors.
   - Prioritizing fragile, water-insecure and displacement-affected settings where environmental conditions and population mobility amplify transmission risks.
   - Aligning MCDE efforts with water, sanitation and hygiene (WASH) platforms and strengthening WASH interventions in areas targeted for disease elimination.
   - Removing barriers to access by promoting equitable access to essential testing, prevention and treatment services for priority diseases without financial hardship, including, where provided for by national policy, services free of charge at the point of care, with particular attention to refugees, migrants and other vulnerable populations.
   - Strengthening equity-focused outreach and structured cross-border mechanisms, such as cross-border compacts, country twinning arrangements, peer-learning networks, information-sharing and cross-border referral pathways, to support continuity of diagnosis, treatment and follow-up for mobile, displaced and other vulnerable populations.
   - Strengthening multisectoral collaboration and One Health approaches, and encouraging a whole-of-government approach, to address communicable disease determinants and promote partnerships among the health, environment, veterinary and other health-related sectors.

Conclusion

39. Accelerating communicable disease elimination and control in the Eastern Mediterranean Region requires sustained political commitment and a decisive shift towards integrated, coordinated and people-centred approaches. The MCDE framework will provide a practical pathway for the Region to align efforts, strengthen health systems and deliver impact at scale across diverse settings.

40. The success of the MCDE initiative will depend on country leadership, regional collaboration and sustained investment to translate this vision into measurable and lasting progress towards SDG target 3.3.

41. The 73rd session of the WHO Regional Committee for the Eastern Mediterranean is invited to endorse the regional MCDE approach, including the proposed six shared functions and four action lines, and to take note of the preliminary architecture of the regional MCDE framework, which will be further developed and finalized through consultation with Member States.

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Annex 1. Definitions of the different levels of disease elimination

This annex provides standardized definitions of the different levels of disease elimination, based on the WHO consultation paper on multi-disease elimination[6,] to promote a common understanding and harmonized use of terminology across disease-elimination programmes.

Control is defined as the reduction in incidence, prevalence, morbidity or mortality of a disease, condition or risk factor to a locally acceptable level within a defined geographical area. When reached, continued action is required to maintain the reduction. There is no formal WHO process for confirmation of control.

Elimination as a public health problem is the sustained reduction in incidence, prevalence, morbidity or mortality of a disease, condition or risk factor to a target level at which the public health burden is considered negligible within a defined geographical area. The target level is absolute or relative to a baseline and must be sustained for a certain number of years, as defined globally or regionally by WHO.[7] Countries and regions meeting the criteria for elimination as a public health problem can undergo **validation** by WHO headquarters or a WHO regional office, as appropriate.

Elimination of transmission is the sustained reduction to zero of the incidence of infection caused by a specific pathogen in a defined geographical area, with minimal risk of reintroduction. Surveillance and zero incidence must be sustained for a certain number of years, as defined globally or regionally by WHO. Countries and regions meeting the criteria for elimination of transmission can undergo **verification** by WHO headquarters or a WHO regional office. Verified countries or regions may then be considered free from infection. Post elimination refers to the period following verification.

Interruption of transmission is less formal than elimination of transmission, referring to a reduction to zero of the incidence of infection that is temporary or not yet verified. The period after the last reported case and before verification is referred to as **pre-elimination**.

Eradication is the sustained reduction to zero of the worldwide incidence of infection by a specific pathogen in humans and all potential reservoirs, with no risk of reintroduction, barring escape of the pathogen from containment laboratories. Eradication is the special case of elimination of transmission in all countries. Countries meeting the criteria for elimination of transmission in the context of a target for eradication can undergo **certification** by WHO headquarters.

[6] The multi-disease elimination approach: ending more diseases together. Consultation paper. Geneva: World Health Organization; 2024 (https://cdn.who.int/media/docs/default-source/multi-disease-elimination/mde-consultation-paper.pdf).
[7] Any cases detected during the required minimum period must have been imported from outside of the defined geographical area.

Annex 2. Outline of the multi-communicable disease elimination framework for the Eastern Mediterranean Region

This annex provides an outline of the proposed multi-communicable disease elimination (MCDE) framework, organized around the four action lines proposed within the MCDE approach (as described in paragraph 38 of the technical paper), and a set of cross-cutting strategic interventions, supported by measurable indicators. It is intended to guide the subsequent development of the full regional MCDE framework in consultation with Member States and to support country-led, context-specific implementation across diverse epidemiological and health system settings in the WHO Eastern Mediterranean Region. The illustrative implementation (tracer) indicators are intended to monitor progress strategically. Detailed indicator definitions, metadata, disaggregation, baselines and targets, including additional indicators where appropriate, will be developed as part of a full regional monitoring and evaluation framework.

Strategic intervention	Contribution to expected results (Outputs and Outcomes)	Indicator
Action line 1. Strengthening governance, financing and health system functions to integrate and sustain MCDE efforts		
Develop national MCDE plans or strategies and establish inclusive governance and coordination mechanisms.	Integrated policies and planning; strengthened governance; sustained political leadership.	Number of countries with an approved and costed national MCDE strategy/plan supported by a functional national MCDE coordination mechanism (e.g. a national focal point, committee or working group led by the Ministry of Health).
Promote sustainable financing and resource mobilization for MCDE.	Sustainable financing and domestic investment.	Number of countries with sustainable financing mechanisms supporting implementation of the MCDE approach.
Invest in joint procurement and integrated supply chain management, as part of strengthening integrated health system functions	Strengthened health system capacity and resilience.	Number of countries implementing an integrated approach across two or more priority communicable disease programmes in joint procurement and supply chain management.
Strengthen a multidisciplinary workforce for MCDE by building the competencies of primary health care and community-based providers.	Strengthened health system capacity and resilience.	Number of countries with integrated, multidisciplinary teams and competency-based training programmes for multi-disease service delivery.
Strengthen collaboration across borders to support implementation of MCDE.	Improved coordination, continuity of services and cross-border collaboration.	Number of countries implementing formal cross-border collaboration mechanisms supporting communicable disease elimination.
Action line 2. Operationalizing integrated, people-centred service delivery for MCDE		
Develop or adapt and implement integrated service delivery packages and operational toolkits through primary health care.	Integrated service delivery models established.	Number of countries implementing integrated service delivery packages for two or more priority communicable diseases through primary health care.
Prioritize high-burden settings and vulnerable populations through targeted outreach and context-specific intervention packages.	Improved equitable coverage and access to communicable disease services.	Number of countries implementing targeted intervention packages for high-burden settings and/or vulnerable populations.
Strengthen integrated public health interventions, including integrated vector management.	Improved implementation of integrated prevention interventions.	Number of countries implementing integrated vector management interventions for priority communicable diseases.
Improve access to appropriate health technologies and innovations for communicable disease elimination.	Increased access to quality diagnostics, medicines and innovative technologies.	Number of countries having health technologies supporting integrated communicable disease services.
Action line 3. Tracking and monitoring progress through integrated disease surveillance and information systems		
Progressively integrate national communicable disease surveillance systems by linking routine, event-based, laboratory, environmental and community data across diseases.	Strengthened integrated disease surveillance, monitoring and information systems.	Number of countries with functioning integrated disease surveillance linking routine, event-based, laboratory, environmental and community data across two or more priority diseases.
Strengthen laboratory systems, diagnostic capacity and quality assurance.	Strengthened laboratory and diagnostic capacity.	Number of countries implementing standardized protocols and laboratory quality management systems for two or more priority communicable diseases.
Strengthen cross-border surveillance, data sharing and monitoring of vulnerable populations.	Improved regional surveillance and equitable monitoring.	Number of countries implementing formal cross-border surveillance and information-sharing mechanisms.

Strategic intervention	Contribution to expected results (Outputs and Outcomes)	Indicator
Monitor progress towards disease elimination plans.	Strengthened integrated surveillance, monitoring and information systems.	Number of countries reporting elimination milestones through integrated digital information systems.
Strengthen and sustain post-elimination surveillance.	Strengthened integrated surveillance and response to communicable diseases	Number of countries maintaining post-elimination surveillance system and reporting
Action line 4. Addressing social and environmental determinants of health, as well as barriers to access, affecting the elimination of communicable diseases		
Integrate climate*, environmental and social risk considerations into MCDE planning.	Climate* and environmental risks are incorporated into communicable disease elimination planning.	Number of countries integrating climate*, environmental and social risk considerations into national communicable disease elimination strategies or plans.
Strengthen preparedness and response through EWARS and integration of epidemiological, vector and climate information*.	Strengthened preparedness and response to climate-sensitive* and epidemic-prone communicable diseases.	Number of countries implementing integrated early warning and preparedness systems incorporating epidemiological, vector, environmental and climate information*.
Strengthen multisectoral action to address communicable disease determinants, including WASH and other relevant sectors.	Disease determinants addressed through multisectoral collaboration.	Number of countries with operational multisectoral coordination mechanisms addressing communicable disease determinants (for example, on One Health, integrated vector management, screening and management of communicable diseases in migrants, and human rights' committees or working groups).

EWARS: Early Warning and Response System; WASH: water, sanitation and hygiene.

*The "climate" elements refer to and are consistent with the Operational action plan for climate change and health in the Eastern Mediterranean Region (2026–2030) (EM/RC72/10), adopted by the 72nd session of the WHO Regional Committee for the Eastern Mediterranean through resolution EM/RC72/R.6 (2025), and are meant to be interpreted in accordance with national priorities and circumstances.

Annex 3a. Theory of change underpinning the multi-communicable disease elimination approach for the Eastern Mediterranean Region: vision, impact, outcomes, outputs, assumptions and risks

This annex sets out the theory of change underpinning the multi-communicable disease elimination approach for the WHO Eastern Mediterranean Region, including the vision, impact, outcomes, outputs, assumptions and risks. A visual representation of the theory of change is provided in Annex 3b.

Vision

A Region free from eliminable priority communicable diseases

Impact

- Reduced incidence of targeted communicable diseases
- Reduced morbidity and mortality associated with targeted communicable diseases
- Sustained disease elimination achievements
- Achievement of Sustainable Development Goal target 3.3 on communicable diseases by 2030

Outcomes

Long-term outcomes (LO)

1. Integrated communicable disease programmes and shared health system functions
2. Resilient, adaptive and high-quality health systems for communicable disease elimination
3. Sustained political leadership and domestic investment
4. Disease risk determinants addressed through multisectoral action

Medium to short-term outcomes (M/SO)

1. Strengthened health system functions and capacity for communicable disease elimination
2. Sustainable partnerships and resource mobilization
3. Empowered communities and increased uptake of services
4. Strengthened governance, financing and multisectoral action
5. Improved equitable coverage of communicable disease interventions
6. Strengthened integrated surveillance and response to communicable diseases

Outputs

Foundational outputs, aligned with outcomes, across all four action lines of the multi-communicable disease elimination approach:

1. Integrated policies, plans and guidelines aligned across priority communicable diseases (LO1, M/SO6)
2. Integrated primary health care service packages of services established to deliver prevention, detection, treatment and response for communicable diseases (LO1, LO2, M/SO1, M/SO5, M/SO6)
3. Resilient supply chain systems established to ensure uninterrupted access to essential commodities (LO2, M/SO1, M/SO5, M/SO6)
4. Integrated digital surveillance, monitoring and reporting tools and systems strengthened across priority communicable diseases (LO1, M/SO6)
5. Diagnostic networks established and strengthened to ensure capacity for communicable disease detection (LO2, M/SO1)
6. Community engagement and outreach packages for communicable diseases developed to drive service demand and uptake (LO2, LO4, M/SO3, M/SO5)

7. Operational plans for cross-border collaboration developed to support continuity of prevention, treatment and surveillance (LO1, LO2, M/SO1, M/SO5)
8. Climate*, environmental and social risk considerations integrated into communicable diseases elimination planning and strategies (LO4, M/SO4)
9. Investment cases and advocacy packages produced (LO3, M/SO2, M/SO4)

Assumptions

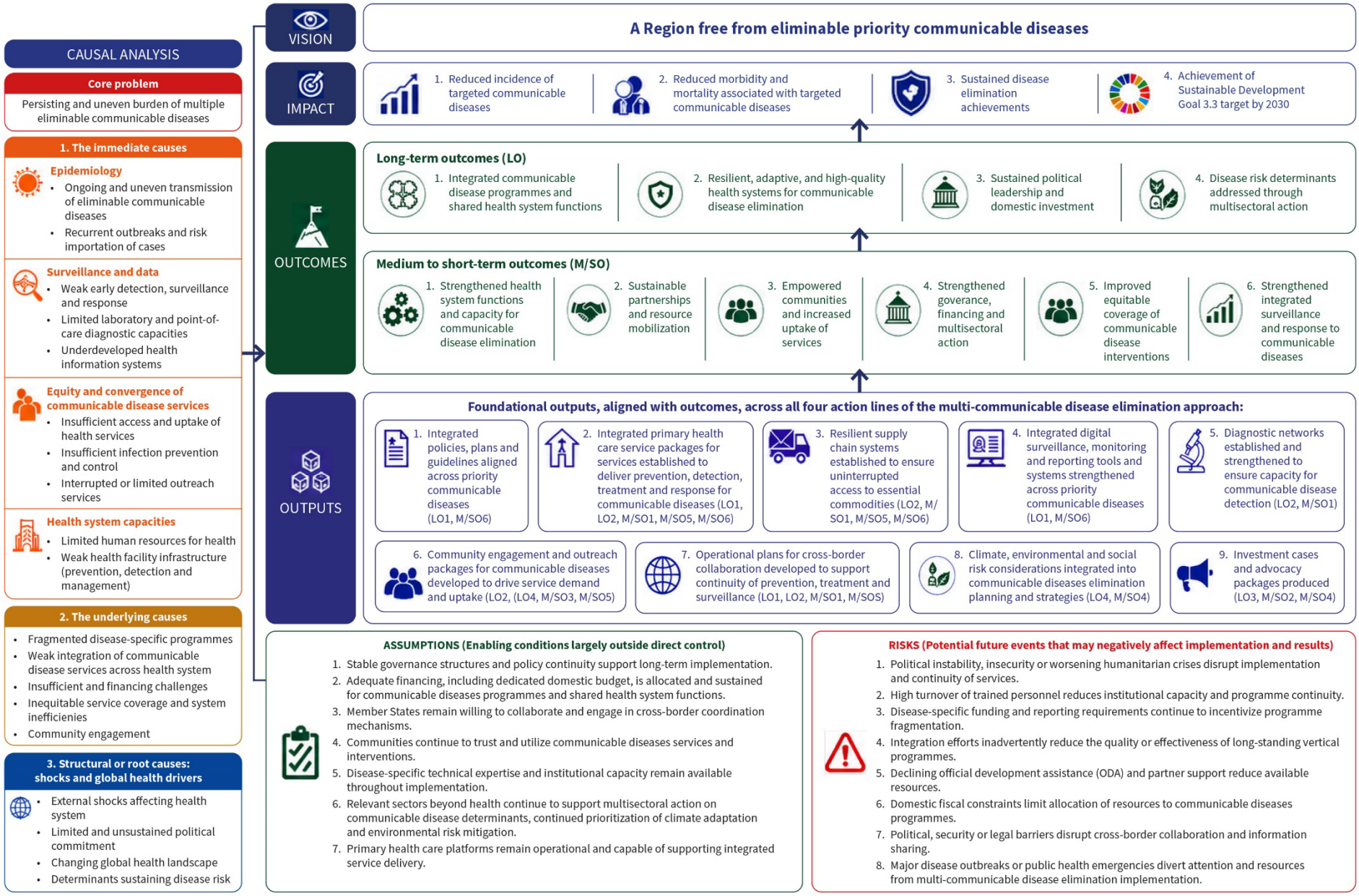
1. Stable governance structures and policy continuity support long-term implementation.
2. Adequate financing, including dedicated domestic budget, is allocated and sustained for communicable disease programmes and shared health system functions.
3. Member States remain willing to collaborate with and engage in cross-border coordination mechanisms.
4. Communities continue to trust and utilize communicable disease services and interventions.
5. Disease-specific technical expertise and institutional capacity remain available throughout implementation.
6. Relevant sectors beyond health continue to support multisectoral action on communicable disease determinants, continued prioritization of climate* adaptation and environmental risk mitigation.
7. Primary health care platforms remain operational and capable of supporting integrated service delivery.

Risks

1. Political instability, insecurity or worsening humanitarian crises disrupt implementation and continuity of services.
2. High turnover of trained personnel reduces institutional capacity and programme continuity.
3. Disease-specific funding and reporting requirements continue to incentivize programme fragmentation.
4. Integration efforts inadvertently reduce the quality or effectiveness of long-standing vertical programmes.
5. Declining official development assistance (ODA) and partner support reduce available resources.
6. Domestic fiscal constraints limit allocation of resources to communicable disease programmes.
7. Political, security or legal barriers disrupt cross-border collaboration and information sharing.
8. Major disease outbreaks or public health emergencies divert attention and resources from multi-communicable disease elimination implementation.

*The “climate” elements refer to and are consistent with the Operational action plan for climate change and health in the Eastern Mediterranean Region (2026–2030) (EM/RC72/10), adopted by the 72nd session of the WHO Regional Committee for the Eastern Mediterranean through resolution EM/RC72/R.6 (2025), and are meant to be interpreted in accordance with national priorities and circumstances.

Annex 3b. Visual representation of the theory of change underpinning the multi-communicable disease elimination approach for the Eastern Mediterranean Region



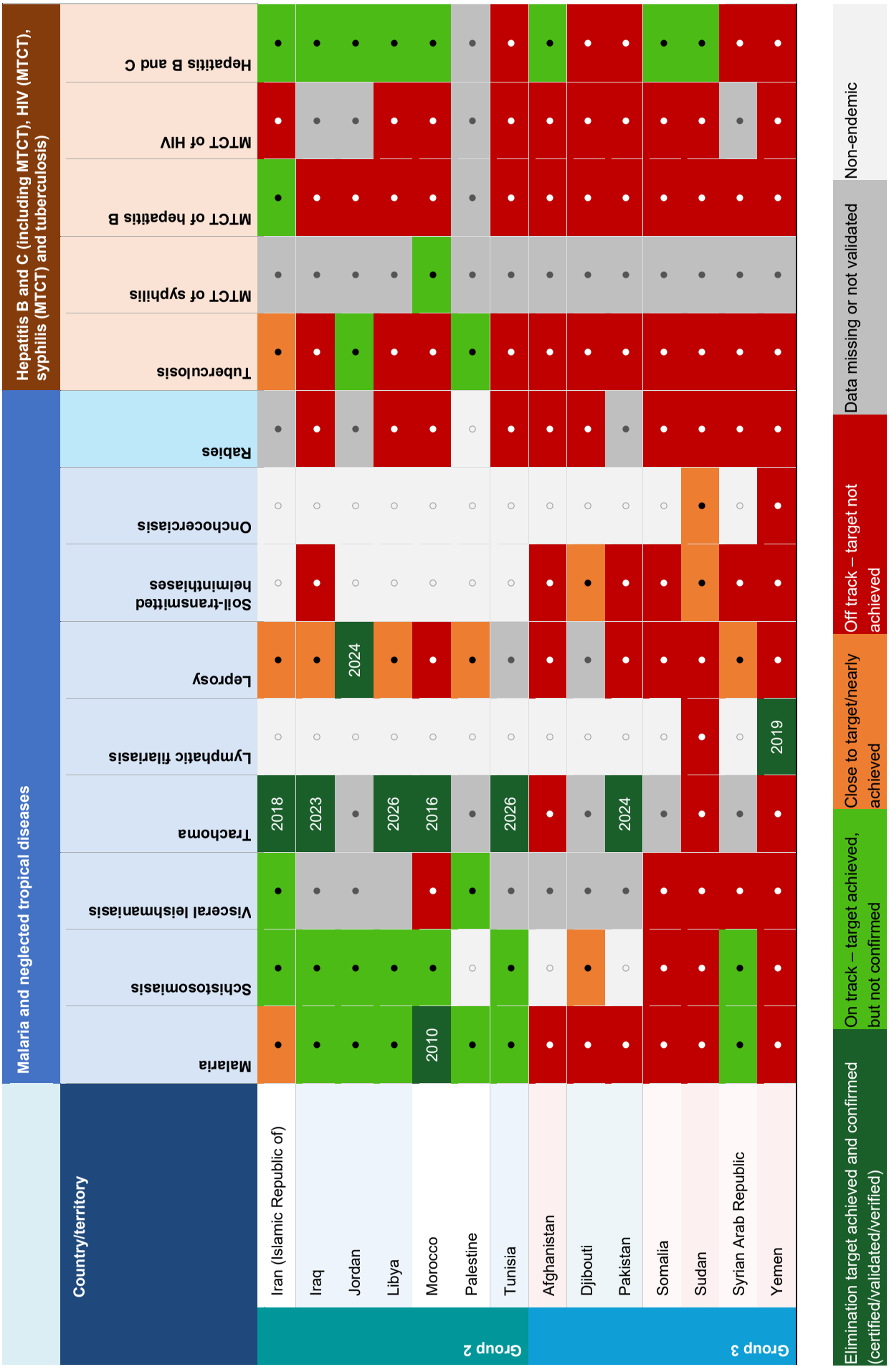
Note: Arrows indicate the causal flow from actions to impact.

Annex 4. Status of disease elimination in the Eastern Mediterranean Region, 2026

This annex tabulates progress towards the elimination of 14 priority communicable diseases in the WHO Eastern Mediterranean Region, including the disease-specific targets for hepatitis B and C, malaria, eight neglected tropical diseases and tuberculosis, and the transmission-pathway targets for mother-to-child transmission (MTCT) of HIV, hepatitis B and syphilis. Progress was assessed against WHO-defined targets, using the most recent available regional data,[8] and countries were grouped according to their level of progress towards the elimination of priority diseases.[9] These data will be further validated in consultation with Member States before official publication on the WHO Eastern Mediterranean Region website.

		Malaria and neglected tropical diseases									Hepatitis B and C (including MTCT), HIV (MTCT), syphilis (MTCT) and tuberculosis)				
	Country/territory	Malaria	Schistosomiasis	Visceral leishmaniasis	Trachoma	Lymphatic filariasis	Leprosy	Soil-transmitted helminthiases	Onchocerciasis	Rabies	Tuberculosis	MTCT of syphilis	MTCT of hepatitis B	MTCT of HIV	Hepatitis B and C
Group 1	Bahrain	●	○	●	●	○	●	○	○	○	●	●	●	●	●
	Egypt	2024	●	●	2025	2018	●	●	○	●	●	●	●	●	●
	Kuwait	●	○	●	●	○	●	○	○	○	●	●	●	●	●
	Lebanon	●	●	●	●	○	●	○	○	●	●	●	●	●	●
	Oman	●	●	●	2012	○	●	○	○	○	●	2022	●	2022	●
	Qatar	●	○	●	●	○	●	○	○	○	●	●	●	●	●
	Saudi Arabia	●	●	●	2022	○	●	○	○	○	●	●	●	●	●
	United Arab Emirates	2007	○	●	●	○	●	○	○	○	●	●	●	●	●

[8] Using country data available at the WHO Regional Office for the Eastern Mediterranean.
[9] Group 1: more than 50% of the assessed targets already achieved.
Group 2: 25–50% of the assessed targets achieved.
Group 3: less than 25% of the assessed targets already achieved.


Malaria and neglected tropical diseases
Hepatitis B and C (including MTCT), HIV (MTCT), syphilis (MTCT) and tuberculosis)
Country/territory
Malaria
Schistosomiasis
Visceral leishmaniasis
Trachoma
Lymphatic filariasis
Leprosy
Soil-transmitted helminthiases
Onchocerciasis
Rabies
Tuberculosis
MTCT of syphilis
MTCT of hepatitis B
MTCT of HIV
Hepatitis B and C
Group 2
Iran (Islamic Republic of)
Iraq
Jordan
Libya
Morocco
Palestine
Tunisia
Group 3
Afghanistan
Djibouti
Pakistan
Somalia
Sudan
Syrian Arab Republic
Yemen
2018
2023
2024
2026
2016
2026
2024
2010
2019
Elimination target achieved and confirmed (certified/validated/verified)
On track – target achieved, but not confirmed
Close to target/nearly achieved
Off track – target not achieved
Data missing or not validated
Non-endemic