

INTERNATIONAL WORKING GROUP

ON THE **ECONOMICS OF
DISEASE ELIMINATION
AND INTEGRATION**

3rd Convening | 19 May 2026

On the sidelines of the 79th World Health Assembly Geneva,
Switzerland | Hybrid

Hosted by the Global Institute for Disease Elimination (GLIDE)



PURPOSE AND OBJECTIVES

This report summarizes the 3rd Convening of the International Working Group on the Economics of Disease Elimination and Integration (IWG-EDEI), held on 19 May 2026 alongside the 79th World Health Assembly. The session examined how economic evidence can help decision-makers assess disease elimination investments under constrained resources, compare trade-offs, and identify where further analysis is needed.

The report highlights findings from the Thanzi Labwino programme and captures key discussion points on health opportunity costs, health system resilience, subnational analysis, integration, and policy-relevant evidence gaps. It is intended as a meeting synthesis rather than a prescriptive strategy paper.

EXECUTIVE SUMMARY

GLIDE convened the 3rd IWG-EDEI session in Geneva with 38 attendees from 14 countries, representing multilateral agencies, academic institutions, governments, regional bodies, and non-governmental organizations. The session featured a Thanzi Labwino programme overview and three research presentations on health system resilience in African small and island states, the economic value of elimination, and district-level schistosomiasis modelling in Malawi. A facilitated roundtable followed.

The discussion highlighted the importance of grounding disease elimination ambitions in rigorous, context-specific economic analysis. Elimination can represent good value in some contexts, but not universally; economic evidence is most useful when it enables genuine choices between elimination, control, and alternative uses of scarce resources.

Four messages emerged. First, investment appraisal should account for health opportunity costs, uncertainty, and resilience, which is distinct from routine health system performance. Second, analytical frameworks and decision-support tools should be tailored to specific diseases and settings, with subnational analysis used where national averages conceal important differences. Third, existing frameworks should address evidence gaps through a One Health approach that reflects animal reservoirs, environmental and vector-related factors, behaviour, and transmission dynamics. Fourth, analysis should be shaped by country and regional priorities, grounded in realistic implementation capacity, and support integration where it produces measurable improvements in service delivery, sustainability, or equity.

CONTEXT: SETTING THE SCENE

Opening remarks by H.E. Dr Farida Al Hosani (GLIDE), Mr Sibusiso Sibandze (East, Central and Southern Africa Health Community, ECSA-HC), and Dr Michael Charles (RBM Partnership to End Malaria) placed the discussion in a changing financing environment. Countries face constrained choices, competing health priorities, and rising expectations to deliver faster, more integrated, scalable, and sustainable impact.

Health economics was framed as a tool for policy-relevant trade-off analysis. It does not replace judgment, ethics, leadership, or community priorities; rather, it helps decision-makers consider opportunity costs, value for money, the value of integration, and the conditions under which disease elimination can be a sound investment.

"Economic evidence does not replace judgement, leadership, or community priorities. But it can help us better understand trade-offs, the opportunity costs of different investments, the value of integration, and the conditions under which disease elimination is not only possible, but a sound investment."

H.E. Dr Farida Al Hosani, CEO, GLIDE

The opening also emphasized country and regional ownership. In East, Central, and Southern Africa, neglected tropical diseases (NTDs) remain high on the policy agenda, and the 2025 Health Ministers resolution on NTDs illustrates how policy-relevant economic evidence can feed regional decision-making. Integration was discussed not as a slogan, but as a practical question: whether it produces measurable benefits for countries, populations, and communities.

THANZI LABWINO PROGRAMME OVERVIEW

The Thanzi Labwino programme was presented as part of a broader network of researchers and policymakers focused on informing health resource allocation decisions across African regions. Its work combined research evidence generation, capacity strengthening, and research-policy engagement.

GLIDE funding at the end of 2022 supported the project through February 2026 and helped unlock University of York match funding for dedicated researcher time. The project also helped mobilize further University of York support for the Thanzi Health Economics Distance Learning MSc, a part-time, fully remote programme for individuals working in health policy and research roles in Africa. Across three cohorts, the programme supports 17 students from 11 African countries.

The programme also created policy engagement pathways. A GLIDE-hosted working group in Abu Dhabi brought together directors of health planning and Ministry of Health leaders from nine member states to discuss financing for NTDs and disease elimination. Deliberations fed into a February 2025 Health Ministers meeting and contributed to a regional resolution.

IMPLICATIONS FOR POLICY AND ANALYSIS

- Disease elimination funding can align with universal health coverage when it supports activities that advance both agendas, such as community-based delivery, diagnostics, surveillance, or health system platforms.
- Capacity strengthening is not separate from evidence use. Locally grounded analysts and policy partners increase the likelihood that economic evidence will inform real decisions.
- Regional institutions can help translate technical evidence into policy dialogue when evidence is framed around country priorities and financing constraints.

RESEARCH PRESENTATION 1

HEALTH SYSTEM FINANCING, PERFORMANCE AND RESILIENCE IN AFRICAN SMALL AND ISLAND STATES

Finn McGuire presented research on health system performance, vulnerability, and resilience in 14 African small and island states, each with a population below 3 million. Together, these countries represent less than %2 of Africa's population but more than one-quarter of its states.

WHAT WAS PRESENTED

The analysis examined how state size and location affect economic development, policy constraints, and health system performance. Small and island states often face small domestic markets, reliance on international trade, limited economies of scale, higher production and transaction costs, and greater exposure to economic, environmental, and climate shocks.

IMPLICATIONS FOR POLICY AND ANALYSIS

- In small, island, or shock-exposed settings, investment appraisal should assess resilience and exposure to shocks separately from routine performance.
- Resilience considerations should be used selectively, where shocks or vulnerabilities materially affect elimination, surveillance, or maintenance of gains.
- Comparative measurement of health system resilience remains an open methods area, particularly for small states where absolute capacity constraints may be important.

RESEARCH PRESENTATION 2

WHEN IS ELIMINATION OF AN INFECTIOUS DISEASE COST-EFFECTIVE? AN ANALYTICAL FRAMEWORK TO GUIDE ELIMINATION PRIORITIES

Dr Hugo Turner presented an analytical framework for assessing when elimination of transmission is good value. The presentation addressed a recurring limitation in elimination investment cases: they often emphasize large benefits and future cost savings, which can be useful for advocacy but difficult to compare across diseases or use for allocation decisions.

WHAT WAS PRESENTED

The framework combines disease economic burden, intervention costs, health burden, baseline prevalence, intervention impact, stopping thresholds, discount rates, time horizon, cost-effectiveness thresholds, and analytical perspective. It uses net health benefit rather than conventional cost-effectiveness ratios because elimination decisions often involve changing risk, long time horizons, and discontinuation or maintenance of interventions over time.

MAIN FINDINGS

The presentation emphasized health opportunity cost: the health gains that could have been achieved if the same resources were used for other health investments. Net health benefit converts programme costs into foregone health using an opportunity-cost threshold, then compares that hypothetical health loss with programme health gain (Figure 1).

A positive net health benefit indicates expected population health improvement after accounting for foregone health from alternative uses of the same resources. A negative value does not mean the disease should not be controlled or treated; it means the specific goal of breaking transmission needs a stronger economic basis in that setting.

"The goal of breaking disease transmission needs a much stronger economic basis. We need to consider opportunity costs, what you could have done with that money, and avoid thinking in disease silos that do not reflect the reality most policymakers face."

Dr Hugo Turner, Imperial College London

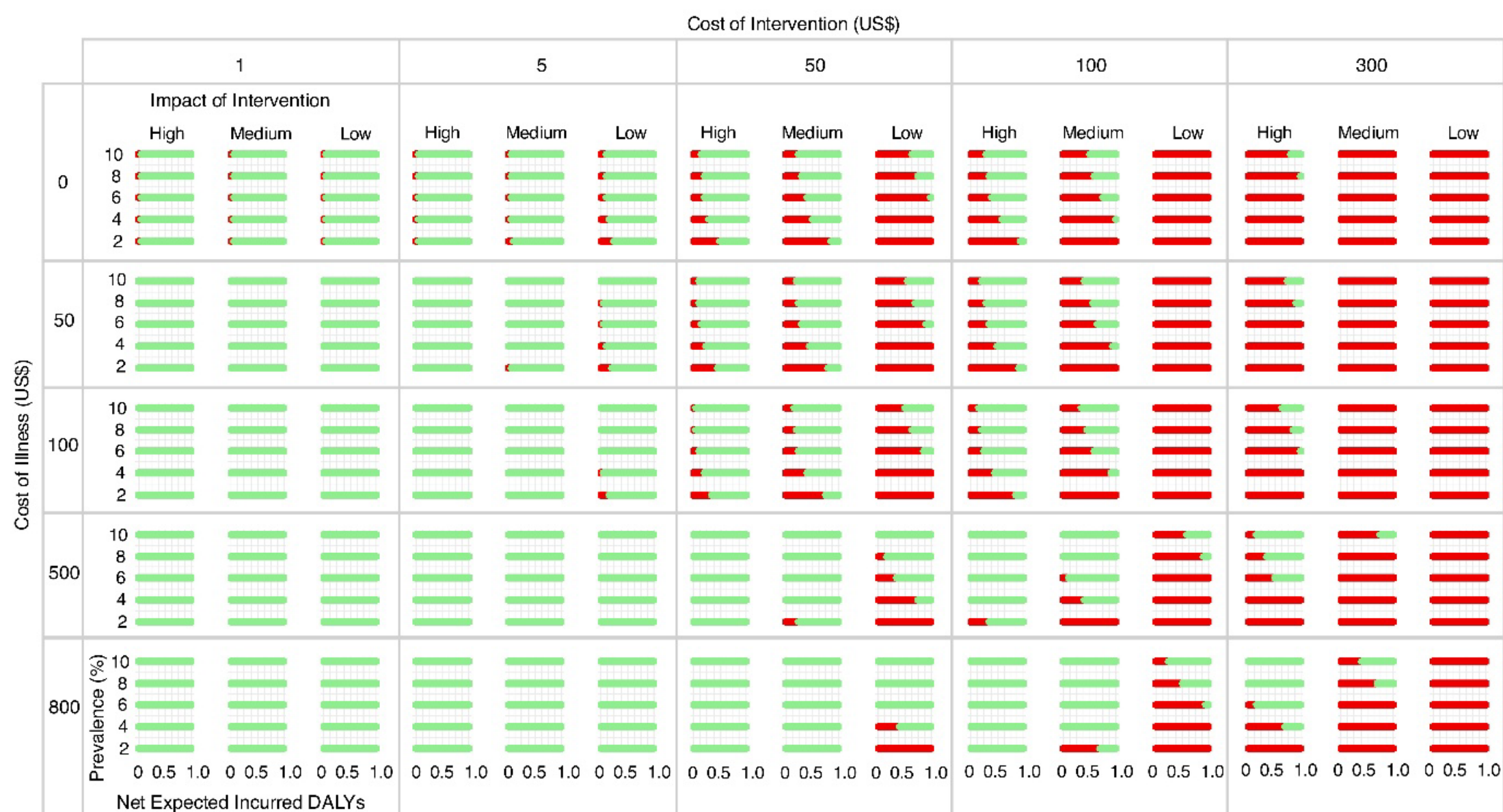


Figure 1. Influence of intervention costs, impact, disease burden, and analytical assumptions on the net health benefit of elimination. Green indicates positive net health benefit and red indicates negative net health benefit. Source: Ahmed et al. (2026).

IMPLICATIONS FOR POLICY AND ANALYSIS

- Elimination can be good value, but not universally. Value depends on multiple interacting factors, including health opportunity costs, baseline burden, intervention effectiveness, and the time horizon.
- Investment cases should compare elimination with realistic alternative uses of funds, not only with doing nothing.
- Further work is needed on the distinction between elimination as a public health problem and full interruption of transmission, and on the rigorous inclusion of surveillance and maintenance costs.

RESEARCH PRESENTATION 3

OPTIMISING SCHISTOSOMIASIS CONTROL IN MALAWI

Dr Tara Mangal presented an integrated epidemiological and economic modelling analysis of schistosomiasis control and elimination strategies across all 32 districts of Malawi, covering both *Schistosoma* species present in Malawi.

WHAT WAS PRESENTED

The analysis compared three treatment strategies: mass drug administration for school-aged children, expansion to preschool-aged plus school-aged children, and community-wide treatment including adults. It assessed infection burden, disability-adjusted life years, feasibility and timing of elimination, incremental cost-effectiveness, net health benefit, and maximum allowable delivery costs under alternative assumptions about water, sanitation and hygiene (WASH) trajectories, disability weights, and implementation costs.

MAIN FINDINGS

The analysis showed why short-term efficiency and long-term elimination can point in different directions. Paediatric treatment delivers large short-term health gains because schistosomiasis morbidity is concentrated in children, but adults sustain a substantial infection reservoir that can continue transmission despite repeated treatment of children (Figure 2).

School-aged child treatment produced positive net health benefit versus no mass drug administration in every district. Expanding only to preschool-aged children was negative in most districts relative to school-aged child treatment alone. Expanding to adults produced positive net health benefit in most districts relative to school-aged child treatment.

Community-wide treatment reached the elimination threshold in all districts by targeting adult infections and shortening programme duration, but required higher initial resources. Its economic justification depended on local transmission intensity, planning horizon, and achievable delivery costs. Maximum allowable implementation costs

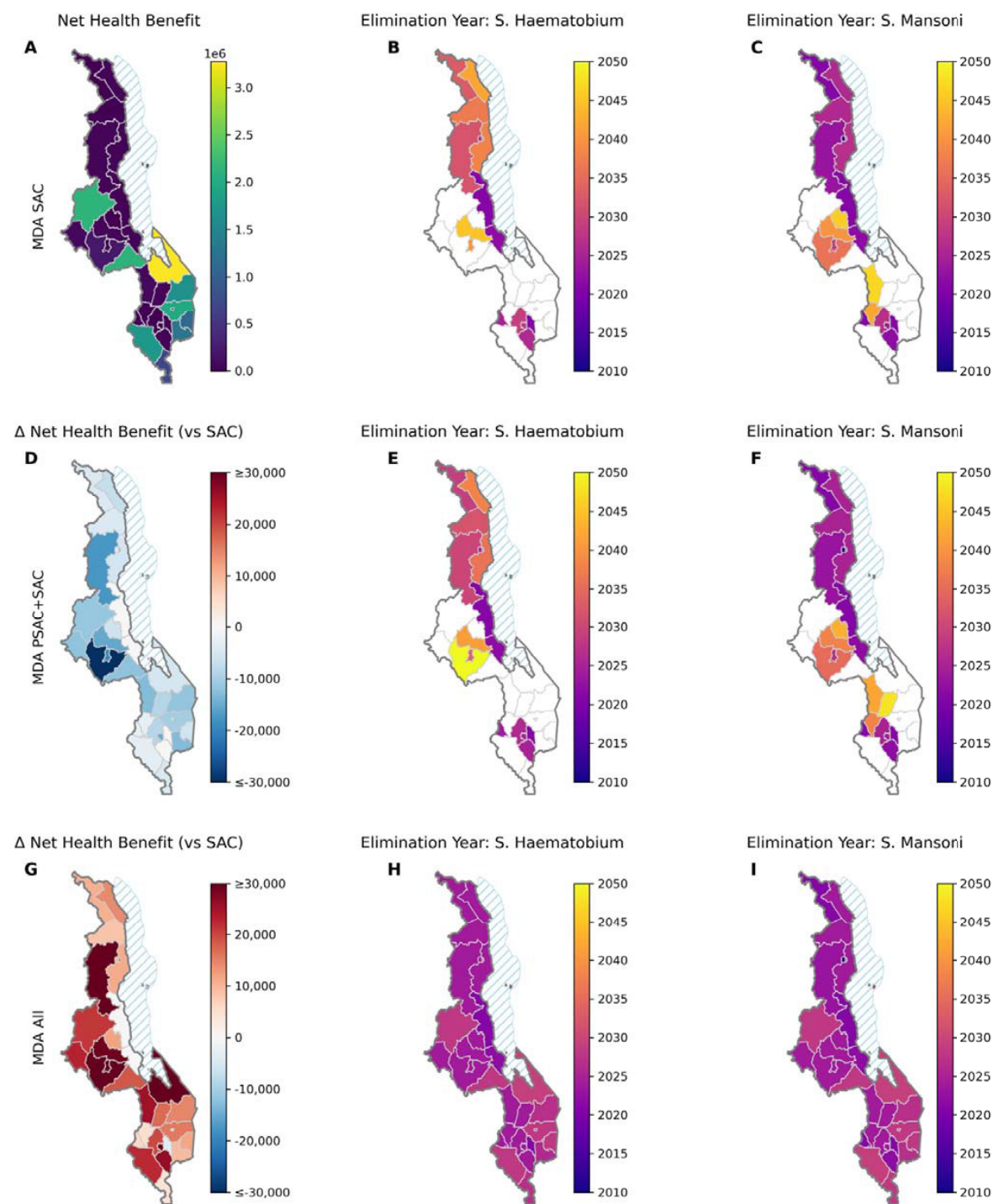


Figure 2. District-level net health benefit and projected year of elimination under mass drug administration targeting school-aged children, preschool - and school-aged children, and all age groups. Source: Mangal et al. (2026).

IMPLICATIONS FOR POLICY AND ANALYSIS

- Elimination decisions need subnational analysis. National averages can obscure district-level variation in prevalence, transmission, health system capacity, and delivery costs.
- Where local transmission, delivery-cost, and capacity data are available, programme planners should use subnational analysis before committing to uniform national strategies.
- Child-focused treatment can deliver short-term value, while elimination in high-burden areas may require broader community-wide treatment supported by district-specific economic and epidemiological evidence.

ROUNDTABLE DISCUSSION AND CLOSING REFLECTIONS

A facilitated roundtable led by Prof. Raul Santaaulalia-Llopis of NYU Abu Dhabi concluded that economic frameworks for disease elimination should support genuine, context-specific policy choices under constrained resources rather than serve primarily as advocacy tools. Participants identified four priorities for strengthening these frameworks.



1. STRENGTHEN INVESTMENT APPRAISAL

Distinguish routine health system performance from resilience, particularly in small and island states. Appraisals should address uncertainty and consider opportunity costs alongside the projected benefits of elimination.



2. TAILOR TOOLS TO DISEASES AND CONTEXTS

Decision-support tools, including AI-enabled tools, can make analysis more accessible. However, they should be adapted to specific diseases and settings and supported by appropriate governance, training, and safeguards.



3. ADDRESS GAPS THROUGH A ONE HEALTH APPROACH

Frameworks should better reflect animal reservoirs, environmental and vector-related factors, behaviour, and transmission dynamics. Evidence gaps also remain around efficiency, sustainability, costs, financing, financial protection, poverty, and broader development outcomes.



4. GROUND ANALYSIS IN POLICY AND IMPLEMENTATION REALITIES

Analysis should be country-owned, responsive to subnational differences, and grounded in realistic delivery capacity. Integration should be pursued where it produces measurable improvements in service delivery, sustainability, or equity.

Overall, the discussion called for decision-useful economic analysis that enables policymakers to make informed choices under resource constraints and supports sustainable long-term impact.

CONCLUSION

The 3rd IWG-EDEI convening showed that the economics of disease elimination is moving from broad principle toward more practical analytical approaches. The frameworks and models presented are not universal tools, but they demonstrate how elimination decisions can be made more specific, more comparable, and more grounded in local epidemiology, health system capacity, implementation realities, and opportunity costs.

Elimination ambitions therefore need to be supported by rigorous economic analysis. Economic evidence can help identify where elimination is likely to be good value, where control or morbidity reduction may be the better near-term priority, and where further data are needed before committing scarce resources.

ACKNOWLEDGEMENTS

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SELECTED PUBLICATIONS INFORMING THE SESSION

The following publications informed the presentations and discussions during the IWG-EDEI convening.

1. Ahmed S, Mangal TD, Hallett TB, Turner HC. When is elimination of an infectious disease cost-effective? An analytical framework to guide elimination priorities. *Cost Effectiveness and Resource Allocation*. 2026. <https://doi.org/10.1186/s2-00777-026-12962>
2. Mangal TD, Colbourn T, Phillips AN, et al. Linking transmission dynamics and economic evaluation to assess schistosomiasis programme strategies across districts in Malawi. *medRxiv*. 2026. <https://doi.org/2026.05.06.26352519/10.64898>
3. McGuire F, Mohan S, Rao M, et al. Health financing and systems in African small and island states: unique challenges and opportunities in achieving universal health coverage. *SSM – Health Systems*. 5:100104;2025. <https://doi.org/10.1016/j.ssmhs.2025.100104>
4. McGuire F, Rao M, Walker SM, et al. High health system performance, low health system resilience: navigating vulnerability—an illustrative example using small and island states. *Health Policy*. 162:105431;2025. <https://doi.org/10.1016/j.healthpol.2025.105431>
5. Rao M, Freeman M, Thijssen J, et al. Insights from financial economics to value healthcare investments that reduce system-level risks: example of disease elimination and eradication. *Applied Health Economics and Health Policy*. 458–24:449;2026. <https://doi.org/10.1007/s3-01037-026-40258>
6. Rao M, Nkhoma D, Mohan S, et al. Using economic analysis to inform health resource allocation: lessons from Malawi. *Discover Health Systems*. 3:48;2024. <https://doi.org/10.1007/s4-00115-024-44250>
7. Rao M, Walker S, Claxton K, et al. Guiding health resource allocation: using population net health benefit to align disease burden with cost effectiveness for informed decision making. *Applied Health Economics and Health Policy*. 766–23:759;2025. <https://doi.org/10.1007/s00964-025-40258-x>