
REPORT OF THE 18TH MEETING
OF THE WHO ALLIANCE FOR
THE GLOBAL ELIMINATION OF

TRACHOMA BY 2020

ADDIS ABABA, 28–29 APRIL 2014



**World Health
Organization**



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Abbreviations and acronyms

DFID	United Kingdom Department for International Development
GTMP	Global Trachoma Mapping Project
ICTC	International Coalition for Trachoma Control
ITI	International Trachoma Initiative
MDA	mass drug administration
NGO	nongovernmental organization
NTD	neglected tropical disease
SAFE	Surgery, Antibiotics, Facial cleanliness, Environmental improvement
TAP	Trachoma Action Plan
TEMF	Trachoma Elimination Monitoring Form
TF	trachomatous inflammation – follicular
TT	trachomatous trichiasis
UIG	Ultimate Intervention Goal
USAID	United States Agency for International Development
WASH	water, sanitation and hygiene

Introduction, opening ceremony and purpose

The 18th meeting of the WHO Alliance for the Global Elimination of Trachoma by 2020 (GET2020) was held at the United Nations Conference Centre in Addis Ababa, Ethiopia, on 28–29 April 2014. Its purpose was to assess progress on the elimination of trachoma, distil learning and establish priorities in order for all countries to meet the 2020 target.

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Dr Teshome Gebre, Regional Director for Africa of the International Trachoma Initiative (ITI) and head of the local organizing committee, welcomed participants to the meeting and introduced the officiates of the opening ceremony: Dr Pierre Kilebou M’Pelé, WHO Representative, Ethiopia; Dr Dirk Engels, Director, Department of Control of Neglected Tropical Diseases (NTDs), WHO/Geneva; and His Excellency Dr Keseteberhan Admasu, Minister, Federal Ministry of Health, Ethiopia. The officiates shared words of welcome and wishes for success during the course of the meeting.

Dr Pierre Kilebou M’Pelé noted that trachoma control is achievable through strong partnerships for implementation of the “SAFE” (Surgery, Antibiotics, Facial cleanliness, Environmental improvement) strategy, confirmed WHO’s commitment to those partnerships and promised vigorous support to trachoma elimination efforts. Dr Dirk Engels recalled the recent transition of responsibility for trachoma within WHO to the Department of Control of Neglected Tropical Diseases. He gave the Department’s full backing to the goals of GET2020. Dr Keseteberhan Admasu reminded participants that Ethiopia has the highest burden of trachoma in the world, and thanked the Alliance for choosing Addis Ababa as the venue for the 18th meeting. He committed Ethiopia’s network of more than 35 000 health extension workers and countless health development army personnel to participate in the fight against trachoma.

The two-day meeting was conducted in open sessions for which Chairs and Co-chairs were appointed as follows: Abdissa Kurikie and Boubacar Sarr (session 1); Georges Yaya and Sheila West (session 2); Lucienne Bella and Yael Velleman (session 3); and Serge Resnikoff and Dirk Engels (session 4).

The agenda is contained in *Annex 1* and the list of participants in *Annex 2*.

SESSION 1

SHOWCASE: ETHIOPIA

Mr Oumer Shafi, NTD Coordinator, Federal Ministry of Health, Ethiopia

2 Ethiopia has made important progress in the elimination of trachoma. The annual number of azithromycin treatments administered has increased from 400 000 in 2006 to 22 497 883 in 2013. Region-specific trachoma action plans (TAPs) have been developed in some regions. Mapping is almost completed in all suspected endemic districts. The SAFE strategy is being implemented in full in many endemic areas.

Surgery: By 2013, a cumulative total of 855 491 trichiasis surgeries had been done; an additional 133 940 surgeries were done in 2013 alone. At this pace, the backlog of people in need of sight-saving surgery will be completed before the 2020 deadline.

Antibiotics: Since the inception of mass drug administration (MDA) in 2006 with 400 000 antibiotic treatments, a cumulative total of 119 697 067 treatments have been administered.

Facial cleanliness: Of the population living in known endemic areas, 75% have received hygiene and sanitation education by 38 000 health educators trained for this purpose.

Environmental improvement: Some 7 915 949 latrines have been built; an estimated 6 million remain to be constructed. However, current latrine utilization is low (20%). Access to potable water has increased.

The success of the programme results from a number of factors, including the development of trachoma action plans in three of the most heavily endemic regions. These regions are now preparing comprehensive NTD plans that will include the TAPs. Also credited with the success of the programme are the various reference documents and guides that have been developed and are being applied within Ethiopia. Increased partner support has had a large influence on the ability of the Federal Ministry of Health and Regional Health Bureaus to expand and scale-up the distribution of azithromycin.

Challenges to be addressed include the lack of a sufficient human resource base. A number of integrated eye care workers trained in trachomatous trichiasis (TT) surgery have either left their posts or stopped doing surgery; the reasons for this attrition are unclear. Without the necessary human resources, programme implementation suffers, particularly in high-burden regions such as Oromia. The other major challenge impacting the F and E components of the SAFE strategy is the weak collaboration between the health sector and the water, sanitation and hygiene (WASH) community.

The way forward is through stronger collaboration with the various sectors, increased advocacy at all levels and the inclusion of women in the trachoma elimination workforce through civic participation schemes such as the women's development army.

Discussion

A number of questions and comments were raised following Mr Shafi's presentation.

- A rhetorical question posed towards Ethiopia and the entire trachoma community was how to meet the challenge of scaling-up TT services while maintaining the ethical obligation to provide the highest quality surgery possible.
- In response to a question about why the number of MDA treatments in Ethiopia had increased in 2010 but levelled off in 2012, it was pointed out that mapping was incomplete in 2012 and a near-complete picture of trachoma's endemicity country-wide is now available; the apparent stagnation in 2012 should therefore not be a problem in the future.



- Concerning surgical quality and national processes for detecting surgical failure and recurrence, it was acknowledged that Ethiopia does not currently have a system for monitoring failures and recurrence, but research is available to show that the incidence of recurrence is about 20%.
- Regarding trichiasis services and how, given the magnitude of the problem, Ethiopia tracks and measures ongoing activities, integrated eye care workers have a tool to measure what is happening on the ground. However, there is no national register of TT patients and efforts are needed to standardize reporting and remove the problem of conflicting data between government at various levels and programme partners.
- Concerning the challenge of involving and motivating the WASH sector at the ministerial level and beyond, ministries are now involved, but this is not enough; the critical factor is at the implementation level, which currently is very weak. More effort will be made to strengthen the involvement of the various sectors.

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WHO REPORT

Dr Anthony Solomon (Medical Officer, Trachoma, WHO/NTD Geneva)

Highlights of the past year include the extent of mapping carried out under the auspices of the Global Trachoma Mapping Project (GTMP); the significant increase in funding either currently available or in the pipeline; the progress in conducting TAPs and the development of a cadre of TAP facilitators; and the publication in English and French of the second edition of the training manual *Trichiasis surgery for trachoma*.¹

Global progress in implementing the SAFE strategy in 2013

Delay in the Medical Officer assuming his post at WHO delayed the request to countries to complete trachoma elimination monitoring forms (TEMFs). Of the 55 countries invited to submit forms, 30 provided TEMFs with the following information:

Within the **S** component: 3010 TT surgeons were trained; the mean percentage of ophthalmic technicians working in rural areas was 38%; 26% of ophthalmic technicians in the countries reporting have been certified as TT surgeons. Only 11 of the 30 countries reported having adequate surgical instruments to address the backlog of surgeries. Overall, in the 30 countries reporting, 83 350 people were operated on in 2013, representing 117% of the combined annual intervention objective of 72 731 set by those reporting countries.

For the **A** component, only 13 041 720 people were treated in 2013 within countries submitting TEMFs, representing 45% of the annual intervention objective for those countries of 28 937 752 people. Some of this shortfall against the objective is attributable to various conflicts throughout the world.

The most significant result for **F** and **E** was that 539/632 districts were visited by health educators to promote facial hygiene and sanitation in 2013. Efforts are needed, however, to refine the data collected.

At the policy level, most countries reported having the necessary political support (22/30); however, only 16 countries have trachoma task forces.

¹Trichiasis surgery for trachoma, Second edition. Geneva: World Health Organization, 2015.
http://apps.who.int/iris/bitstream/10665/155227/1/9789241549011_eng.pdf
http://apps.who.int/iris/bitstream/10665/155230/1/9789242549010_fre.pdf

Status of implementing the recommendations of the 17th meeting

Some of the recommendations of the 17th meeting of the Alliance for GET2020 held in 2013 have not been addressed, for various reasons. The following recommendations warrant particular attention:

Recommendation 3 states in part that “the endemic status of some countries remains unclear and they should be included in GTMP plans for mapping to initiate programmes or achieve validation of elimination.” Although the importance of the sentiment is not disputed, the part of the recommendation pertaining to validating elimination is inconsistent with the terms of the funding provided for mapping by the United Kingdom Department for International Development (DFID). The GTMP grant is for baseline mapping. Other mechanisms need to be found to support epidemiological assessment to generate data for validation of elimination.

Recommendation 4 addresses the need for further clarity on the evidence required to demonstrate elimination, and on how to conduct post-elimination surveillance. While recognizing that such clarity is essential to national programmes, it has not yet been addressed and needs to be discussed.

Recommendation 5 urges donors to use the GET2020 meeting to coordinate their efforts. This has been done. Other platforms have also been used to further donor coordination.

Recommendation 6 urges the Alliance secretariat to reach out to the WASH partners to engage them as members of the Alliance. Dr Solomon noted that much remains to be achieved in this area and that the WHO Department of Control of NTDs will pursue this in the next 12 months.

Recommendation 7 suggests in part that the Alliance reach out to and engage additional partners and countries. This recommendation has been acted on, as indicated by the fact that the 18th meeting is the largest meeting of the Alliance to date, with 209 participants and 45 countries represented.

Recommendation 9 notes that, with the expansion of trachoma elimination activities expected due to the GTMP, WHO will need to strengthen its capacity to provide the needed technical assistance and support. Dr Solomon’s full time role at WHO increases the human resource capacity devoted to trachoma at WHO headquarters from 20% of one full-time member of staff to 100%; it was noted, however, that it was likely that further enhancement of this human resource capacity might be required.

Priorities for the Medical Officer for Trachoma

Over the next year, Dr Solomon will, among other activities, listen to countries and partners and try to provide timely responses to issues raised; continue to provide scientific oversight to the Global Trachoma Mapping Project; and work with the trachoma community to establish guidelines for undertaking impact assessments, guidelines for interventions in districts in which the TF prevalence in children is between 5.0% and 9.9%, and guidelines for validation of elimination of trachoma as a public health problem.

Discussion

In response to a question concerning processes in countries that have achieved their targets and are awaiting validation, there is a body of work to be done to ensure that standard operating procedures established for trachoma are consistent with those that will be established

for other diseases in which elimination as a public health problem is the goal. WHO is defining a logical framework for each of these, including disease-specific and cross-disease considerations for the different NTDs. A draft of this framework will be available for discussion in 2015.

One speaker commented that advocacy at the sub-national level is essential for the F and E components and that efforts are needed to map implementation of these components.

In a second reference to the F and E components and why the collaboration between the WASH sector and the SAFE strategy was not mentioned in the WHO plan, Dr Solomon acknowledged the importance of this link and commented that advocacy around the association between NTDs and poverty should help to attract interest in and direct investments for the WASH components.

Given the presumed benefits of integrating trachoma within an NTD framework at country level, it was asked whether WHO intends to manage the arrival and customs clearance of azithromycin in endemic countries. Dr Solomon acknowledged that customs clearance of donated drugs that are not channeled through WHO can be problematic; WHO is open to discussion with the pharmaceutical companies making such donations. For azithromycin, in most cases the current system appears to be working well, with some notable exceptions that are being actively addressed.

GLOBAL TRACHOMA MAPPING PROJECT REPORT

Mr Thomas Millar, Sightsavers

In the 16 months since its inception, the GTMP has supported ministries of health to undertake baseline trachoma mapping of 1032 districts in 19 countries, representing a combined population of 124 million people. In collecting these data, 1.3 million people have been examined. Although great progress has been made, much work remains to be done. The original estimate of 1238 districts in need of mapping has been revised upwards through discussion with ministries of health, and the GTMP is now targeting an additional 600 suspected trachoma-endemic districts. In some countries, the project is also undertaking efforts to coordinate the mapping of trachoma with mapping of other NTDs, such as in Nigeria, where both schistosomiasis and lymphatic filariasis were included.

Discussion

In response to a question about the cost of mapping trachoma using GTMP systems and processes, it was reported that the average cost of GTMP mapping is about US\$ 7500 per district.

Concerning the number of suspected trachoma-endemic districts that will not be covered by the GTMP, normally all suspected endemic districts are covered; the exceptions to date are those districts in which insecurity prevents the safe deployment of ministry of health mapping teams.

TRACHOMA ACTION PLANS

Dr Michael Gichangi, Director of Prevention of Blindness, Ministry of Health, Kenya

The concept of trachoma action plans (TAPs) originated during the 14th meeting of the Alliance for GET2020 held in 2010 as a way to assist countries in focusing on elimination of trachoma and moving beyond control. In Kenya, the TAP serves as a clear implementation guide and monitoring tool for elimination; an advocacy toolkit; and a mechanism for aligning trachoma stakeholders and the national leadership. The document needs to be periodically revised based on successes and challenges encountered.

Discussion

In response to a question concerning the lack of consultation with neighbouring countries whilst developing the TAP, Dr Gichangi noted that it is a transitional document that requires

constant adaptation to the reality of the situation in the country; the TAP represents a starting point.

Concerning the large TT backlog in Kenya with a relatively short period of time before the 2020 elimination target, Dr Gichangi confirmed that the current national estimate is a backlog of 34 000. In 2004, trachoma was mapped in Kenya, but it was not until 2008 that SAFE activities were implemented. An impact survey conducted in 2010 led to the recommendation that the national elimination target date be adjusted to 2020; all agreed that the Kenya data must be refined.

Finally, the reason why trachoma is not integrated with the other NTDs in Kenya is simply because the programme for the prevention of blindness started the programme and continues to run it, having made important steps forward. However, the trachoma programme coordinates closely with other NTD programmes and the links between them are strong.

SESSION 2

SURGERY

TRICHIASIS SURGERY IN OROMIA: APPROACHES AND PROSPECTS

Dr Zelalem Habtamu Jemal, Oromia Regional Health Bureau

With a high burden of trachoma including an estimated TT backlog of 208 000 people needing surgery, Oromia has responded in a number of ways. After forming a trachoma task force, a TAP was completed that prioritized zones for intervention using baseline mapping data. Clinical nurses have been trained as TT surgeons and health extension workers have been engaged in mobilizing patients. Both static and mobile services are used and Oromia is currently working to build dedicated teams of TT surgeons to address the backlog.

SETTING UP A TRICHIASIS SURGERY PROGRAMME IN A NEWLY DISCOVERED ENDEMIC FOCUS

Dr Julián Trujillo Trujillo, Ministry of Health, Colombia

There are difficulties involved in delivering services to the newly discovered focus of trachoma in the Vaupés Department of the Amazon Region. These include the Department not being connected to the rest of the country by road; with only a few rural airstrips, access to many communities is achievable only by walking long distances or travelling by river. The sparsely settled Department has a population of 25 000, of whom 95% are indigenous. Mapping in 2012–2013 showed a TF prevalence of 26% in 1–9 year olds, and a TT prevalence of 0.052%. Given the remoteness of the area and the difficulties involved in follow-up, patients with trichiasis and their families are brought to the Department's capital for a week, where surgery is provided free of charge by volunteer ophthalmologists. Patients are offered incentives for surgery such as fishing kits and batteries for lanterns.

THE CAMPAIGN STRATEGY FOR DELIVERING TRICHIASIS SURGERY

Dr Boubacar Kadri, Programme National de Lutte Contre la Ceicite, Niger

Niger has an estimated backlog of 26 000 TT cases, of which 15 000 are in the Maradi Region and more than 5000 in the Zinder Region. The strategies for resolving this backlog include providing both fixed and mobile services, focusing on highly endemic districts and pre-screening patients in lower endemic districts to determine whether numbers are sufficient to warrant a surgical camp.

Advocacy for greater engagement of partners and strengthened mobilization of patients to accept surgery are also necessary, as is the need to understand why people refuse services and how to manage those who refuse.

MAINTAINING SURGICAL QUALITY AT NATIONAL SCALE

Professor Lamine Traoré, Programme National de Lutte Contre la Cécité, Mali

Mali estimates its current TT backlog at 25 000 cases, with nearly 73 000 operated on since 1999. The challenges facing the programme include maintaining the quality of surgery and reducing the recurrence rate, which is currently estimated to be 26%. One solution is training technical directors of community health centres to provide post-operative follow-up and suture removal. Mali also notes a 10% refusal rate, which warrants research to understand the barriers to surgical uptake. In addition, as the backlog is reduced, cases are more difficult to find, requiring changes in approach. Mali conducts outreach using motor vehicles transporting an entire surgical team and by motorcycle with just one surgeon tracking down cases.

ENSURING SURGICAL QUALITY WHEN SCALING DOWN

Dr Cung Hong Son, Viet Nam National Institute of Ophthalmology

The trachoma programme in Viet Nam began in 1957, and over the years has been supported by a number of partners, including UNICEF, Helen Keller International, ITI and the Fred Hollows Foundation. The United States Agency for International Development (USAID), through FHI360, is a more recent partner, and will support mapping of trachoma in 24 districts. As the prevalence of TF has fallen, the main focus of the programme has switched to managing TT. Cases are identified and referred by trained village health workers, former TT patients and various organizations. Skilled surgeons are selected to ensure quality and all surgeries are conducted in hospitals. The Cuenod-Nataf surgical procedure is used in Viet Nam, as it is believed by local personnel to confer a lower risk of recurrence. Patients receive post-operative follow-up at 1 week and 3 months.

CROSS-BORDER ISSUES IN THE ELIMINATION OF BLINDING TRACHOMA IN NEPAL

Dr Sailesh Mishra, Programme Director, Nepal Netra Jyoti Sangh

Nepal has set an elimination date of 2017. A major problem is that the number of TT surgeries conducted in some regions exceeds the local Ultimate Intervention Goal (UIG), due to Indian citizens crossing the border for services. Of the 1733 people operated on for TT in Nepal in 2013, only 546 were Nepali. In some districts, 85% of TT surgeries are provided to Indians. Most regions of India do not recognize trachoma as a public health problem and so there are no data to understand

the situation along the border with Nepal. Without control efforts on the Indian side of the border, Nepal's success in elimination is threatened. These issues need to be jointly managed by the two countries. Advocacy will be needed, as will an epidemiological profile of trachoma in the Indian states bordering Nepal.

HEAD START: SURGICAL SIMULATION TO IMPROVE TRICHIASIS SURGERY TRAINING

Dr Emily Gower, Associate Professor, Wake Forest Baptist Medical Center

In recognition that surgical outcomes are less than optimal; that many new surgeons need to be trained and existing surgeons retrained; and that the overall training of TT surgeons needs improvement, HEAD START has been developed as a transitional training tool between theoretical instruction and surgery on real patients. HEAD START is a latex head with removable eyelid cartridges on which trainees can practise making incisions and suturing. The trainer can monitor the skills of trainees and assist with improving their competencies. It affords trainees an opportunity to make and learn from mistakes without putting people at risk. Training-of-trainers courses are being rolled out.

The training time required per TT surgeon is 2–3 hours. The training kit includes 150 eyelid cartridges for the Trabut or bilamellar tarsal rotation procedure. The current cost of the system (US\$ 2850) is expected to decrease as its use increases.

Discussion

A comment directed at Colombia suggested that a patient and his or her family spending a week away from home in order to have TT surgery is too costly and that a change in technique should be considered. It was furthered suggested that the deployment of ophthalmologists to perform TT surgery is not cost-effective.

In a comment directed towards Mali, the need to define a “refuser” was raised. The definition of a refuser in the Morocco programme is someone who understands that they have trichiasis, that blindness may be the result if the condition goes uncorrected and that the surgery is free of charge and painless. This information must be provided in front of witnesses. The opinion was expressed that only if the person refuses in that context can the case be removed from the backlog. Difficulties in finding numbers of patients with TT commensurate with the estimated backlog must be addressed.

Another comment expressed concern over the high rate of recurrence in Mali, particularly as a second operation on the same eye is more complex and should be done by an ophthalmologist.

There was discussion about whether individuals with only a few eye lashes touching the globe merit surgery or not. The current recommendation from WHO is that anyone with TT (i.e. at least one eyelash rubbing on the eyeball, or evidence of recent removal of in-turned eyelashes) should be offered trichiasis surgery, in part because of the difficulty in following up individuals who only have “minor” trichiasis, and the expectation that disease in such individuals will continue to progress.

Clarification was requested as to whether the HEAD START device was developed as part of a larger programme or specifically for trichiasis. It was developed specifically for TT.

ANTIBIOTICS

TAKING ANTIBIOTIC DISTRIBUTION TO SCALE IN THE AMHARA REGION OF ETHIOPIA

Sr Guadie Berhan, Prevention of Blindness Officer, Amhara Regional Health Bureau

A challenge for Amhara, which had a baseline TF prevalence of 62%, was how to maximize coverage of azithromycin mass drug administration (MDA). One very successful approach (the MALTRA week) combines trachoma elimination activities with malaria control. Before MALTRA (2003–2006), 4 925 038 doses of azithromycin were distributed (annual mean=1 231 260 doses), but since its advent (2007–2013) the number of doses delivered has increased to 88 764 703 (annual mean=12 680 672 doses), with a coverage of 85%.

Trachoma impact studies conducted in 150 districts show the prevalence of TF to be <5% (6 districts), 5–9.9% (15 districts) and >10% (129 districts).

ACHIEVING AND PROVING HIGH COVERAGE OF AZITHROMYCIN MDA

Dr Khumbo Kalua, Trachoma Technical Advisor, Ministry of Health, Malawi

In order to eliminate trachoma from Malawi by 2020 there is a critical need to obtain maximum coverage with azithromycin for at least 3 annual rounds. The challenges facing Malawi are getting accurate population figures given the lack of recent census data and inaccurate population estimates; and the discrepancy between reported coverage rates and the coverage actually achieved. The

solutions Malawi has found are conducting censuses in villages targeted for MDA, listing all residents; and instituting a cascade of micro-planning from the national level to the communities. This is followed by full community mobilization, distribution using a static site approach and then house-to-house mop-up. Finally, to prove coverage, an independent team visits selected clusters 1–2 weeks after MDA to interview residents. Currently the proven coverage ranges from 86% to 92%.

PLANNING AND IMPLEMENTATION OF AZITHROMYCIN MDA IN AN AREA CO-ENDEMIC FOR YAWS AND TRACHOMA

Mr Oliver Sokana, National Public Health Eyecare Coordinator, Solomon Islands

In the Solomon Islands, where both yaws and trachoma are endemic, coordinated mapping for the two diseases has been completed in several provinces. As both diseases can be treated with azithromycin – albeit at different dosages and with a different number of rounds of mass treatment – planning for integrated distribution of azithromycin has begun. The drug will be distributed in 9 of the 10 provinces in the Solomon Islands, with post-distribution surveillance for yaws scheduled for 6 months after each round. This will be built into the TAP. There will also be impact assessments for trachoma conducted after three rounds of MDA. Partnerships with WASH partners will be ongoing.

PLANNING AND IMPLEMENTATION OF AZITHROMYCIN MDA WITHIN AN INTEGRATED NTD FRAMEWORK

Dr Onyebuchi Uwazoeke, Federal Ministry of Health, Nigeria

The Nigerian NTD MDA programme uses five drugs: azithromycin, praziquantel, ivermectin, albendazole and mebendazole. The goal of integration is to reduce the cost of drug delivery at all stages while taking into account the safety of recipients; in co-endemic areas not all drugs can be co-administered and a period of 3–4 weeks is necessary to complete all MDAs.

Prior to MDA, advocacy and sensitization are necessary at all levels, but particularly at the community level, following which health workers and community distributors are trained and MDA takes place. Within an NTD framework, the challenges are ensuring that all programmes are coordinated, that the training provided is sufficient to distribute the drugs safely, that there is effective community mobilization and that the reporting is accurate. Reporting is complicated by the available censuses generally not corresponding with the government's population figures.

REPORT OF THE INTERNATIONAL TRACHOMA INITIATIVE

Dr Paul Emerson, Director, International Trachoma Initiative

As the incoming director of ITI, Dr Emerson outlined his vision for what he termed “ITI 3.0”. In this third iteration, ITI will provide expertise to assist countries in eliminating

trachoma by 2020. This assistance will be in planning programme implementation, micro-planning for MDA, budgeting and the use of data for decision-making. Its ambition is to help ministries of health access azithromycin faster and easier, ensuring that the right amount of drug arrives at the right place at the right time.

ITI staff will be at the disposal of countries to assist with completing the azithromycin application and developing the necessary memoranda of understanding. Logistics will be strengthened at local, regional and global level and countries should expect to see the participation of ITI staff in TAP exercises and planning as well as during distribution.

Discussion

In response to a question about the help that countries may be able to access, Dr Emerson reiterated that ITI will provide assistance in programme planning.

Concerning whether integrating azithromycin distribution will affect its cost in Nigeria, the cost of drug delivery within an integrated delivery model is very reasonable at an estimated US\$ 0.15 per person.

A speaker suggested that for coverage surveys, districts with problems at both ends of the spectrum (i.e. districts reporting > 100% coverage as well as districts significantly below the optimal level, such as those reporting 45% coverage) should be selected for evaluation; this point was not universally agreed.

In relation to the possibility of replicating the Amhara Region MALTRA programme in other areas, it was suggested that the programme would need to be conducted during the peak malaria season in order to diagnose febrile patients and maximize the synergy of combining management of the two diseases.



SESSION 3

REPORT OF THE INTERNATIONAL COALITION FOR TRACHOMA CONTROL

Professor Martin Kollman, Chair of ICTC

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The International Coalition for Trachoma Control (ICTC) is now 10 years old, having been established in April 2004. It has grown to a membership of 30 organizations. The ICTC exists to support national programmes, WHO and the Alliance for GET2020. During its 10 years, ICTC members in partnership with national programmes have helped to facilitate > 1 million TT surgeries, provide 322 million azithromycin treatments, reach 174 million people with sight-saving messages focused on face-washing and construct > 3 million latrines.

ICTC has been very active in developing a number of materials designed to strengthen the efforts of national programmes and their partners to achieve elimination of trachoma as a public health problem. Among these materials are guides for the supervision of MDA and TT programmes; a guide for efficient and effective TT outreach; a guide for MDA micro-planning; and guides for the training of trainers for both MDA and for TT surgeon training. A guide for the implementation of F and E is being developed.

ICTC has also launched a large-scale SAFE programme in five countries through funding from The Queen Elizabeth Diamond Jubilee Trust, with funding from DFID in the pipeline for a similar SAFE initiative in an additional 5–6 countries.

Discussion

Dr Solomon (from the perspective of WHO) and Dr Emerson (from the perspective of being the Immediate Past Chair of ICTC) addressed how to make the best use of all of the ICTC documents. WHO should make use of all materials from ICTC as well as other existing materials, to avoid reinventing the wheel. In the near term, WHO will focus on generating overdue guidance on surveillance and validation of elimination. The ICTC documents are meant to be summaries of what is done and what works, not as recommendations to countries. ICTC follows WHO recommendations and is in no way in competition with WHO.

The ICTC counts among its membership a number of research institutions. All the documents produced by ICTC are based on research findings.

Work is in progress on the concomitant administration of other NTD drugs with

azithromycin, most notably ivermectin and albendazole.

Concerning the standardization of costs, the costs for and funding of programmes are critical for ICTC members' work, and making sure that the funding is used in the most effective manner is a constant consideration.

FACIAL CLEANLINESS AND ENVIRONMENTAL IMPROVEMENT

APPROACHES TO F AND E IN SOUTHERN ETHIOPIA

Dr Habtamu Beyene, Deputy Chief, Regional Health Bureau for Southern Nations, Nationalities and People's Regional State

Southern Nations, Nationalities and People's Regional State is now completely mapped. The evaluation unit-level prevalence of TF in 1–9 year-olds ranges from 12% to 45%. The Regional Health Bureau, in partnership with AMREF, Orbis and Water Aid, has been conducting MDA and has reached 6.5 million people while also operating on 98 000 people for trichiasis. The Region recognizes the need to advocate for greater attention to F and E so that the SAFE strategy will be implemented in its entirety. Progress has been made in this regard, with evidence provided that 95% of households have access to latrines, while 88.5% are using improved sanitation facilities. An Orbis survey indicated that the prevalence of facial cleanliness was 69%. With the commitment of the Regional Health Bureau, the deployment of 8000 health extension workers and continued community mobilization and empowerment, there are opportunities for even greater gains.

CONTRIBUTION OF F AND E TO ELIMINATING TRACHOMA IN THE GAMBIA

Mr Sarjo Kanyi, Programme Manager, National Eye Health Programme, The Gambia

The national trachoma elimination programme includes facial cleanliness and environmental improvement as objectives, in order to maintain the prevalence of TF < 5%. It has adopted a number of strategies including health education provided through the cadre of Nyateros (Friends of the Eye) who speak with communities about the importance of face-washing. The national programme also promotes the building of pit latrines and trains masons in their construction, as well as the construction of bore holes. A national day for general cleaning of the environment takes place on the last Saturday of every month. Although the national programme is committed to implementing the SAFE strategy in full, it needs further technical assistance for F and E and research organizations to help collect data on indicators for F and E.

OBTAINING GOVERNMENT SUPPORT TO ALIGN WASH WITH NATIONAL ELIMINATION PROGRAMME NEEDS

Dr Belgesa Elkheir, National Coordinator, Trachoma Control Programme, Sudan

Between 2006 and 2012, trachoma mapping was completed throughout Sudan with the exception of Darfur State, which is to be mapped by the end of 2014. Along with MDA and surgery, health education focused on hygiene behaviour change and latrine utilization is being delivered. Results from Baw and Dongola have shown increases in the prevalence of facial cleanliness (to 86%)

and in latrine use (to 80%). The challenges are in those areas where access to safe water is limited and in areas where there are insufficient latrines. Data presented showed that in some populations, only 6.7% of the people were able to collect water in 30 minutes or less, and access to latrines was as low as 1.3%. In tackling these issues, Sudan needs to prioritize the provision of water and latrine construction in endemic areas.

TAKING A PILOT WASH PROGRAMME TO SCALE

Professor Asad Aslam Khan, National Coordinator, Prevention of Blindness Programme, Pakistan

Pakistan is piloting the implementation of full SAFE in one district in each of three provinces: Punjab, Sindh and Khyber Paktunkhwa. In its inception phase, the pilot conducted participatory rural appraisals and formed Community Citizen Boards, after which house-to-house surveys were conducted. With the data to hand, the full SAFE strategy was implemented.

For the F and E components, awareness was raised concerning hygiene and sanitation through health education sessions and assistance; financial support was provided for WASH. Ophthalmic assistants were hired and trained as health educators who then visited target villages once a week to conduct talks, convene focus groups and visit schools. Also for E, village health committees were formed to foster sustainability and to oversee cleaning up the environment, and spraying of insecticides. The Committees are also charged with advocating funds from the local government for community development projects

Model latrines have been constructed and this initiative has proven successful: 80–90% of target households have constructed indoor latrines.

Scaling up to additional districts is being planned, although the programme needs funding to do so. Issues include the large populations in the districts, the poor current condition of water and sanitation infrastructure, and generally low socioeconomic indicators. However, opportunities are provided by the government-launched Safe Water Project, a good human resource base and strong primary health care. With these resources plus governmental commitment and partnerships with international NGOs, the pilot should be able to be taken to scale.

Discussion

Concerning the reported coverage with latrines in southern Ethiopia (95% latrine coverage and 88.5% of households having improved forms of sanitation), it was clarified that these were preliminary data from the Regional Health Bureau.

The impact on the environment from insecticide spraying (included as part of the pilot F and E programme in Pakistan) will be addressed by representatives from the departments concerned with environmental issues, as the project is scaled up.

Finally, the question was raised (rhetorically) of whether the trachoma community should go beyond SAFE to embrace other programme activities and achieve impact against other NTDs, such as schistosomiasis.

DONOR PANEL

Department for International Development, Lions Club International Foundation, The Queen Elizabeth Diamond Jubilee Trust, United States Agency for International Development

In her introduction of the panel, Ms Eleanor Fuller from The Queen Elizabeth Diamond Jubilee Trust described a meeting of the donors in anticipation of this panel and the agreement reached: to all coordinate more closely in the

future, not only to avoid duplication but also to create synergies that will help to achieve global elimination of trachoma. In summing up the questions the donors had received from members of the Alliance, she noted two central themes: closer coordination with WASH and strengthening the health systems of endemic countries.

Following this introduction, the panelists discussed the role of their respective organizations in trachoma elimination.

The Queen Elizabeth Diamond Jubilee Trust

This newly created trust focuses on countries within the Commonwealth. Within its 5-year timeframe, The Trust seeks to enrich the lives of people in target countries by eliminating avoidable blindness, and to empower a new generation of leaders. The trachoma elimination programme, which will be active in Africa and the Pacific Region, seeks to support governments to implement all four components of the SAFE strategy.

United Kingdom Department for International Development

Following the grant DFID made to complete mapping of all unmapped districts suspected of being trachoma-endemic, the next step is a £ 39.4 million grant to implement the SAFE strategy in a number of countries.

United States Agency for International Development

The Government of the United States of America supports trachoma elimination as one of its target NTDs and looks for opportunities where improvements in supervision, monitoring and evaluation are needed. For example, USAID funding will support 53 trachoma impact assessments in 2014. Partner coordination is essential to allow USAID to identify programme needs and assist in filling those gaps.

Lions Club International Foundation

Trachoma is receiving increased interest from the Lions, in recognition that it is a potential platform through which to strengthen the capacity of national eye care systems to deliver comprehensive eye health programmes.

Discussion

The panel explained how resources are distributed among endemic countries. The objective of the national trachoma elimination programme in each country is to eliminate trachoma, and the role of donors is to help them to achieve this objective. There is a need for integration, cost reduction and sharing of examples of best practices, as well as better distribution of the financial resources available. Donors were requested to extend their roles to do more to strengthen health care systems, or at least broader NTD programmes, in trachoma-endemic countries.

SESSION 4

PRIORITIES FOR GET2020 AND WHO

DATA MANAGEMENT

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Data management and reporting are currently slow. The goal is to ensure that implementation data from the previous year are available from each country in time for the Alliance meeting. The requirements for trachoma data collection should align with other systems for NTDs that are already in place. This includes reviewing the data that are requested by ITI on the azithromycin application form.

FUNDING

Funding is an ongoing activity at WHO within the current strategy to support eradication, elimination and control of NTDs in the poorest populations. WHO must identify what financial resources are needed and compare them with what is available.

WASH

The trachoma community has achieved its results through the implementation of the SAFE strategy. Greater engagement with the WASH sector and consolidating the evidence base for the F and E components will be important for realizing the goals of GET2020. It may be useful to invite key donors within the WASH sector to jointly collect evidence to establish the link with trachoma.

Discussion

Components S and A

There is a need to disseminate information on technical developments and best practices, particularly on the management of those who refuse surgery and of recurrent cases, and what needs to be done for surveillance and validation.

The integration of trachoma with other diseases should be seen as a way to break down the silos of vertical programming, improving

programme performance and reducing costs of intervention. An effort should be made to explore possibilities of integration and to document best practices from models such as the MALTRA week in Amhara, Ethiopia.

Components F and E

The F and E components remain a significant challenge. In the six years until 2020, there is an urgent need to foster relationships and to establish a dialogue between WASH and trachoma programmes. WASH donors and NTD donors should be parties to these

conversations, to enhance possibilities for proactive contributions to be made to the elimination of trachoma. Coordination with donors is critical to ensure that resources follow needs according to agreed priorities.

It is important that all partners – national programmes, NGOs and donors – make clear to each other their own needs. For example, donors should communicate clearly the award criteria tied to their support to remove any misunderstandings and potential frustrations by the recipients.



Conclusions and recommendations

CONCLUSIONS

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1. The Alliance thanks the Government of Ethiopia for hosting the 18th meeting of the Alliance, which is only the fourth time the Alliance has met outside of Geneva. The great progress being made by Ethiopia to move forwards towards elimination of trachoma is encouraging given the number of people affected nationally.
2. The Alliance highlights the need to move with urgency to ensure trachoma elimination activities are implemented in all endemic areas in all countries by the end of 2015 in order to achieve the goal of GET2020. Alliance members stand ready to support Member States to achieve their national elimination objectives.
3. The Alliance recognizes the role of WHO in the Alliance, and congratulates WHO for increasing the momentum for the elimination of trachoma while maintaining the integrity of the full SAFE strategy.
4. This meeting has included the largest number of participants to date, representing WHO Member States, NGOs, local and international partners, and donors. The Alliance celebrates this expansion, but notes the absence of several endemic Member States and the need for more substantive engagement with the WASH community.
5. The Alliance recognizes the new and renewed extraordinary commitments of support from the private sector, bilateral agencies and other donors. The particular generosity of Pfizer, DFID, USAID and The Queen Elizabeth Diamond Jubilee Trust, among many others, is noted with great thanks.
6. The Alliance congratulates ICTC on its 10th anniversary in April 2014 and thanks it for a decade of hard work and achievement in supporting implementation of the SAFE strategy.
7. The Alliance thanks ITI for encouraging all countries meeting relevant epidemiological criteria to apply for Pfizer-donated azithromycin for trachoma control, for its offer of

technical assistance to Member States, and for its renewed commitment to ensuring that MDA is deployed in the context of the full SAFE strategy. A report of MDA implemented without F and E activities is of concern as these activities are essential to achieving sustained reduction in trachoma.

8. The Alliance notes the tremendous progress made by the Global Trachoma Mapping Project, with more than 1000 districts mapped in the past 16 months. Collaboration between funders, particularly DFID and USAID, has been a key platform for that work.
9. The Alliance recognizes that TAPs have been successfully utilized to guide SAFE implementation, and highlights the importance of promoting the inclusion of TAPs in the national plans for control and elimination of NTDs.
10. The Alliance recognizes the effort made by 30 countries to report data using the TEMF before this 18th meeting but regrets the lack of complete global data for 2013.
11. The Alliance acknowledges the progress made to increase surgical coverage for TT, although concerns about overall output and quality remain. The Alliance notes the development of the mannequin-based tool for trichiasis surgery training. Cross-border movement may potentially impact national achievement of UIGs for TT.
12. Recognizing that the countdown to 2020 has begun, and that it is no longer “business as usual”, the Alliance emphasizes the importance of focussing on the underserved components of the SAFE strategy, namely F and E. This includes inviting identified WASH stakeholders to Alliance meetings, convening discussions between the WHO Department of Control of NTDs and the WHO WASH group, and providing guidance on joint planning, funding, implementation and monitoring.
13. The Alliance recognizes the continuing need for focused operational research to optimize trachoma elimination strategies.

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RECOMMENDATIONS

1. The Alliance recommends that WHO facilitate inclusive participation by providing notice for the 19th meeting of the Alliance 6 months in advance, and again securing an appropriate conference facility. WHO should invite WHO WASH representatives, UNICEF, the World Bank Water and Sanitation Program, and other key stakeholders to participate in the meeting.
2. The Alliance recommends that ICTC and WHO collaborate to identify new donors (including consideration of both within-country and international resources) in order to fill funding gaps, taking into account the anticipated large scale-up of activities following the completion of global mapping.
3. The Alliance recommends that ICTC and WHO collaborate to review existing capacity-building materials and tools, identify gaps, promote application of preferred practices and guidelines, and ensure that such resources are accessible to those who need them. The Alliance further requests WHO to strengthen its capacity to provide technical advice and support.
4. The Alliance requests WHO to commission work to better estimate the TT backlog.
5. The Alliance requests all partners to take steps to improve surgical output and quality. The Alliance encourages countries to utilize the updated WHO guidelines for TT surgery (“the yellow manual”) as part of this process.

6. The Alliance urges endemic countries and their partners to support cross-border coordination of delivery of SAFE. WHO Regional Offices should facilitate and support this transnational coordination, including bi-national agreements where needed. WHO should encourage all endemic countries to participate in the meetings of the Alliance in order to facilitate inter-country coordination and support from partners.
7. The Alliance requests WHO to convene a forum or task force to bring together the WASH and NTD departments in order to identify common challenges, share best practices, coordinate actions between the sectors, outline joint learning agendas and foster coordinated implementation at national and international levels that support countries in the implementation of F and E interventions, without slowing down the pace of trachoma elimination.
8. The Alliance requests Member States to investigate mechanisms to incorporate TAPs into national plans for control and elimination of NTDs. The Alliance should assess the utility of the TAP, update the template where appropriate and present a new TAP template at the meeting of the Alliance in 2015.
9. The Alliance urges endemic countries that did not submit data using the TEMF 2014 to return the forms as soon as possible to ensure that their data are included in the global picture. The offer by WHO Regional Offices to support completion of the forms is noted with thanks.
10. The Alliance requests WHO to revise the TEMF for 2015 to reduce the time burden required to complete the form and maximize the value of the data collected. This includes harmonization with other international NTD data collection and storage systems (for example, the Joint Reporting Form and the National NTD Database template), and with the annual azithromycin application process.
11. The Alliance recommends that WHO define and standardize the indicators and the methodology to assess clean face. Progress on these indicators should be included in the revised TEMF. Simple indicators that capture economic process and capacity strengthening should also be considered for inclusion in the TEMF. The Alliance notes the need to create indicators to serve as a proxy for F and E interventions, as well as the integration of F and E in the framework of WASH.
12. The Alliance recommends that summary presentations (using a standard template) be made at the meeting of the Alliance in 2015 by each of the relevant WHO Regional Offices. The presentations should include data on the burden and needs of each country for SAFE (and other core indicators on economics and capacity strengthening) and a summary for the Region.
13. The Alliance requests WHO to advise on how to formalize the relationship between the Trachoma Scientific Informal Workshop and the Alliance. The Alliance recommends that WHO include the report of the Trachoma Scientific Informal Workshop in the agenda of the meeting of the Alliance in 2015.
14. The Alliance requests WHO to support national programmes and partners to generate accurate cost data on SAFE strategy components. The Alliance requests WHO to estimate the economic benefit of successful interventions.

15. The Alliance recommends that WHO use the current guidelines to validate the elimination of blinding trachoma for those countries that have already finished their work. The Alliance requests WHO to convene a working group to define by the end of 2014:
 - the process and scale of data collection required to demonstrate the achievement of elimination; and
 - the nature, scale and duration of post-elimination surveillance required to ensure that the achieved level of low endemicity will be sustained in the future or further reduced.
16. The Alliance requests WHO to clarify the criteria to determine where trachoma mapping is not required, and to define and standardize the methodology recommended for MDA coverage surveys.
17. The Alliance recommends that ICTC, in collaboration with selected national partners, prepare a feasibility assessment including a “risk matrix” setting out potential barriers to achievement of the GET2020 targets along with the potential solutions, for discussion at the meeting of the Alliance in 2015.

Annexes

ANNEX1: AGENDA

18th Meeting of the WHO Alliance for the Global Elimination of Blinding Trachoma by 2020

United Nations Conference Centre (UNECA), Addis Ababa, Ethiopia, 28–29 April 2014

Meeting purpose: to assess progress on the elimination of blinding trachoma, distil learning and establish priority actions in order for all countries to meet the 2020 target.

Monday, 28 April 2014

Moderator: Dr Teshome Gebre, Regional Director for Africa, ITI

Session 1

Time	Topic	Speakers
08:30 – 09:00	Registration	
09:00 – 09:30	Opening session	
	Welcome address	Dr Pierre Kilebou M'Pelé (WHO Representative, Ethiopia)
	Keynote remarks	Dr Dirk Engels (WHO/NTD Director)
	Opening speech	H.E. Dr Keseteberhan Admasu (Minister, Federal Ministry of Health, Ethiopia)
09:30 – 10:00	Group photograph, and coffee break	
10:00 – 10:30	Nomination of officers	Teshome Gebre (ITI)
	Purpose, outcome and outputs of meeting	Chair
	Adoption of agenda	Anthony Solomon (WHO)
	Administrative matters	
10:30 – 11:00	Showcase: Ethiopia	Oumer Shafi (Ethiopia)
11:00 – 11:30	WHO/NTD report	Anthony Solomon (WHO)
11:30 – 11:45	Global Trachoma Mapping Project	Tom Millar (Sightsavers)
11:45 – 12:15	Trachoma Action Planning	Michael Gichangi (Kenya)

12:15 - 14:00 Lunch

Session 2

Time	Topic	Speakers
14:00 – 15:30	Issues for the ‘S’ component	
	1) Use of mapping data to target surgery, and training of health extension workers to identify TT	Zelalem Habtamu Jemal (Oromia RHB)
	2) Setting up a TT surgery program in a newly-discovered endemic focus	Julián Trujillo Trujillo (Colombia)
	3) The campaign strategy for delivering TT surgery	Boubacar Kadri (Niger)
	4) Maintaining surgical quality at national scale	Lamine Traoré (Mali)
	5) Ensuring surgical quality when scaling down	Cung Hong Son (Vietnam)
	6) What if delivery exceeds the UIG?	Sailesh Mishra (Nepal)
	7) The “HeadStart” project	Emily Gower (Wake Forest)
15:30 – 16:00	Coffee break	
16:00 – 17:30	Issues for the ‘A’ component (ITI report, countries, discussion)	
	1) Going to scale, and doing coverage surveys	Berhan Guadie (Amhara RHB)
	2) How to achieve and prove high coverage in azithromycin MDA	Khumbo Kalua (Malawi)
	3) Planning and implementation of azithromycin MDA in an area co-endemic for yaws & trachoma	Oliver Sokana (Solomon Islands)
	4) Planning and implementation of azithromycin MDA in an integrated NTD framework	Onyebuchi Uwaez (Nigeria)
	5) International Trachoma Initiative report	Paul Emerson (ITI)
	Discussion	All

17:30 – 19:00 Reception

Tuesday, 29 April 2014

Session 3

Time	Topic	Speakers
08:30 – 09:00	ICTC report	Martin Kollmann (ICTC/CBM)
09:00 – 10:30	Issues for the 'F' and 'E' components	
	1) Approaches to F&E in southern Ethiopia	Habtamu Beyene (SNNPRHB)
	2) The contribution of F&E to trachoma elimination in The Gambia	Sarjo Kanyi (The Gambia)
	3) How to obtain government support to align WASH with the needs of trachoma elimination programmes	Balgesa Babiker (Sudan)
	4) Taking a pilot WASH programme to scale	Asad Aslam Khan (Pakistan)
	Discussion	All
10:30 – 11:00	Coffee break	Oumer Shafi (Ethiopia)
11:00 – 12:00	Donor panel	Eleanor Fuller (Queen Elizabeth Diamond Jubilee Trust)

12:00 - 14:00 Lunch

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Session 4

Time	Topic	Speakers
14:00 – 15:00	What are the priority actions for the GET2020 Alliance?	Anthony Solomon (WHO)
15:00 – 15:30	What are the priority actions for WHO/NTD?	Anthony Solomon (WHO)
15:30 – 16:00	Coffee break	
16:00 – 17:15	Conclusions and recommendations	Chair
17:15 – 17:30	Meeting feedback and meeting close	Chair

ANNEX2: LIST OF PARTICIPANTS

NATIONAL REPRESENTATIVES (by countries)

Name	Contact details
Dr Ahmad Shah SALAM* National Coordinator Comprehensive Eye Care Ministry of Public Health Public Health Avenue Kabul AFGHANISTAN	Tel: +93 70 29 85 10 Fax: +93 20 23 01 37 Email: ahmadshahsalam2003@yahoo.com
Ms Madeleine HEYWARD Advisor (Health) Australian Permanent Mission to the UN, Geneva Chemin des Fins 2 – Case Postale 102 1211 Geneva 19 SWITZERLAND For AUSTRALIA	Tel: +41 22 799 91 65 Email: who@health.gov.au
Dr Ronaldo CARVALHO SCHOLTE Consultor Técnico Coordenação Geral de Hanseníase e Doenças em Eliminação Secretaria de Vigilância em Saúde - MS SCS Qd 4 Bloco A Ed. Principal 3º andar CEP: 70304-000 - Brasília - DF BRAZIL	Tel: +55 (61) 3213-8195 Email: ronaldo.scholte@saude.gov.br
Mr Martin KABORE Programme National de Prévention de la Cécité Ministère de la Santé 09 BP 7009 Ouagadougou BURKINA FASO	Email: kaboremartin@yahoo.fr
Dr Onésime NDAYISHIMIYE Directeur PPNIMTNC Ministère de la santé Publique Avenue des Etats-Unis, Bâtiments ex PSP II Bujumbura BURUNDI	Tel: +25 7799 100 36 Email: ndayones@yahoo.fr
Dr Seiha DO National Coordinator Prevention of Blindness House 121, Street 110 Lk wat Phnom, Phnom Penh CAMBODIA	Tel: +855 128 40 796 Fax: +855 232 11 072 Email: dosheiha@gmail.com

Name	Contact details
Professor Lucienne BELLA Coordinator PNLC Ministère de la Santé publique Yaoundé CAMEROON	Tel: +23 7199 96 52 86 Email: ngonbidjoe@yahoo.fr
Dr Georges YAYA Directeur Programme national de lutte contre les maladies cécitantes BP 556 Bangui CENTRAL AFRICAN REPUBLIC	Tel: +236 61 69 25 Fax: +236 61 04 35 Email: geya@live.fr
Dr Julian TRUJILLO TRUJILLO Profesional Especializado Subdirección de Enfermedades Transmisibles Dirección de Promoción y Prevención Ministerio de Salud y Protección Social Bogota COLOMBIA	Tel: +57 1 3305000 ext. 1467 Cell: +57 3112179795 Email: jtrujillot@minsalud.gov.co
Dr Englosran Roger KOUAKOU Chargé d'Etude au PNSO-LO BP 902 Abidjan 22 CÔTE D'IVOIRE	Tel: +225 22 443 701/07 030 086 Email: englosran.kouakou@medecins.ci
Dr Jean NDJEMBA Chef du bureau des maladies oculaires Ministère de la Santé Av de la justice 41 Kinshasa DEMOCRATIC REPUBLIC OF THE CONGO	Tel: +243 0815 08 66 55 Email: drndjemba@yahoo.fr
Dr Issa Abdi BOGOREH Coordinateur Adjoint du PNLC Balbala Hospital Djibouti DJIBOUTI	Tel: +253 81 94 81 Email: bogoreh@hotmail.com
Dr Khaled AMER National Coordinator Prevention of Blindness 79th Elnoza Street Heliopolis Cairo EGYPT	Tel: +201 21 04 0873 Email: amerk888@gmail.com
Dr Genet KIFLU GEBRU Eye Health Coordinator Ministry of Health Addis Ababa ETHIOPIA	Email: kigenet@yahoo.com

Name	Contact details
Mr Sarjo KANYI Programme Manager/ Cataract Surgeon National Eye Health Programme Ministry of Health & Social Welfare P.O. Box 950 Banjul GAMBIA	Tel: +220 9901716, 3011349 6651344, 7510996 Email: sarjo.kanyi@yahoo.com
Dr Oscar DEBRAH National coordinator Prevention of Blindness Eye Care unit Ghana Health service PMB Ministries Accra GHANA	Tel: +23321666815 Email: oscardebrah2005@yahoo.com
Dr Marco Antonio DÍAZ Responsable del Programa de Discapacidad Departamento Regulación de los discapacidad Programas de Atención a las Personas Ministerio de Salud Pública y Asistencia Social Guatemala City GUATEMALA	Tel: +502 23228383 ext. 214 Email: mad.salud@gmail.com or mspas@yahoo.com
Dr André GOEPOGUI* Coordonnateur du Programme National de Lutte Contre l'Onchocercose et la Cécité et les Maladies Tropicales Négligées (PNLOC/MTN) BP : 585 Ministère de la Santé Publique Conakry GUINEA	Tel: +224 660 20 14 31 / 628 51 80 63 Email: agoep@yahoo.fr
Dr Milena N'BOTE BLIF Coordenador do Projecto Tracoma Ministère de la Santé Publique Av. Unidade Africana CP50 Bissau GUINEA-BISSAU	Tel: +245 696 56 89 Email: pnlcegueira@yahoo.com.br
Dr Behzad DAMARI* Head of Center for Non-communicable Diseases Ministry of Health Jomhuri Hafez Cross 2th floor Room 203 Tehran ISLAMIC REPUBLIC OF IRAN	Tel: +98 2 66760433
DDr Zaid Abdul Nafi RIDHA National Coordinator Prevention of Blindness Ministry of Health Baghdad IRAQ	Tel: +9647901386746 Mobile: +9647901386746 Email: sanafrahmaw@yahoo.com or Sanaazaid_mawgod@yahoo.com

Name	Contact details
Dr Michael Mbee GICHANGI Head Division of Ophthalmic Services Ministry of Health PO Box 43319 Nairobi KENYA	Tel: +254 7333 34 3012 Email: gichangi58@yahoo.com
Dr Khamphoua SOUTHISOMBATH National Program Coordinator Ministry of Health Vientiane LAO PEOPLE'S DEMOCRATIC REPUBLIC	Tel: +856 20 55 601 720 Email: southi1961@gmail.com
Dr Khumbo KALUA Senior Community Ophthalmologist Ministry of Health Lions Sightfirst Eye Hospital P.O Box E180 Blantyre MALAWI	Tel: +265 999 95 81 76 Email: khumbokalua@yahoo.com
Professeur Lamine TRAORÉ Coordinateur PNLC Ministère de la Santé BP 228 Bamako MALI	Email: traorel@live.fr
Dr Mohamed SIDI BABA Centre priorité à la vue, Teyarett Ministère de la Santé et des Affaires Sociales B.P. 4158 Nouakchott MAURITANIA	Email: mohdjid2@yahoo.fr
Nadia Angélica FERNANDEZ SANTOS Jefa Depto. de Oncocercosis y OETV Dirección del Programa de Enfermedades Transmitidas por Vector Dirección Adjunta de Programas Preventivos Centro Nacional de Programas Preventivos y Control de Enfermedades Secretaría de Salud Benjamin Franklin 132, piso 1, Col. Escandón, Del. Miguel Hidalgo, México, D.F., C.P. 11800 MEXICO	Tel: +52 2614 6461 Fax: +52 2614 6462 Email: nadiafernandezetv@yahoo.com.mx
Dr Jaouad HAMMOU Chef de services Maladies oculaires et otologiques Ministère de la Santé 71 Avenue Ibn Sina, Agdal Rabat MOROCCO	Tel: +212 376712 44 Fax: +212 37 67 12 98 Email: hjaouad2020@yahoo.fr

Name	Contact details
Dr Marília MASSANGAIE GUAMBE Focal point Trachoma Ministerio da Saude Maputo MOZAMBIQUE	Tel: +258 82 76 72 757 Email: mariliamassangaie@yahoo.com.br
Mr Sailesh Kumar MISHRA Program Director NNJS P.O Box 335 Katmandu NEPAL	Tel: +984 124 1014 Fax: +977 1 4219316 Email: nnjs@wlink.com.np or kath@nnjs.wlink.com.np
Dr Boubacar KADRI PNLCC BP11347 Niamey NIGER	Tel: +227 96967009 Email: kadriboubacar@gmail.com
Dr Onyebuchi UWAZOEKE Trachoma Programme Manager NPPB Federal Ministry of Health Abuja NIGERIA	Email: happywaez@yahoo.com
Dr Saleh AL-HARBI Senior, National Supervisor National program of Eye and Ear health care Ministry of health P.O. Box 395, P.C.100 Muscat OMAN	Tel: +96895959757 Fax: +96824692715 Email: freeomani@yahoo.com
Professor Asad Aslam KHAN National Coordinator PBL 7 Shah Jehan Road Lahore, 5400 PAKISTAN	Tel: +92 300 8456377 Fax: +92 42 7248006 Email: drasad@lhr.comsats.net.pk
Dr Boubacar SARR Coordinateur PNPSOS Ministère de la Santé et de la Prévention Médicale 4 Avenue Aimé Césaire BP 4024 Dakar SENEGAL	Tel: +221 77 550 77 73 Fax: +221 33 869 42 06 Email: bouksarr@yahoo.fr
Mr Oliver SOKANA National Public Health Eye care Coordinator Ministry of Health PO Box 349 Honiara SOLOMON ISLANDS	Tel: +677 20610 Email: osokana@moh.gov.sb

Name	Contact details
Dr Abdirisak Ahmed DALMAR* National Coordinator for Prevention of Blindness Directorate of Health Ministry of Human Development and Public Services Mogadishu SOMALIA	Tel: +252 615 5505599 or +252 619 5505599 Email: drdalmar@yahoo.co.uk
Dr Lucia KUR National Coordinator, Trachoma control Ministry of Health Government of Southern Sudan Juba SOUTH SUDAN	Tel: +249 912288182 Fax: +88 (216) 217 01533 Email: luciaku55@yahoo.com
Dr Balgesa Mohamed El Kheir BABIKER Ophthalmologist National Coordinator of Trachoma Control Program National Program for Prevention of Blindness Federal Ministry of Health Nile Avenue Khartoum SUDAN	Tel: +249 183741422 Email: drbilghis_2000@yahoo.com
Dr Patrick TURYAGUMA Trachoma Program Manager Ministry of Health PO box 7272 Kampala UGANDA	Tel: +256 7724 74672 Email: patrick.turyaguma@gmail.com
Dr Edward KIRUMBI Trachoma Focal Point Programme Officer- NTD Programme Ministry of Health & Social Welfare P.O. Box. 9083 Dar-es-salaam UNITED REPUBLIC OF TANZANIA	Tel: +255 22 212 13 80 Email: kirumbie@yahoo.com
Mrs Fasihah TALEO National Coordinator Neglected Tropical Diseases Public Health Directorate Health Department Port Vila VANUATU	Email: ftaleo@vanuatu.gov.vu
Professor Cung Hong SON Deputy Director Vietnam National Institute of Ophthalmology 85 Ba Trieu Hanoi VIET NAM	Tel: +84 4 39437 027 Mobile: +84 913514588 Email: cunghongson@yahoo.com or bvmtw@vnio.vn

Name	Contact details
Dr Tawfik K. AL-KHATIB National Eye Health Coordinator Ministry of Public Health and Population Sana'a YEMEN	Tel: +967 777 786 846 Email: tawfik234@yahoo.com
Dr Davison John KWENDAKWEMA Beverly Eye Centre 31-33 Mupundu Road Town Centre Ndola ZAMBIA	Tel: +260977782259 or +260212611220 Email: dkwenda@microlink.zm

*Unable to attend

PARTNERS

Name	Contact details
African Medical and Research Foundation	
Dr Awoke TASEW	Email: aweketasew2@gmail.com
Dr Florence TEMU	Email: fsipora@yahoo.com
Alnoor Magrabi Foundation	
Dr Gamal Ezz ELARAB	Email: gamalezzelarab@yahoo.com
Bill & Melinda Gates Foundation	
Mr Aryc MOSHER	Email: aryc.mosher@gatesfoundation.org
Carter Center	
Ms Aisha STEWART	Email: aisha.stewart@emory.edu
Dr Zerihun TADESSE	Email: zerihtad@yahoo.co.uk
Mr Mulat ZERIHUN	
Children's Hospital Oakland Research Institute	
Professor Deborah DEAN	Email: ddean@chori.org
Christoffel Blinden Mission	
Professor Martin KOLLMANN	Email: khm.kollmann@gmail.com
Dr Babar QURESHI	Email: mbqureshi1@googlemail.com
Dr Demisse TADESSE	Email: demissiet2@gmail.com
Mr Aklilu THOMAS	Email: akliluthomas@gmail.com

Name	Contact details
Conrad N. Hilton Foundation	
Mr Gregory ANDERSON	Email: Gregory@HiltonFoundation.org
Dr Shaheen KASSIM-LAKHA	Email: shaheen@hiltonfoundation.org
Department for International Development	
Mr Iain JONES	Email: I-Jones@dfid.gov.uk
Emory Eye Center	
Professor Danny HADDAD	Email: dhaddad@emory.edu
END Fund	
Mr Warren LANCASTER	Email: wlancaster@end.org
Mr Scott MOREY	Email: smorey@endfund.org
END Neglected Tropical Diseases in Asia	
Mr James JOHNSON	Email: jamjohnson@fhi360.org
ENVISION Project, RTI International	
Ms Katie CROWLEY	Email: Kcrowley@rti.org
Mr Philip DOWNS	Email: PDowns@rti.org
Dr Jeremiah NGONDI	E-mail: jngondi@rti.org
Ms Lisa ROTONDO	Email: lrotondo@rti.org
Federal Ministry of Health of Ethiopia	
Mr Oumer SHAFI	Email: Oumerjaji@gmail.com
Ms Genet KIFLU	Email: kigenet@yahoo.com
Mr Sorsa FELTAMO	
Mr Nigusu G/YESUS	
Mr Akililu ZEWDIE	
Ms Roman KEDU	
Ms Yaneabeba SIMA	
Ms Meseret YETUBIE	
Mr Birhanu ASFAW	
Ms Meseret MELAW	
Mr Asfaw SEMA	

Name	Contact details
Fred Hollows Foundation	
Mr Ahmed ABAJOBIR	Email: aabojobir@hollows.org
Mr Berhanu BERO	Email: bbero@hollows.org
Dr Wonda Alemayehu GEBREMICHAEL	Email: walemayehu@yahoo.com
Ms Isabella MONTGOMERY	Email: imontgomery@sightsavers.org
Ms Joanne O'SULLIVAN	Email: josullivan@hollows.org
Mr Nigel PEDLINGHAM	Email: npedlingham@hollows.org
Ms Virginia SARAHA	Email: vsarah@hollows.org
Grarbet Tehadiso Mahber	
Professor Redda T. HAIMANOT	Email: redda@ethionet.et
Dr Gabremaskal H. NIGUSSIE	Email: ghnigussie@gmail.com
Helen Keller International	
Ms Whitney GOLDMAN	Email: WGoldman@hki.org
Ms Emily TOUBALI	Email: etoubali@hki.org
IMA World Health	
Ms Sarah CRACIUNOIU	Email: sarahcraciunoiu@imaworldhealth.org
Dr Deogratias DAMAS	Email: deogratiasdamas@imaworldhealth.org
Ms Ann VARGHESE	Email: annvarghese@imaworldhealth.org
International Agency for the Prevention of Blindness	
Mr Peter ACKLAND	Email: packland@iapb.org
Mr Richard LE MESURIER	Email: rtlemes99@gmail.com
International Trachoma Initiative	
Dr Colin BECKWITH	Email: cbeckwith@taskforce.org
Ms Birgit BOLTON	Email: bbolton@taskforce.org
Dr Paul EMERSON	Email: pemerson@taskforce.org
Mr Eshetu GELETU	Email: egeletu@taskforce.org
Ms Kimberly JENSEN	Email: Kimberly.jensen@emory.edu
Dr Teshome Gebre KANNO	Email: tgebre@taskforce.org
Dr Menbere Alemu KASSA	Email: malemu@taskforce.org
Mr Alex PAVLUCK	Email: apavluck@taskforce.org
Ms Joanna PRITCHARD	Email: jpritchard@taskforce.org
Mr Tesfaye TEFERI	Email: tteferi@taskforce.org
Ms Anyess TRAVERS	Email: atravers@taskforce.org

Name	Contact details
Johns Hopkins University	
Dr Aida ABASHAWEL	Email: aabasha1@jhu.edu
Dr Michael S. BAILEY	Email: mbailey@jhucpp.org
Dr E. Kuor KUMOJI	Email: ekumoji@jhucpp.org
Professor Sheila WEST	Email: shwest@jhmi.edu
Ms Leah WOHLGEMUTH	Email: lwohlgem@jhsph.edu
Juntendo University	
Professor Koichi ONO	Email: fzb06006@nifty.com
Kilimanjaro Centre for Community Ophthalmology	
Professor Paul COURTRIGHT	Email: pcourtright@kcco.net
Mr Chad MacARTHUR	Email: chadmacarthur@hotmail.com
Edson Elish MWAIPOPO	Email: eeliah@kcco.net
Kongwa Trachoma Project	
Mr Haran MKOCHA	Email: hmkocha@yahoo.com
Light for the World	
Dr Amir Bedri KELLO	Email: amirbedrikello@gmail.com
Ms Kalkidan KETSELA	Email: kketseta@light-for-the-world.org
Mr Johannes TRIMMEL	Email: j.trimmel@light-for-the-world.org
Mr Nemera WOYESSA	Email: nwoyessa@light-for-the-world.org
Lions Clubs International Foundation	
Mr Philip ALBANO	Email: Phillip.Albano@lionsclubs.org
Professor Henri ADALA	Email: henriadala@gmail.com
Dr Tebebe Yemane-BERHAN, The Honourable World Laureate	
Mr Mohama TCHATAGBA	Email: Mohama.Tchatagba@lionsclubs.org
London School of Hygiene and Tropical Medicine	
Professor Robin BAILEY	Email: robin.bailey@lshtm.ac.uk
Dr Matthew BURTON	Email: matthew.burton@lshtm.ac.uk
Mr Esmael Habtamu ALI	Email: Esmael.Ali@lshtm.ac.uk
Dr Anna LAST	Email: anna.last@lshtm.ac.uk
Melbourne School of Population and Global Health	
Professor Hugh TAYLOR	Email: h.taylor@unimelb.edu.au

Name	Contact details
Menschen für Menschen	
Dr Asnake WORKU	Email: asnake.mfmpco@ethionet.et
Michael Dejene Public Health Consultancy Services	
Dr Michael DEJENE	Email: Mikedejene@yahoo.com
National Committee for the Prevention of Blindness, Ethiopia	
Dr Yilikal ADAMU	Email: yilikaladamu@gmail.com
Operation Eyesight Universal	
Dr Boateng WIAFE	Email: bwiafe@operationeyesight.com
ORBIS	
Ms Rebecca CRONIN	Email: rcronin@orbis.org.uk
Mr Temesgen KABETO	Email: Temesgen.Kabeto@orbis.com
Dr Yeneneh MULUGETA	Email: Yeneneh.Mulugeta@orbis.com
Dr Alemayehu SISAY	Email: Alemayehu.Sisay@orbis.org
Mr Allan THOMPSON	Email: athompson@orbis.org.uk
Organisation pour la Prévention de la Cécité	
Dr Karim BENGRINE	Email: k.bengraine@opc.asso.fr
Professor Serge RESNIKOFF	Email: serge.resnikoff@gmail.com
OSE	
Dr Elias HAILU	
Pfizer	
Mr Joseph BELISLE	
Ms Julie JENSON	Email: julieM.Jenson@pfizer.com
Ms Kim LEWIS	Email: kim.lewis@pfizer.com
Ms Caroline ROAN	Email: caroline.roan@pfizer.com
Prevention of Blindness Union	
Dr M. Mansur RABIU	Email: mrabiou@emr-iapb.org
Queen Elizabeth Diamond Jubilee Trust	
Ms Eleanor FULLER	Email: eleanor.fuller@qejubileetrust.org
Mr Matt LITTLE	Email: matt.little@qejubileetrust.org

Name	Contact details
Regional Health Bureaus (RHBs) of Ethiopia	
Mr Ali HUSSEIN	Afar RHB
Mr Ayelign MULALEM	Amhara RHB
Ms Zebideru ZEWDIE	Amhara RHB
Mr Abduiselam SHENGLE	Benshangul-Gumuz RHB
Mr Dudimo ADAR	Gambella RHB
Mr Shalo DABA	Oromia RHB
Dr Zelalem HABTAMU	Oromia RHB
Mr Kefle G. MARIAM	Southern Nations, Nationalities and Peoples RHB
Mr Abdulfetah MEHAMUD	Somali RHB
Mr Haggos GODIFAY	Tigray RHB
RTI International	
Dr Fikreab KEBEDE	Email: fikreabk@yahoo.com
Mr Scott McPHERSON	Email: smcpherson@rti.org
Sightsavers	
Dr Agatha ABOE	Email: aaboe@sightsavers.org
Dr Colin MACLEOD	Email: macleodkc@hotmail.com
Ms Siobhain McCULLAGH	Email: smccullagh@sightsavers.org
Mr Thomas MILLAR	Email: tmillar@sightsavers.org
Professor Caleb MPYET	Email: mpyetc@yahoo.com or cmpyet@sightsavers.org
Mr Geordie WOODS	Email: gwoods@sightsavers.org
UNICEF	
Dr Peter SALAMA	Email: psalama@unicef.org
United States Agency for International Development	
Dr Yared Kebede HAILE	Email: yhaile@usaid.gov
Ms Angela WEAVER	Email: aweaver@usaid.gov
University of Pennsylvania	
Dr John H. KEMPEN	Email: john.kempen@uphs.upenn.edu
Wake Forest Baptist Medical Center	
Dr Emily W. GOWER	Email: egower@wakehealth.edu
Water Action	
Mr M Adane KASSA	

Name	Contact details
WaterAid	
Mr Teferi Abebe KIDANE	Email: TeferiAbebeKidane@wateraid.org
Ms Yael VELLEMAN	Email: YaelVelleman@wateraid.org
World Bank	
Dr Hamed ALAA	Email: alaahamed@worldbank.org or alaahamedeg@gmail.com
World Vision	
Ms Etsub BRHANESILASSIE	Email: Etsub_Brhanesilassie@wvi.org
Dr Gagik KARAPETYAN	Email: gkarapetyan@worldvision.org
Mr Robel LAMBISSO	Email: Robel_Lambisso@wvi.org
Mrs Christen SNOW	Email: chsnow@worldvision.org

WORLD HEALTH ORGANIZATION – REGIONAL AND COUNTRY OFFICES

Name	Contact details
WHO/AFRO	
Dr Simona MINCHIOTTI	Email: minchiottis@who.int
WHO ETHIOPIA	
Dr Pierre MPELE-KILEBOU, WHO Representative	Email: mpelep@who.int
Dr Ababayehu Assefa MENGISTU	Email: mengistua@who.int
Mrs Loza Mesfin TESFAYE	Email: lozam@et.afro.who.int
Dr Abate Mulugeta BESHAH	Email: abatem@who.int
Mr Waltaji Terfa KUTANIE	Email: waltajit@et.afro.who.int
WHO/AMRO	
Ms Martha SABOYA	Email: saboyama2@paho.org
WHO/EMRO	
Dr Riadh BEN ISMAIL	Email: ismailr@who.int
Dr Ismat CHAUDHRY	Email: dr.ismatch@yahoo.com
WHO/WPRO	
Dr Andreas MUELLER	Email: muellera@who.int

WORLD HEALTH ORGANIZATION – HEADQUARTERS

Name	Contact details
Dr Dirk ENGELS, Director, Control of Neglected Tropical Diseases	Email: engelsd@who.int
Dr Anthony SOLOMON	Email: solomona@who.int

INTERPRETERS

Name	Contact details
Mr Damien Parfait Roger ATANGANA Addis Ababa, Ethiopia	Email: dprantagana@yahoo.com
Mr Edmond Oladipo JOHNSON Addis Ababa, Ethiopia	Email: afriklingualink@gmail.com
Mr Ephrem KAMANZI Nairobi, Kenya	Email: ekamanzi@gmail.com
Mr Gilbert MANIRAKISA Nairobi, Kenya	Email: manigilbert@gmail.com
Mr Sisko MULAMBA-TSHIKALA Nairobi, Kenya	Email: sisko_mt@yahoo.fr

