

Summary Proceedings

Twenty-Seventh Annual Trachoma Control Program Review

Stronger Together:

Building Sustainable Trachoma Elimination Strategies

THE
CARTER CENTER



Waging Peace. Fighting Disease. Building Hope.

Addis Ababa, Ethiopia

March 30-31, 2025

“Stronger Together: Building Sustainable Trachoma Elimination Strategies”

The Twenty-Seventh Annual Trachoma Control Program Review



The Carter Center
Addis Ababa, Ethiopia

Acknowledgments

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And to many others who may not be listed, our sincere gratitude.

Acknowledgements

The Carter Center's Trachoma Control Program (TCP) made meaningful strides in 2025 in the global effort to eliminate trachoma as a public health problem. Working alongside ministries of health in Ethiopia's Amhara region, Niger, South Sudan, and Sudan, the TCP supports the implementation, monitoring, and evaluation of the World Health Organization (WHO)-endorsed SAFE strategy—encompassing Surgery, Antibiotics, Facial cleanliness, and Environmental improvement. Despite persistent security challenges across several program areas, 2025 was a year of tangible progress, with country programs delivering results that brought each nation closer to elimination thresholds and making a real difference in the lives of millions at risk of trachoma—the world's leading cause of infectious blindness.

The scale of the TCP's cumulative impact since 1999 reflects the depth of commitment to eliminate trachoma as a public health problem and reduce all suffering caused by this blinding disease. To date, The Carter Center has assisted 982,948 people with trichomatous trichiasis (TT) surgical management and distributed more than 254 million doses of Pfizer-donated azithromycin and tetracycline eye ointment. Health education efforts have reached more than 3,800 villages and 9,000 schools, while support for environmental improvement has included the training of over 14,100 masons and the construction of more than 3.6 million latrines—infrastructure that reduces the conditions that allow trachoma to spread and protects communities long after the interventions are complete.

The progress described in this report would not be possible without the dedication of the ministries of health and community health workers who deliver these interventions in their communities every day. Equally essential are the partners, collaborators, and donors whose commitment and generous support make this work possible, including Abbott, The Ajram Family Foundation, Alwaleed Philanthropies, ARISE Fund, Christian Blind Mission (CBM), Cure Blindness Project, Drugs & Diagnostics for Tropical Diseases, The END Fund, The Ghanta Family Foundation, Conrad N. Hilton Foundation, International Trachoma Initiative (ITI), The Peter and Deborah Lamm Foundation, Lions Clubs International Foundation, The London School of Hygiene and Tropical Medicine, Manaaki Foundation, Mission Aviation Fellowship, Orbis International, Pfizer Inc., Francis I. Proctor Foundation, The Rauch Family Foundation, RestoringVision, Schreiber Philanthropy, Sightsavers, The Task Force for Global Health, University of California San Francisco, University of Vermont, The Virginia Wellington Cabot Foundation, WHO, and many others.

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Acronyms

APHI	Amhara Public Health Institute
ARHB	Amhara Regional Health Bureau
ATIRA	<i>A Longitudinal Study of Trachoma Infection Clearance and Re-Acquisition in a Persistently Hyperendemic Setting</i>
CBM	Christian Blind Mission
CDC	United States Centers for Disease Control and Prevention
Ct	<i>Chlamydia trachomatis</i>
DBS	Dried Blood Spots
DNA	Deoxyribonucleic Acid
ESPEN	Expanded Special Project for Elimination of Neglected Tropical Diseases
ETAG	Ethiopia Trachoma Advisory Group
EU	Evaluation Unit
FGC	Full Geographic Coverage
FMOH	Federal Ministry of Health
GESI	Gender Equity and Social Inclusion
GPS	Global Positioning System
HEADSTART	Human Eyelid Analogue Device for Surgical Training And skill Reinforcement in Trachoma
ICTC	International Coalition for Trachoma Control
iDARE	Identify, Design, Apply/Assess, Record, and Expand
IDP	Internally Displaced Person(s)
IECW	Integrated Eye Care Worker
ITI	International Trachoma Initiative
KETFO	Kebele Elimination of Trachoma for Ocular Health
LFA	Lateral Flow Assay
MDA	Mass Drug Administration
MFTA	More Frequent Than Annual
MOH	Ministry of Health
MMP	Mobile and Migrant Population
mRNA	Messenger Ribonucleic Acid
NALA	NTD Advocacy, Learning, Action
NGO	Non-Governmental Organization
NTD	Neglected Tropical Disease
OCO	Ophthalmic Clinical Officer
PC-NTD	Preventive Chemotherapy-Neglected Tropical Disease
PCR	Polymerase Chain Reaction
Pgp3	Placid gene protein 3
PNSO	<i>Programme National de Santé Oculaire</i>

PREPARE-CC	Promoting Resilience, Preparedness, Adaptation, and Response to Climate Change in Complex Crises
PTH	Permethrin-Treated Headwear
PTT	Post-operative Trachomatous Trichiasis
RNA	Ribonucleic Acid
SAFE	Surgery, Antibiotics, Facial Cleanliness, Environmental Improvement
SANPLAT	Sanitary Platform
SCR	Seroconversion Rates
STP	School Trachoma Program
TCP	Trachoma Control Program
TEO	Tetracycline Eye Ointment
TF	Trachomatous Inflammation-Follicular
TI	Trachomatous Inflammation-Intense
TIS	Trachoma Impact Survey
TIS+	Enhanced Trachoma Impact Survey
TSS	Trachoma Surveillance Survey
TT	Trachomatous Trichiasis
WASH	Water, Sanitation, and Hygiene
WHA	World Health Assembly
WHO	World Health Organization
WI HER	Women Influencing Health, Education and Rule of Law
WUHA	WASH Upgrades for Health in Amhara

Executive Summary

The Twenty-Seventh Annual Trachoma Control Program (TCP) Review convened March 30–31, 2026, at the Ethiopian Skylight Hotel in Addis Ababa, Ethiopia, hosted by The Carter Center – Ethiopia office. This year’s Review was held under the theme “Stronger Together: Building Sustainable Trachoma Elimination Strategies”—a reflection of the collective resolve that continues to drive progress across all program areas. Over two days, participants examined the achievements and challenges of 2025, while exploring innovative approaches to accelerate progress toward the elimination of trachoma as a public health problem across the four Carter Center TCP-assisted countries: Ethiopia, Niger, South Sudan, and Sudan. The Review brought together a diverse gathering of stakeholders, including representatives from the ministries of health of all four assisted countries, as well as partners and donors, including but not limited to the Amhara Regional Health Bureau (ARHB), Children’s Investment Fund Foundation, Christian Blind Mission (CBM), Cure Blindness Project, The END Fund, ELMA Philanthropies, Gates Foundation, Global Institute for Disease Elimination, International Trachoma Initiative (ITI), LifeStraw, Lions Club International Foundation, Lions Club of Ethiopia, The London School of Hygiene and Tropical Medicine, Orbis International, Pfizer Inc., Pure Health, Sightsavers, the Francis I. Proctor Foundation at the University of California at San Francisco, The Rauch Family Foundation, Schreiber Philanthropy, The Task Force for Global Health, and the World Health Organization (WHO).

As in previous years, the Review provided national programs with a dedicated forum to share progress toward elimination, discuss challenges, and identify measures needed to reach elimination thresholds. Complementing these country reports, global trachoma updates were provided by key partners, including WHO, ITI, and Pfizer. The remainder of the Review was organized around focused WHO-endorsed Surgery, Antibiotics, Facial cleanliness, and Environmental improvement (SAFE) country updates, and thematic sessions covering water, sanitation, and hygiene (WASH); complementary indicators; surgical eye care; and strategies for accessing hard-to-reach populations—each reflecting the multifaceted approach required to achieve and sustain elimination. This year’s meeting was co-chaired by Dr. Angelia Sanders, Senior Associate Director of the TCP, and Dr. Zerihun Tadesse, Senior Country Representative, The Carter Center – Ethiopia, on day one, and by Dr. Scott Nash, Senior Associate Director of the TCP, and Dr. Sara Lavinia Brair, Senior Country Representative, The Carter Center – Sudan, on day two.

Dr. Dereje Duguma, Ethiopia’s Deputy State Minister, delivered opening remarks on the first day of the Review, welcoming all delegates to Addis Ababa. Dr. Duguma opened with a reflection on the global progress made against trachoma, noting that the number of people requiring interventions has declined by more than 90% over the past two decades—from over 1.5 billion in 2002 to fewer than 100 million today. He emphasized Ethiopia’s continued focus on trachoma among other neglected tropical diseases (NTDs), particularly given the significant burden that remains in the country.

Dr. Duguma acknowledged persistent challenges, including diminishing donor funding which could undermine NTD control, elimination, and eradication efforts as well as WASH programs across the country. Despite these pressures, he noted that the Ministry remains committed to strengthening and expanding the health system to ensure that NTD prevention and treatment remain accessible to all.

He highlighted the tangible results made possible through the dedication of health workers and partners. To date, 385 districts in Ethiopia have fallen below the 5% elimination threshold for trachomatous inflammation-follicular (TF), meaning nearly 36 million people no longer require mass drug administration (MDA). Additionally, more than 1.9 million trachomatous trichiasis (TT) surgeries have been performed since 2003—a testament to the scale and sustained impact of Ethiopia’s trachoma program.

Dr. Duguma closed his remarks by expressing deep gratitude to the partners whose tireless support has been instrumental in driving this progress—including the regional health bureaus, The Carter Center, Pfizer, ITI, the Ethiopia Trachoma Advisory Group (ETAG), WHO, and many donors. He noted that through their sustained commitment, these partners have become an integral part of Ethiopia’s health system and with continued joint effort and prioritization to tackle Ethiopia’s trachoma burden, elimination is within reach.

Ms. Kelly Callahan, Director of the TCP, provided an overview of the programmatic achievements in 2025 toward the elimination of trachoma as a public health problem in Carter Center-assisted countries. The Carter Center, in partnership with the ministries of health in Ethiopia, Niger, South Sudan, and Sudan, demonstrated a steadfast commitment to achieving programmatic objectives despite ongoing security and operational challenges. In 2025, the Carter Center-assisted programs performed 31,085 TT surgeries, of which 20,059 (65%) were women; and over 13.3 million doses of antibiotics were distributed through MDA, including 268,612 doses distributed as part of the more frequent than annual (MFTA) MDA strategy in Amhara, Ethiopia. Additionally, more than 8,342 people were trained in health education, and 3,905 latrines were built.

The presentations and discussions during the meeting reflected the determination of The Carter Center and its partners to navigate existing challenges and maintain momentum toward elimination. Program representatives spoke candidly about both achievements and obstacles, while global partners reinforced the shared commitment to accelerate progress. The exchange of experiences, innovations, and lessons learned across Ethiopia, Niger, South Sudan, and Sudan underscored the value of convening as a collective—and affirmed that the path to a trachoma-free world, while challenging, remains firmly within reach.

Carter Center Chief Executive Officer Ms. Paige Alexander brought the Twenty-Seventh Annual TCP Review to a close with a message of gratitude, reflection, and renewed commitment. Ms. Alexander remarked that 2025 signified the first full year since the passing of President Jimmy Carter and honored his enduring legacy and unwavering conviction that NTDs—including trachoma, Guinea worm, and river blindness—should never be accepted as inevitable. Reflecting on the two days of presentations and discussions, Ms. Alexander noted that the Review had reinforced a defining truth of the Program’s mission: that this work is powered by people—health workers, volunteers, ministries of health, donors, and partners—united by the shared belief that no one should lose their sight to a preventable disease. She recognized the significant progress reported across all programs while acknowledging that challenges remain, including funding gaps, geographical coverage, trachoma persistent districts, and limited investment in WASH infrastructure. Ms. Alexander highlighted the innovative developments showcased during the Review, including the use of complementary indicators to guide programming, country-specific approaches to TT case finding, the integration of eye health monitoring into trachoma surveys, and the delivery of cataract and eyeglass services during TT surgical camps. She extended

special thanks to the Ethiopia Ministry of Health (MOH), the Carter Center – Ethiopia team under the leadership of Dr. Zerihun Tadesse, the Carter Center – Atlanta organizing committee, and all partners for their collective efforts. Her closing message served as a powerful call to action, reminding partners that with continued resolve and collaboration, the global elimination of trachoma remains firmly within sight.

SAFE in Ethiopia

Presented by Mr. Tesfahun Bishaw, Neglected Tropical Diseases Program Manager, Ministry of Health – Ethiopia

Background

Ethiopia has the highest trachoma burden globally, with more than 68% of the global population, or 64 million people, living in trachoma endemic districts. There has been great progress toward the elimination of trachoma as a public health problem due to years of dedicated efforts to reduce the burden of disease. All regions have demonstrated a decrease in mean TF in the last 10 years; in 2015, the mean TF prevalence was 26%, but in 2025, that had been reduced to 9%. Currently, 383 districts are below 5% prevalence of TF in children ages one to nine years, equating to an estimated 35.8 million people who do not require MDA for trachoma. Of the 541 districts still endemic for trachoma, 67 have a TF prevalence $\geq 30\%$, 317 have a TF prevalence of 10-29%, and 157 have a TF prevalence between 5-9.9%. Further, 254 of those endemic districts are considered persistent, and 93 are recrudescent. Of the 993 districts that were ever endemic for TT, 172 (17.3%) districts have achieved the 0.2% elimination threshold, with 824 still requiring intervention; 33.4% of endemic districts are found in the Oromia region, 19.9% in the Amhara region, 9.0% in South Ethiopia, 8.6% in Central Ethiopia as well as 8.6% in Tigray, with the remaining 20% spread out throughout the six regions. The National Program is continuing its efforts to eliminate trachoma as a public health problem by 2030.

Surgery (S)

Since 2003, Ethiopia has provided nearly 1.88 million TT surgeries, including 79,586 surgeries provided in 2025. While insecurity impacted many areas throughout Ethiopia, making surgery provision difficult in some areas, in 2025 the Program achieved 98% of the annual target. The Amhara region contributed the greatest number of surgeries—comprising 28,239 (35%) of the overall national output and 118.4% of the regional target; Oromia contributed 32% of the overall outputs with 25,752 surgeries completed.

Antibiotic Therapy (A)

There has been extensive progress toward the elimination of trachoma, with most districts in Ethiopia endemic for trachoma and a mean prevalence of 23.8% TF at baseline, and seven of 11 regions with TF mean prevalence $>20\%$. As of the end of 2025, the mean prevalence was 9% TF, and no region had a mean prevalence greater than 20%; all but one of the regions had a mean TF prevalence less than 15%. Of the ever-endemic districts, 383 districts had fallen below the 5% TF threshold, with 541 districts $>5\%$, requiring additional MDA interventions.

In 2025, of the 392 districts planned to implement MDA, 320 (81.6%) were completed, distributing 39,048,687 treatments of antibiotics. Seven of 10 regions that planned MDA were completed; 26 woredas across Afar, Gambella, and Somali were planned but were not completed.

Surveys

To assess progress toward elimination and assess the need for additional MDA interventions, a total of 145 surveys were planned for 2025, and 105 (72%) were completed. Of the 89 trachoma impact surveys (TIS) and 16 trachoma surveillance surveys (TSS) completed, 31 (35%) districts had TF prevalence <5%, and 14 (88%) districts had TF prevalence <5% at TSS.

2026 Plans

In 2026, 348 districts plan to conduct MDA, with 82 of those districts also implementing child MDA; those include 36 districts in Amhara, 20 in Central Ethiopia, 15 in Oromia, and 11 in South Ethiopia. An estimated 88,900 people will be targeted for TT management, including full geographic coverage (FGC) in 29 districts. To assess progress toward elimination and the need for ongoing MDA, 199 districts plan to conduct TIS or TSS.

SAFE in Amhara, Ethiopia

*Presented by Mr. Adisu Abebe, Neglected Tropical Diseases Team Leader,
Amhara Regional Health Bureau*

Background

The Amhara region of Ethiopia, the second-largest region in Ethiopia and the region with the most trachoma burden in the country, has made great progress toward the elimination of trachoma as a public health problem. In 2007, surveys showed that every zone in the region was severely impacted by trachoma, however since then, the region has made great strides toward the elimination of trachoma as a public health problem, with 58 of the 166 health districts achieving the <5% elimination threshold for TF, equating to an estimated seven million people not requiring MDA; 46 of these districts with a population of nearly six million have maintained <5% TF at TSS, fulfilling one of the elimination criteria. While there are still 108 endemic districts for TF, the prevalence of TF has decreased significantly; 10 years ago, there were 72 districts with TF prevalence $\geq 30\%$, although at the end of 2025, that number dropped to only 17. The progress toward the elimination of TT—defined by the WHO as prevalence below 0.2% among individuals 15 years and above—as a public health problem remains a significant undertaking, with 164 of 166 districts still endemic for TT. However, there has been great progress in decreasing the burden of TT in the region. In 2015, there were 102 districts with TT $\geq 3\%$, including 48 districts with TT $\geq 5\%$, but 10 years later, there are no districts with TT $\geq 3\%$, with most districts (56%) between 0.2-0.99%. Further, after providing more than 837,000 TT surgeries since 2001, the estimated remaining number of TT cases to manage is less than 54,000.

The Amhara TCP continued to be impacted by insecurity in 2025; in fact, the Amhara region experienced the greatest number of reported incidents of violence in all of Ethiopia. This made travel to and within intervention areas difficult, affecting the ability to transport supplies, conduct trainings, and implement or supervise some activities. However, the Program implemented adaptive strategies to complete as many activities as possible and reach as many people as possible. As a result, the Program achieved more outputs in 2025 than 2024 and even exceeded some of the 2025 targets, including 144% of the TT surgery target and 404% of the target number of Integrated Eye Care Workers (IECWs) to receive refresher training.

Table 1. Program Achievements in 2025

Indicator	Amhara Region (Carter Center-Assisted)		
	Target	Achieved	% Achieved
# of persons operated	19,599	28,239	144%
# of women operated		17,972	64%
Doses of azithromycin distributed during MDA	14,417,527	12,009,187	83%
Doses of tetracycline distributed during MDA	278,629	242,284	87%
# of surveys administered	47	6	13%

Surgery (S)

The decreasing district-level TT prevalence and estimated backlog throughout the region show great progress, though it makes finding the remaining cases and getting the districts to <0.2% in those 15 years and above more difficult. The estimated 53,400 cases remaining in the region are spread out across 164 districts, with 75% of the districts estimating fewer than 500 TT cases throughout the entire district. This will require extensive case searching to identify these individuals and document that all areas have been adequately covered. With the national guidelines for FGC endorsed by the MOH in 2024, the Amhara region planned to begin implementation of this approach in 2025 to find the remaining cases, offer management, and complete the eligible districts. However, FGC activities were not possible due to insecurity, since FGC targets reaching every household in every village in the selected district; the number of individuals involved, and the population movement and supervision required to reach all areas created too much risk for teams and community members. Instead, IECWs continued to offer TT management services through static services and “mini-campaigns”, during which additional IECW review and planning meetings were conducted to encourage IECWs to mobilize individuals for services within their catchment areas. This strategy resulted in a total of 28,239 individuals receiving surgery, exceeding the annual target of 19,599. In 2025, the Amhara region also exceeded the IECW refresher trainings, training 190 existing IECWs (404% of the 2025 target). The Program prioritized these existing surgeons to not only maintain the quality of surgical service provision, but also to train IECWs on the newly endorsed guidelines from the MOH for epilation as a management strategy for post-operative trachomatous trichiasis (PTT) or minor TT; 365 additional existing IECWs received epilation training, though as a stand-alone orientation, as they did not require all modules of the IECW refresher training. Any future training, for new or existing IECWs, will incorporate the PTT management and epilation guidelines.

Antibiotic Therapy (A)

One of the key strategies to combat trachoma, which has helped to get 35% of districts in Amhara to <5% TF, is MDA. While insecurity continued to significantly impact the region in 2025, the Program was able to implement 80 of the 88 planned MDAs for the year, as compared to 35 districts in 2024.

A total of 12.25 million treatments were distributed, including treatments for eight districts distributed during child MDA, when children ages six months to nine years were treated a second time, four to six weeks after the initial community-wide MDA. To complete the MDA, more than 12,100 people were involved, including 7,357 trained health workers, district coordinators, and supervisors; and 4,763 community leaders and volunteers supported community mobilization and MDA implementation. While there are 108 districts still endemic for TF, 88 districts were targeted for MDA in 2025 as the other 20 had a TF prevalence 5-9.9% and were due for survey; the Program assumed they would fall <5% at survey and thus would not require MDA. Due to the difficult nature of completing surveys in insecure settings, most surveys could not be completed in time to inform the Program of whether additional MDA would be required.

Surveys

Surveys are difficult to conduct in insecure areas as they are done by teams outside of the community; they need involvement of many vehicles; and the community may not want to participate in the survey. Further, surveys typically use mobile phones to enter data onto the Tropical Data platform, although

due to their capability to take phones and global positioning system (GPS) coordinates, many local forces objected to their use. In 2025, six surveys were completed, or 13% of the overall target. Delays in trachoma programming have a knock-on effect on other activities. Once a district completes its last round of MDA in that cycle, it must conduct a TIS, which cannot be done until at least six months after the completion of MDA. Further, if a district cannot complete a survey due to insecurity, even if MDA is suspected to still be required, no additional MDA will be provided until the survey is completed; this can result in significant delays for areas that still have high burdens of trachoma. As such, the Program developed modified strategies to facilitate the completion of more surveys, including both electronic and paper-based surveys; these strategies will be employed more widely in 2026.

Facial Cleanliness (F) & Environmental Improvement (E)

As F & E are also key to achieving elimination, the regional trachoma Program remains focused on implementing F & E through health education activities in communities and in schools. Unfortunately, the School Trachoma Program (STP) was impacted by insecurity in recent years, with many schools closed due to active fighting. However, by the end of 2025, about 75% of all schools reopened, as compared to about 25% at the beginning of the year. While fewer activities could be conducted because of these ongoing closures, the Amhara Program revised the STP primary school tools in preparation for classes restarting and produced the new pre-primary school curriculum which has already been piloted in 60 schools. Training on these materials will be conducted in 2026 for an estimated 30,000 individuals. A total of seven water points were also completed, bringing the total number of water points provided to schools since 2022 to 55. School WASH committee training was conducted for 42 of the schools, reaching 331 participants. The committees were trained in basic water point maintenance and monitoring activities to assess water point functionality and the need for maintenance. They were provided with a water point maintenance kit for basic maintenance, but if more elaborate maintenance was required, they were connected with the woreda water office for support.

Notable Achievements

While insecurity continues to impact the region, the Program was able to achieve increased outputs in 2025, including distributing nearly three times as many MDA treatments in 2025 as in 2024 and providing nearly four times the number of TT surgeries. Through the IECW review meetings and mini-campaigns, there was increased ownership by IECWs in the TT management process, which now can include epilation for PTT and minor TT. The Program also integrated TT screening into MDA campaigns and TT screening and management into cataract outreach.

Programmatic Challenges & Mitigation Measures

The insecurity highly impacted SAFE interventions, resulting in lost MDA registers that are needed for implementation, as well as delays to progress toward elimination. To ensure as many activities were completed as possible, despite the security issues, the teams replaced and completed new household MDA registers; engaged stakeholders at all levels to regularly assess security status; and implemented modified strategies, including remote monitoring, smaller survey team sizes, and paper-based data collection where necessary. The Program also faces the challenge of trachoma persistent districts; 98 of the 108 trachoma endemic districts are considered persistent, meaning districts are not achieving

the <5% TF threshold as expected, and additional MDA is required. To address this challenge, the Program plans to expand child MDA in 2026 and will conduct enhanced coverage surveys (collecting *Chlamydia trachomatis* [CA] and dried blood spots [DBS]) as well as follow-on assessments to assess the impact of the MFTA MDA; complementary indicators will also continue to be collected during surveys, when possible and appropriate, to better understand persistent trachoma.

Program Plans for 2026

Surgery (S)

- Operate 18,091 TT cases
- Train 46 new IECWs
- Retrain 78 IECWs

Antibiotic Therapy (A)

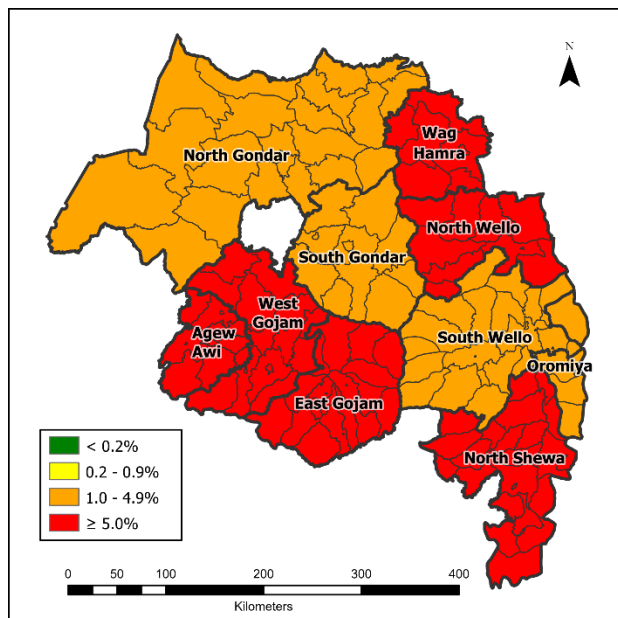
- Distribute 16,273,383 doses of azithromycin, including doses distributed during child MDA in 36 districts
- Distribute 306,299 doses of Tetracycline Eye Ointment (TEO)

Facial Cleanliness (F) & Environmental Improvement (E)

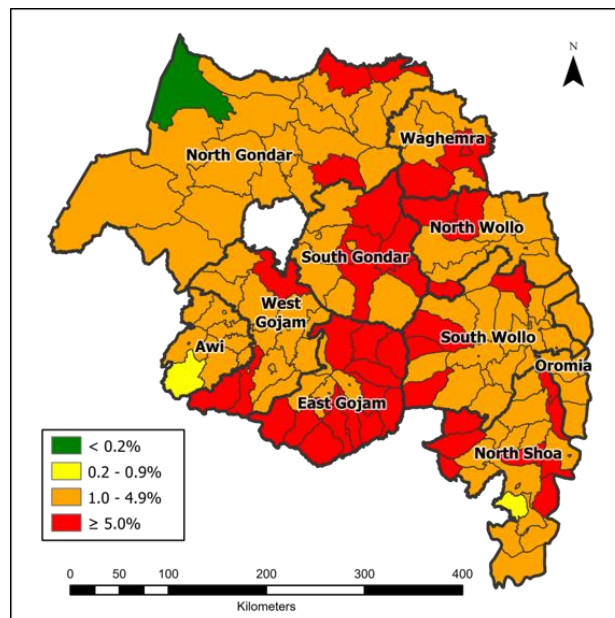
- Train 29,206 school personnel on the STP curriculum
- Complete construction of 16 water points

Amhara, Ethiopia – TT Prevalence: Adults ≥ 15 Years

Baseline (2007)



2015



2025

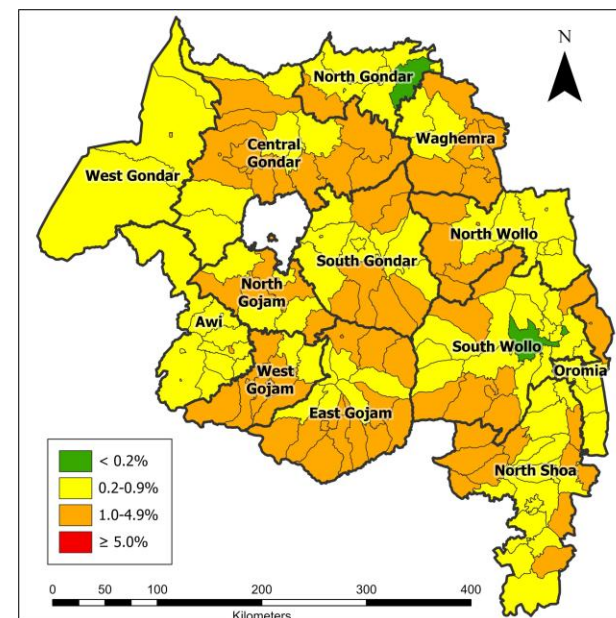


Figure 1 – Estimated TT prevalence at baseline

Figure 2 – Estimated TT prevalence through 2015

Figure 3 – Estimated TT prevalence through 2025

Amhara, Ethiopia – TF Prevalence: Children 1–9 years

Baseline (2007)

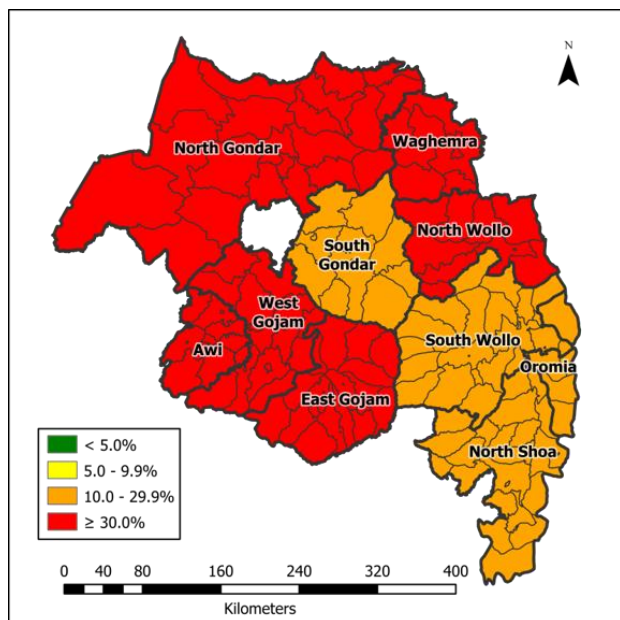


Figure 4 – Estimated TF prevalence at baseline

2015

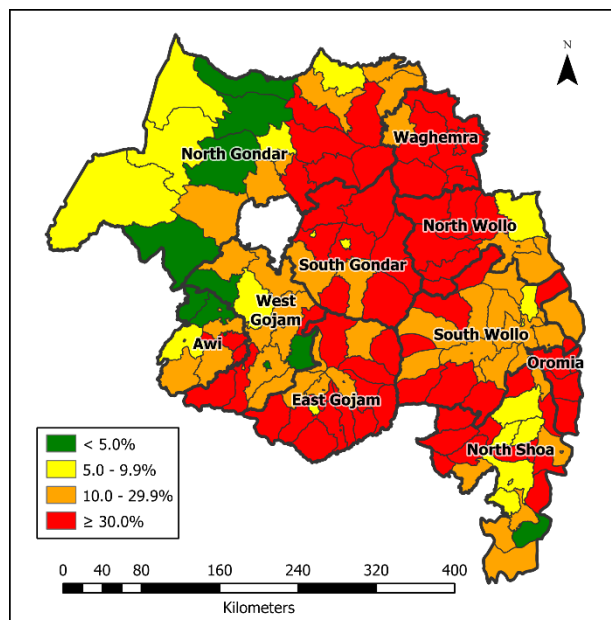


Figure 5 – Estimated TF prevalence through 2015

2025

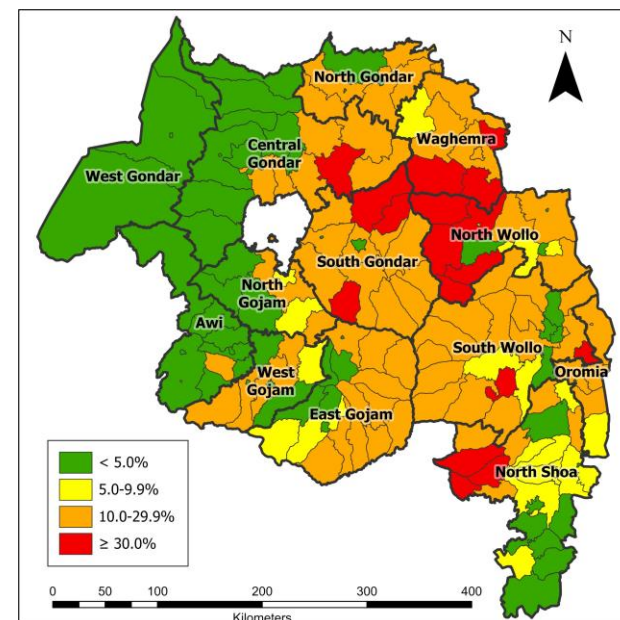


Figure 6 – Estimated TF prevalence through 2025

Amhara, Ethiopia – MDA Completed and Districts Awaiting Survey

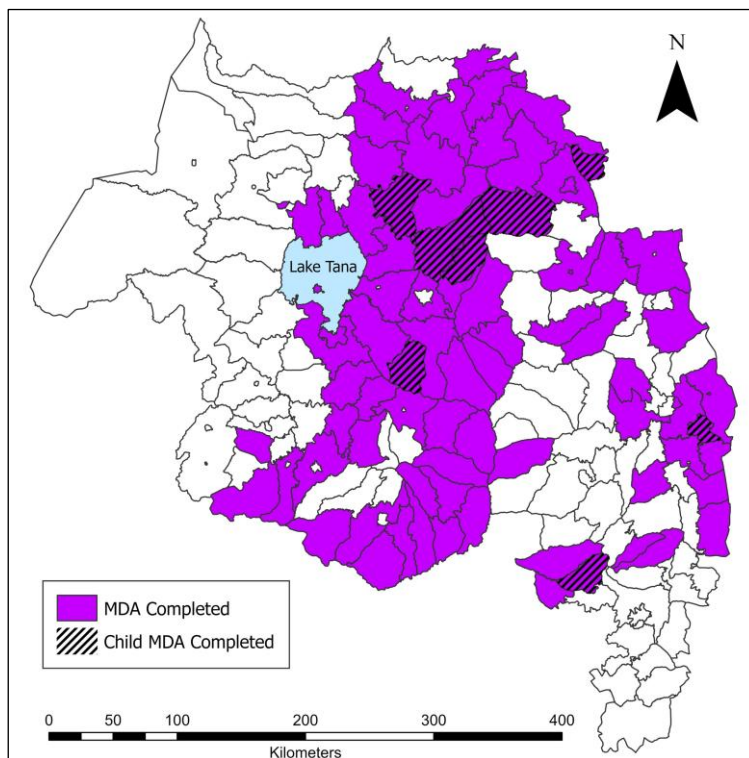


Figure 7 – Completed MDA in 2025

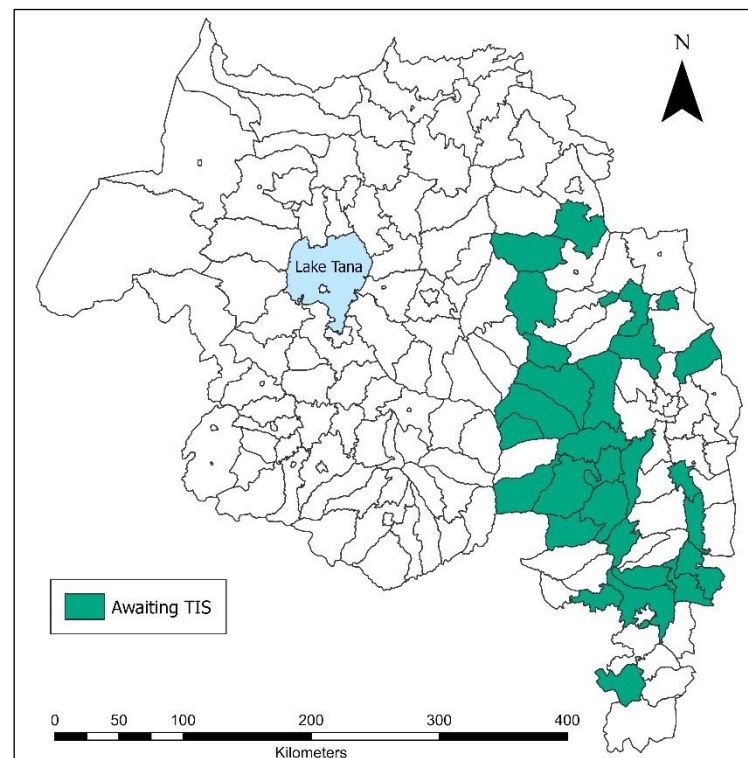


Figure 8 – Awaiting TIS in 2025

SAFE in Niger

*Presented by Mr. Nassirou Baido, Epidemiologist, National Eye Health Program,
on Behalf of Dr. Ibrahim Almou, National Coordinator, National Eye Health Program,
Ministry of Health – Niger*

Background

The National Trachoma Task Force was established in Niger in 1999 by the National Eye Health Program, *Programme National de Santé Oculaire* (PNSO), to address the high levels of trachoma found in baseline surveys conducted between 1997-1999. During these baseline surveys, results indicated that 44% of children ages one to nine years had TF, and 1.7% of women ages 15 years and older had signs of TT. In 2002, district-level population-based prevalence surveys found that 62 of the 72 health districts were endemic for TF, leading to the implementation of the SAFE strategy to address the trachoma burden. At the end of 2025, 28 districts encompassing 46 evaluation units (EU) remain endemic for TF and/or TT, with the projected year of elimination now set for 2028. Of the 96 EUs ever endemic in the country, only five are still endemic for TF, while 37 are endemic for TT. Despite challenges such as political instability, natural disasters, and changes in the donor landscape, the PNSO remains committed to achieving the elimination of trachoma as a public health problem in Niger.

Table 1. Program Achievements in 2025

Indicator	Achieved (% of Target)	
	National	Carter Center-Assisted
# of persons operated	2,290 (57.3%)	1,575 (78.8%)
# of women operated	1,554	1,084
# of EUs which completed <i>ratissage</i>	5	4
# of surveys conducted	0 (0%)	
# of latrines built ¹	3,905 (156.2%)	3,905 (156.2%)

¹ Including SANPLAT and school block latrines.

Surgery (S)

The Program conducted 2,290 TT surgeries nationally in 2025, including 1,554 (68%) women operated. The Carter Center supported 1,575 of these surgeries, of which 1,084 were women operated. In addition, 44 surgeons were retrained through refresher training sessions using the HEADSTART (Human Eyelid Analogue Device for Surgical Training And skill Reinforcement in Trachoma) method, and 56 surgeons received supportive supervision. The PNSO also supported quality assurance activities, with post-operative follow-up at 24 hours and seven days achieved for 100% of patients. Two sessions of three to six-month post-operative follow-up were conducted, visiting 475 patients and examining 594 operated eyes.

The *ratissage* case-finding strategy continued to be the cornerstone of surgical activities in 2025, accounting for 95% of all TT surgeries performed nationally. Under the *ratissage* approach, local community volunteers engaged in health education activities (*relais*) are trained to conduct house-to-house case finding, screening all individuals ages 15 years and older for signs of TT. Suspected cases

are subsequently referred to ophthalmic technicians for confirmation and, if needed, TT surgery. In 2025, 114 health catchment heads and 4,817 *relais* were trained on the *ratissage* method. These *relais* identified 25,960 suspected cases, of which 2,528 were confirmed by surgeons across 150 surgical outreach camps, resulting in 2,179 TT surgeries performed through the *ratissage* strategy.

By the end of 2025, *ratissage* was completed in six EUs, ongoing in 26 EUs, and pending in nine EUs across the four endemic regions of Dosso, Maradi, Tahoua, and Zinder. Only one TT endemic region of Niger, Diffa, is still pending the start of *ratissage*.

Antibiotic Therapy (A)

By the end of 2025, nearly all EUs in Niger had fallen below the 5% elimination threshold for TF, with only five EUs remaining above the 5% threshold. All five EUs still endemic for TF are between 5-9.9% and are located in the regions of Agadez, Tahoua, and Zinder. They have all completed the prescribed number of rounds of MDA and are awaiting surveys.

Surveys

No surveys were completed in 2025. The cancellation of Act to End NTDs West funding in January 2025 eliminated the financial support that had sustained national TIS and TSS activities, which included six surveys (one TIS and five TSS) planned for 2025. Thankfully, advocacy from the Program led ITI to generously agree to fund these six surveys, which have been rescheduled for early 2026. All six surveys will include the collection of DBS and ocular sample swabs for serological and infection monitoring. However, after these surveys are completed, Niger will still require at least 22 additional surveys (five TIS and 17 TSS) to validate the country's elimination status, none of which currently have funding confirmed.

Facial Cleanliness (F) & Environmental Improvement (E)

The Program made substantial progress on F & E activities in 2025, constructing 3,905 household sanitary platform (SANPLAT) latrines and 22 school block latrines, all with Carter Center assistance. In addition, the Program trained 120 schoolteachers on trachoma sensitization and hygiene promotion. At the community level, health education messages reached communities in trachoma-endemic areas through 32,425 radio broadcasts nationally, 16,513 of which were supported by The Carter Center.

Programmatic Challenges and Mitigation Efforts

The abrupt suspension and cancellation of Act to End NTDs West funding in January 2025 was the defining programmatic challenge of the year, bringing a halt to planned survey activities that had relied almost entirely on that support. Ongoing insecurity in areas of Diffa, Tillabéri, southern Maradi, and Dosso continued to limit access for SAFE interventions. Flooding and the corresponding mass population displacement further exacerbated these challenges.

To mitigate these challenges, the Program adapted its implementation strategies, drawing on local expertise and monitoring the security situation closely to identify windows for intervention. ITI's support was secured for the planned 2025 surveys, though future survey funding remains unclear.

Program Plans for 2026

Surgery (S)

- Operate 4,000 TT cases nationally, 2,000 with Carter Center assistance
- Complete TT case-finding in 11 EUs, nine with Carter Center assistance
- Validate 36 EUs through full documented *ratissage*, 19 with Carter Center assistance

Facial Cleanliness (F) & Environmental Improvement (E)

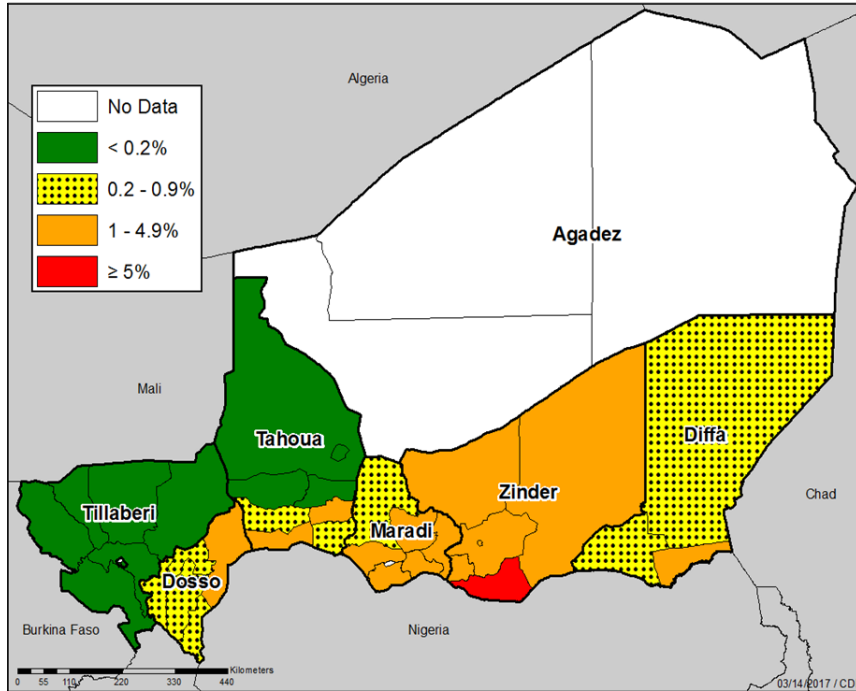
- Construct 1,500 SANPLAT latrines
- Construct 22 school block latrines

Surveys

- Perform 22 surveys (six TIS, 16 TSS), six funded by ITI

Niger – TT Prevalence: Adults ≥ 15 years

Baseline (2002)



2025

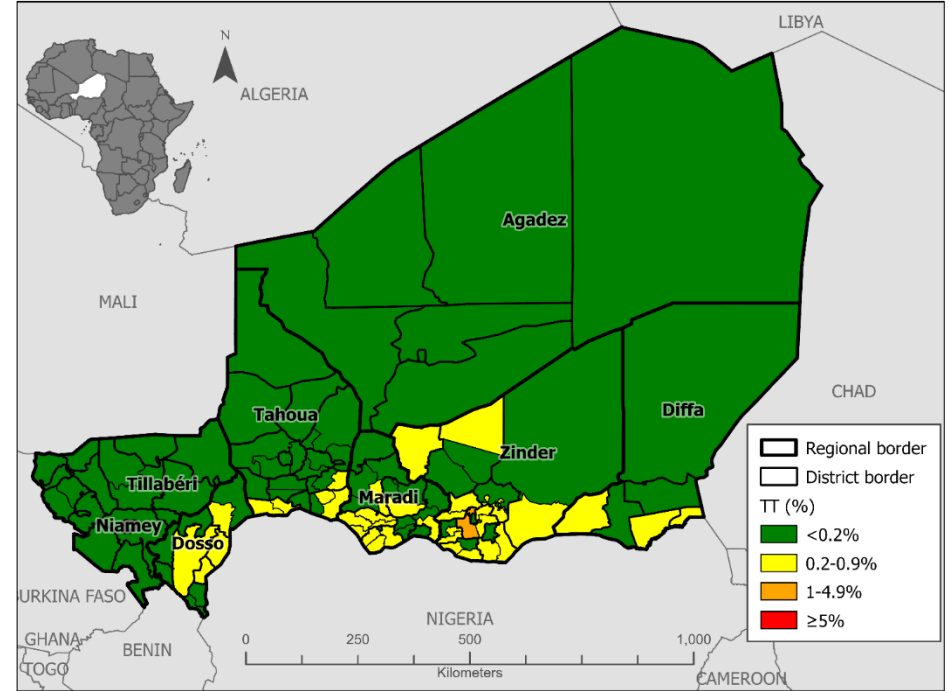


Figure 1 – Estimated TT prevalence at baseline

Figure 2 – Estimated TT prevalence through 2025

Niger – TF Prevalence: Children 1–9 years

Baseline (2002)

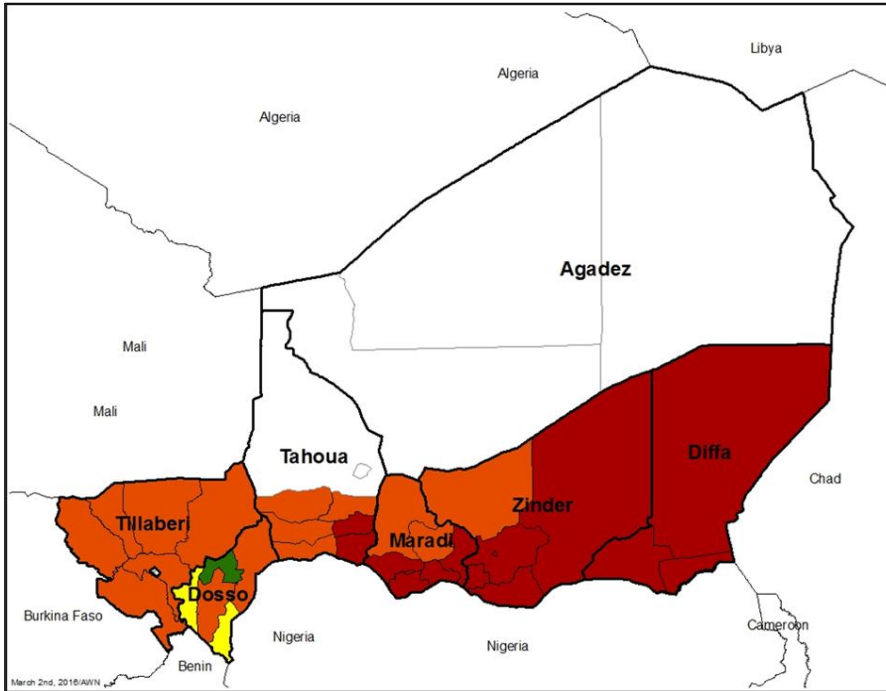


Figure 3 – Estimated TF prevalence at baseline

2025

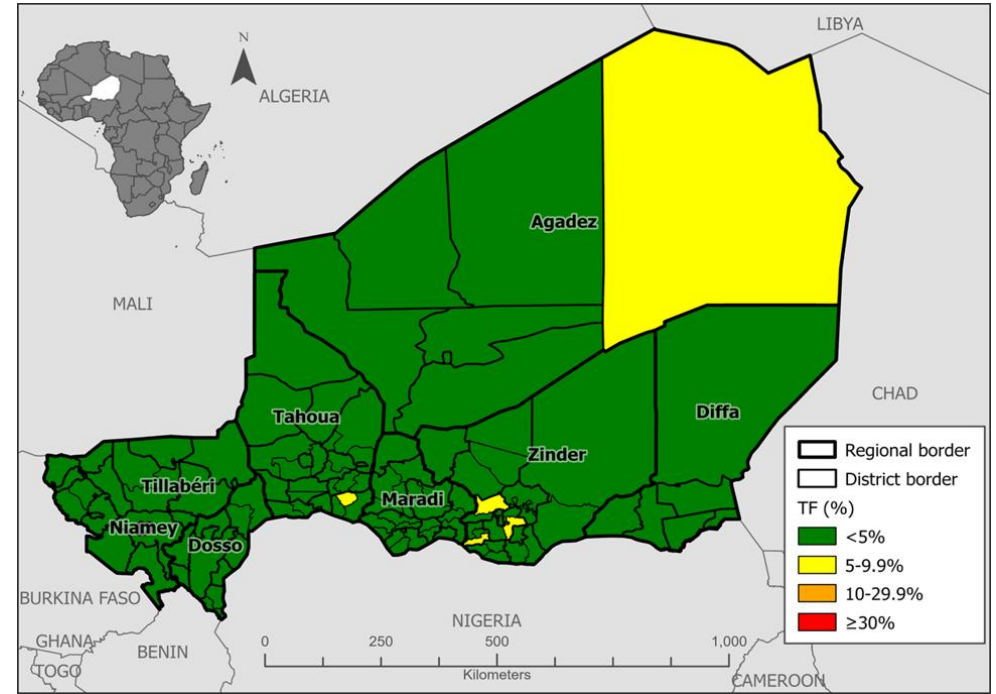


Figure 4 – Estimated TF prevalence through 2025

Niger – *Ratissage* and Pending Survey Activities

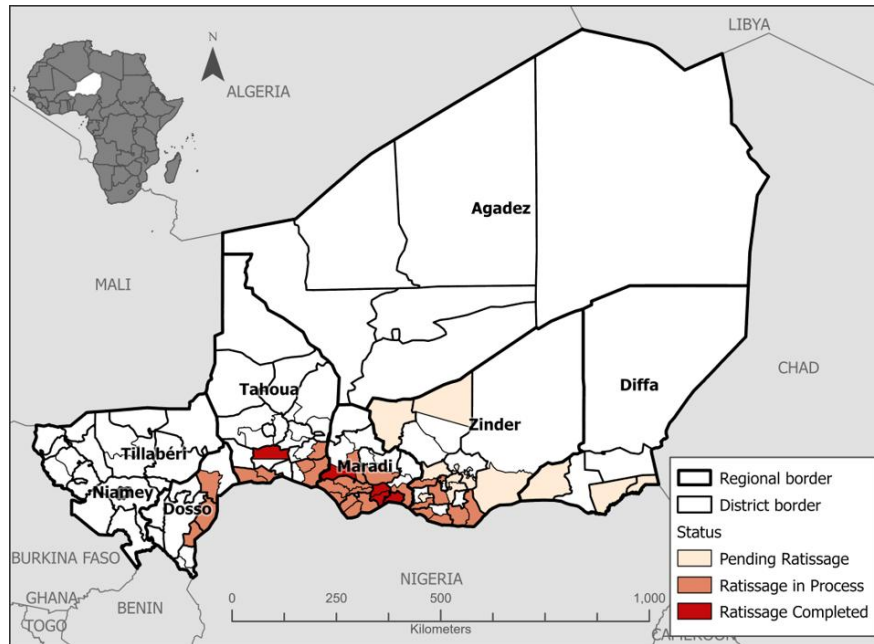


Figure 5 – *Ratissage* Status in 2025

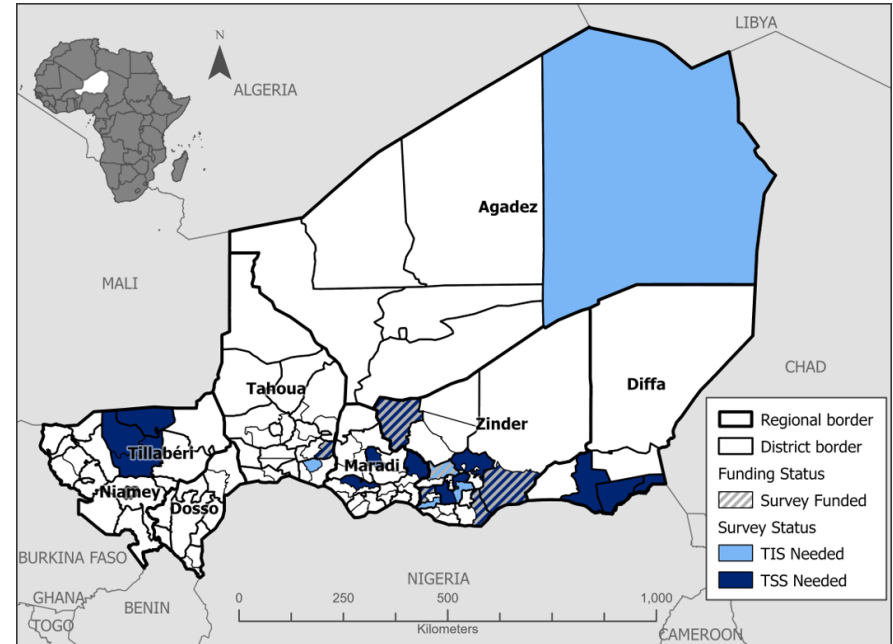


Figure 6 – Pending Surveys at the end of 2025

SAFE in South Sudan

*Presented by Mr. Yak Yak Bol, Director for Preventive Chemotherapy-Neglected Tropical Diseases
Ministry of Health, South Sudan*

Background

South Sudan is a landlocked country in East Africa divided into ten states and three administrative areas, with a population exceeding 12 million. In 2011, it became the world's youngest country after gaining independence from Sudan. Despite ongoing efforts across all health sectors, the country faces significant public health challenges, including being endemic to 19 out of 21 WHO-recognized NTDs. Among the five endemic NTDs that require preventive chemotherapy (PC-NTDs) is trachoma, the world's leading cause of infectious blindness.

Trachoma prevalence surveys conducted between 2021 and 2024 revealed that South Sudan, particularly in the eastern portion of the country, was highly endemic for trachoma. The country currently includes some of the highest trachoma prevalence levels worldwide, with a baseline survey in one county finding over 50% TF in children one to nine years, and 4% TT in adults 15 years and older. In some of these trachoma-endemic counties, cases of pediatric TT, or TT in children under 15 years of age, have been detected in staggering numbers. TT at this age is considered extremely rare and implies a force of infection so intense that it is accelerating disease progression by decades. Furthermore, the medical infrastructure in South Sudan is limited, resulting in millions of people having little to no access to health services. Despite these considerable obstacles, the Program demonstrated numerous successes in 2025.

Table 1. Program Achievements in 2025

Indicator	National		Carter Center-Assisted	
	Target	Achieved	Target	Achieved
# of persons operated	6,000	4,403 (73%)	3,300	1,233 (37%)
# of women operated		3,042 (69%)		977 (79%)
# of surgeons trained/retrained	24	42 (175%)		
# of doses of azithromycin distributed during MDA	1,042,975	894,289 (86%)	782,802	516,320 (66%)
# of doses of TEO distributed during MDA	66,060	73,492 (111%)	35,254	39,714 (113%)
# of villages with health education	3,900	2,044 (52%)	3,900	2,044 (52%)
# of latrines built	7	4 (57%)	5	0 (0%)
Surveys	13	10 (77%)	3	1 (33%)

Surgery (S)

In 2025, the Program provided TT surgeries to 4,403 individuals, making it the second-highest year for TT surgical output in South Sudan's history. Of those operated, The Carter Center supported the provision of surgery to 1,233 people, 977 of whom were women. Most TT surgeries were performed during surgical outreaches, with 16 counties receiving surgical camps, made possible through collaborations between CBM, the MOH, and The Carter Center. Furthermore, cataracts and TT surgeries continue to be integrated during surgical outreaches, stimulating demand and expanding access to multiple eye care services. These efforts led to cataract surgery on 4,008 eyes this year, many of which occurred during these integrated outreaches.

Reflecting the Program's commitment to health system strengthening, 42 surgeons received training in 2025, far exceeding the target of 24 and representing 175% of the goal. In addition, an eye health planning meeting was held in October 2025, which led to the drafting of a National Eye Care Strategic Plan (2026-2030). Finally, the national Ophthalmic Clinical Officer (OCO) training curriculum was revised, which will support the long-term development of the eye care workforce in South Sudan.

In a notable advancement for pediatric TT, nine children ages three to 12 years old were referred from a Carter Center supported outreach to receive surgery at Buluk Eye Clinic in Juba. The Carter Center, CBM, and the Ministry of Health partnered to make this possible, establishing a referral model the Program intends to build on in coming years. To better understand the magnitude and clinical presentation of the pediatric TT phenomenon, operational research was developed and piloted during routine surgical camps, with plans to continue through 2026.

Antibiotic Therapy (A)

The Program administered 894,289 doses of Pfizer-donated azithromycin, with 516,320 doses provided with Carter Center assistance. An additional 73,492 doses of TEO were distributed by the Program, 39,714 doses provided with assistance from The Carter Center. In total, nearly one million people across 13 counties were treated during MDA campaigns, a considerable achievement given challenges related to insecurity, cholera outbreaks, and flooding which limited activities in Jonglei and Upper Nile states in 2025.

Facial Cleanliness (F) & Environmental Improvement (E)

Despite limited funding for F&E activities in 2025, the Program persevered through collaborations and novel solutions. CBM supported the construction of four latrines and four handwashing stations, and 17 boreholes were repaired in Jonglei and Eastern Equatoria States with Carter Center support. Additionally, the Program conducted health education in 2,044 villages as part of MDA and surgical activities. While F&E activities remained constrained by limited funding, the finalization of the WASH-NTD Framework is expected to strengthen resource mobilization for these activities going forward.

Surveys

The Program conducted 10 surveys across the country, including one completed with support from The Carter Center. In Unity State, TISs were carried out across eight counties with results showing all counties remained above the TF elimination threshold, and seven of the eight counties requiring at

least three more rounds of MDA. One survey in Renk County, Upper Nile State, found TF prevalence below the elimination threshold. In Eastern Equatoria State, DBS samples were collected during the Kapoeta North County TIS, with plans to analyze them at the National Public Health Laboratory in Juba in 2026.

Other Notable Achievements

The Program made substantial advances in planning, training, and capacity building in 2025. The Trachoma Action Plan was officially launched, a National Eye Health Workshop was held, the OCO curriculum revision was completed, and a MOH logistical officer attended a three-week Supply Chain Management training in Kenya. Furthermore, the Program also distributed 2,771 reading glasses during trachoma-related activities, with the goal of providing holistic eye care services to some of the most underserved communities in the world.

Programmatic Challenges & Mitigation Efforts

South Sudan faced several challenges in 2025. Insecurity in Jonglei and Upper Nile States interrupted or canceled planned survey, MDA, and surgery activities. A cholera outbreak further constrained programming, and the short implementation window imposed by the rainy season continues to limit the time available for field activities. Reverse logistics for MDA drugs remained a persistent challenge, TT in children continued to require dedicated attention, and TF prevalence reductions in Unity State fell short of expectations.

To mitigate these challenges, the Program adapted activities to operate in areas that were accessible and secure, and prioritized microplanning to maximize efficiency within available windows. Partners worked together to incorporate cascade training costs into budget plans on supply chain management. In Unity State, increased supervision of MDAs was implemented to improve coverage and quality.

Program Plans for 2026

Surgery (S)

- Operate 5,000 TT patients nationally, 2,000 with Carter Center assistance
- Train 37 TT surgeons

Antibiotic Therapy (A)

- Distribute 1,911,757 doses of azithromycin nationally, 715,241 with Carter Center assistance
- Distribute 113,499 doses of TEO nationally, 14,305 with Carter Center assistance

Facial Cleanliness (F) & Environmental Improvement (E)

- Conduct health education in 2,500 villages, all with Carter Center assistance
- Construct 17 latrines, 15 with Carter Center assistance

Surveys

- Conduct 11 surveys nationally, eight with Carter Center assistance

South Sudan – TT Prevalence: Adults ≥15 Years

Baseline (1999 – 2024)

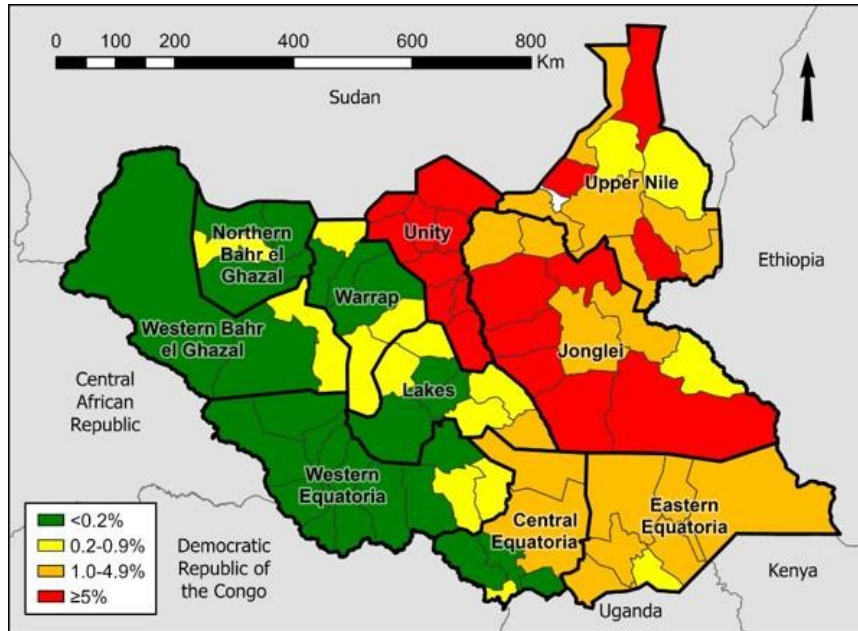


Figure 1 – Estimated TT prevalence at baseline

2025

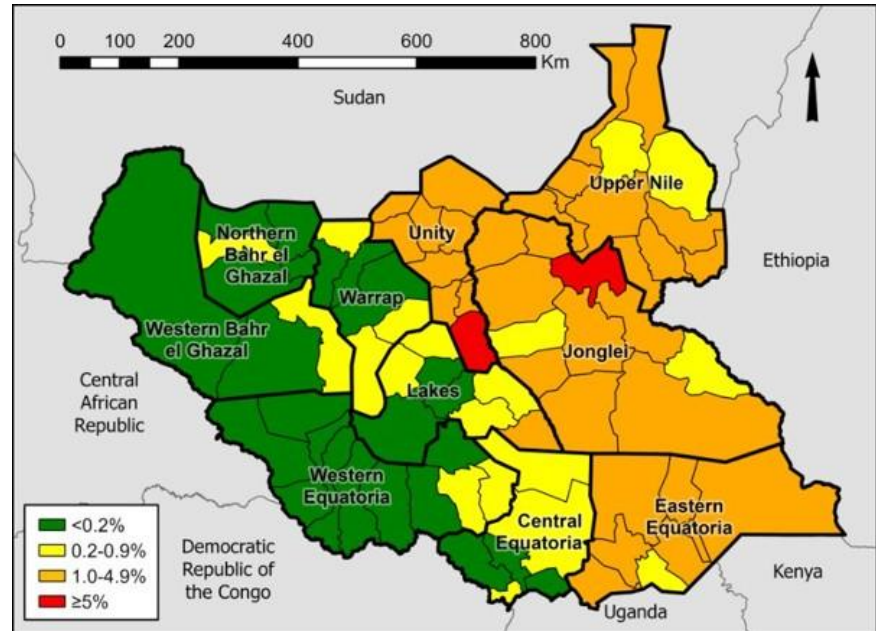


Figure 2 – Estimated TT prevalence through 2025

South Sudan – TF Prevalence: Children 1–9 years

Baseline (1999 – 2024)

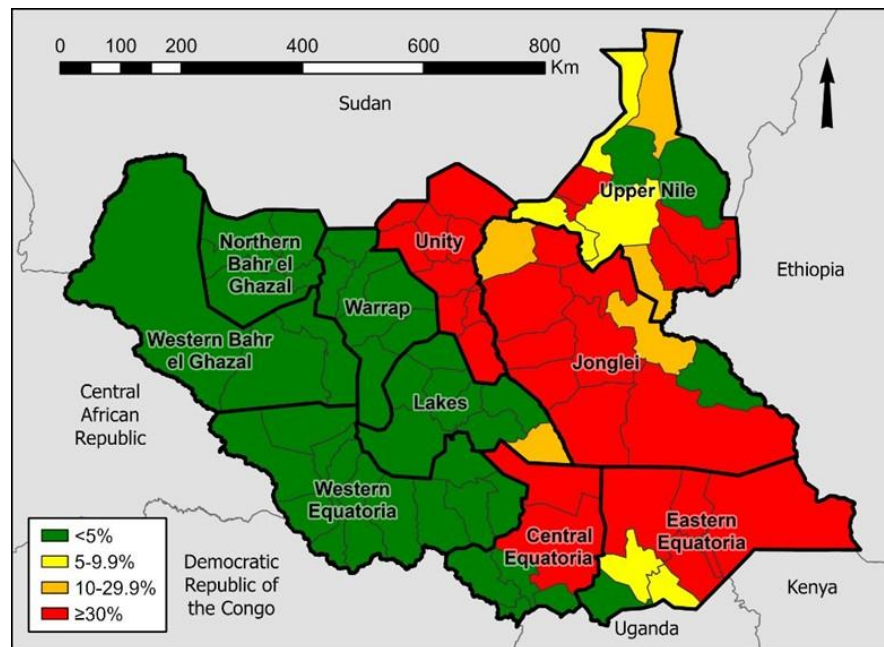


Figure 3 – Estimated TF prevalence at baseline

2025

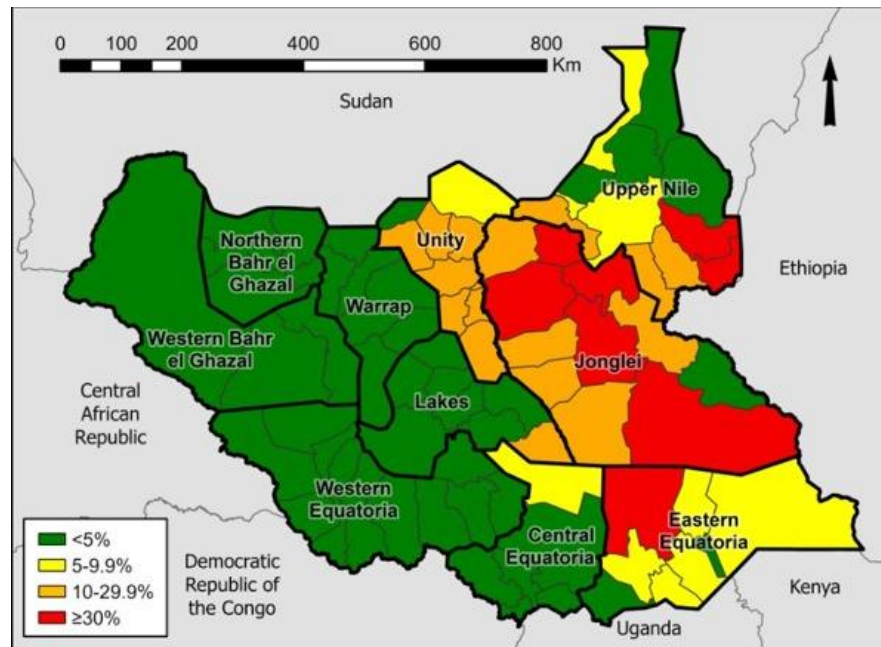


Figure 4 – Estimated TF prevalence through 2025

South Sudan – MDA and Survey Activities

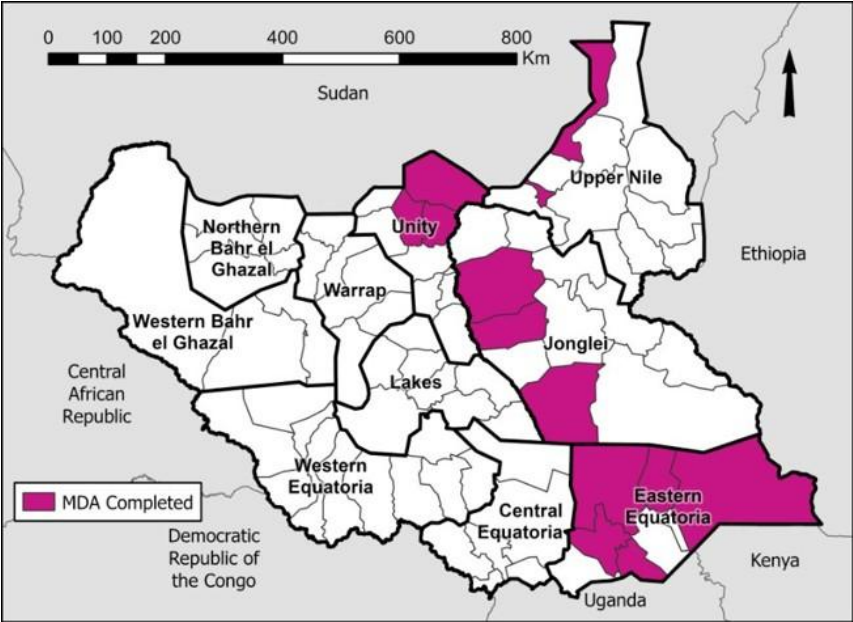


Figure 5 – MDA Completed in 2025

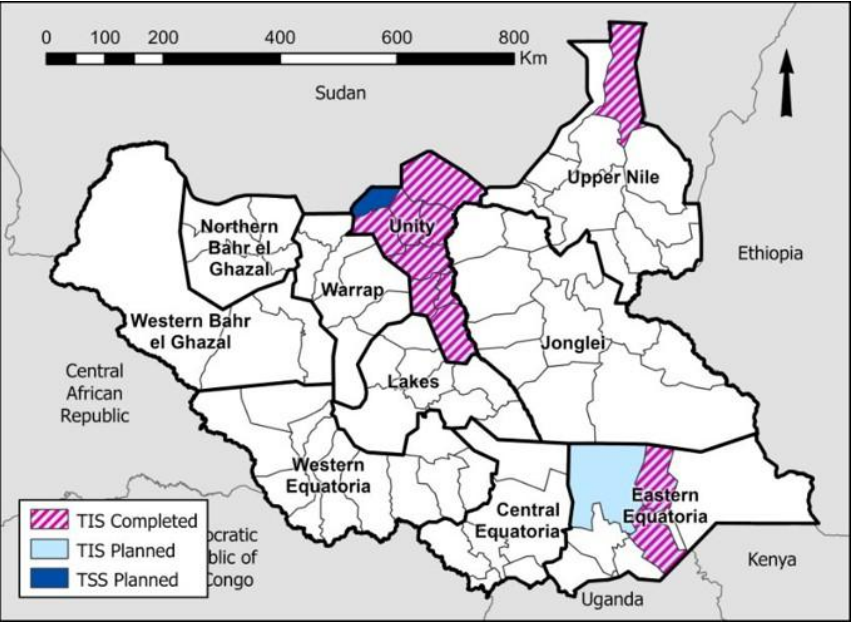


Figure 6 – Surveys Completed in 2025

SAFE in Sudan

Presented by Dr. Sara Lavinia Brair, Senior Country Representative, The Carter Center, on behalf of Dr. Balgesa Elshafie, Sudan National Coordinator for Trachoma Control Program, Federal Ministry of Health, Sudan

Background

The Federal Ministry of Health (FMOH) has been working to eliminate trachoma as a public health problem in Sudan for decades with the goal of reaching elimination by 2030.

On 15 April 2023, a war between the military government of the Sudanese Armed Forces and the paramilitary Rapid Support Forces began in Khartoum state, then gradually expanded to all states. The fighting resulted in millions of Sudanese being displaced either across international borders as refugees or internally as internally displaced persons (IDPs). Recently, fighting has concentrated in seven states in the western region, and the other 11 states have been subjected to scattered drone attacks. In the 11 government-secured states, over three million people have returned. Additionally, the government has returned to the capital Khartoum, and the Khartoum airport has opened for domestic flights. Access to health services has also improved to about 63% in secure states.

Table 1. Program Achievements in 2025

Indicator	National		Carter Center-Assisted	
	Target	Achieved	Target	Achieved
# of persons operated	400	38 (9.5%)	400	38 (9.5%)
# of women operated		26		0
# of surgeons trained/retrained	0	N/A	-	-
# of doses of Zithromax® distributed during MDA	591,224	544,216 (92%)	591,224	544,216 (92%)
# of doses of TEO distributed	12,000	8,194 (68%)	12,000	8,194 (68%)
# of villages with health education	288	288 (100%)	288	288 (100%)
Surveys	1	0 (0%)	1	0 (0%)

Surgery (S)

The National Program conducted 38 TT surgeries during calendar year 2025, 26 of which were performed on women. Most eye care workers have relocated from Khartoum to the various states.

Antibiotic Therapy (A)

The National Program planned to distribute 591,224 doses of azithromycin and 12,000 doses of TEO, with Carter Center's assistance, in three localities and two Ethiopian refugee camps in Gedarif state, and was able to successfully achieve 92% of the azithromycin and 68% of the TEO targets. This was a notable success, since the Program had to identify a different airport and drug storage facilities outside of Khartoum, in coordination with ITI. Though not targeted for 2025, it is worth noting that MDA-eligible localities in North Darfur could not be reached due to continued insecurity.

Facial Cleanliness (F) & Environmental Improvement (E)

The 2025 F & E targets to reach 288 villages with health education during MDA were met. Activities included the distribution of hundreds of trachoma prevention posters, leaflets, and stickers, as well as community education sessions.

Surveys

Due to insecurity, no planned surveys were conducted. However, the Program had one FMOH staff member attend a Tropical Data Training of Trainers training in Nairobi, Kenya, that focused on training specimen managers. The Program plans to include DBS collection in future surveys.

Programmatic Challenges and Mitigation Strategies

The civil war, which broke out in April 2023, was still ongoing as of March 2026, though a majority of the country has become more secure, and the government has resumed operations in Khartoum. The conflict has led to economic hardships, a rise in inflation, a shortage of medical supplies in the local market, and an increase in Program costs. Given the previous looting of the Carter Center Khartoum office and destruction of Carter Center vehicles, the Program is currently working to rebuild its presence in Khartoum and purchase vehicles.

Program Plans for 2026

Surgery (S)

- Operate 400 TT patients with Carter Center assistance
- Train/ retrain 10 TT surgeons

Antibiotic Therapy (A) – no localities are currently eligible for MDA in the localities The Carter Center supports

- Distribute zero doses of azithromycin with Carter Center assistance
- Distribute zero doses of TEO with Carter Center assistance

Facial Cleanliness (F) & Environmental Improvement (E)

- Provide zero villages with health education

Surveys

- Conduct seven prevalence surveys (three TIS, four TSS) with Carter Center assistance

Sudan – TT Prevalence: Adults ≥15 years

Baseline (2022)

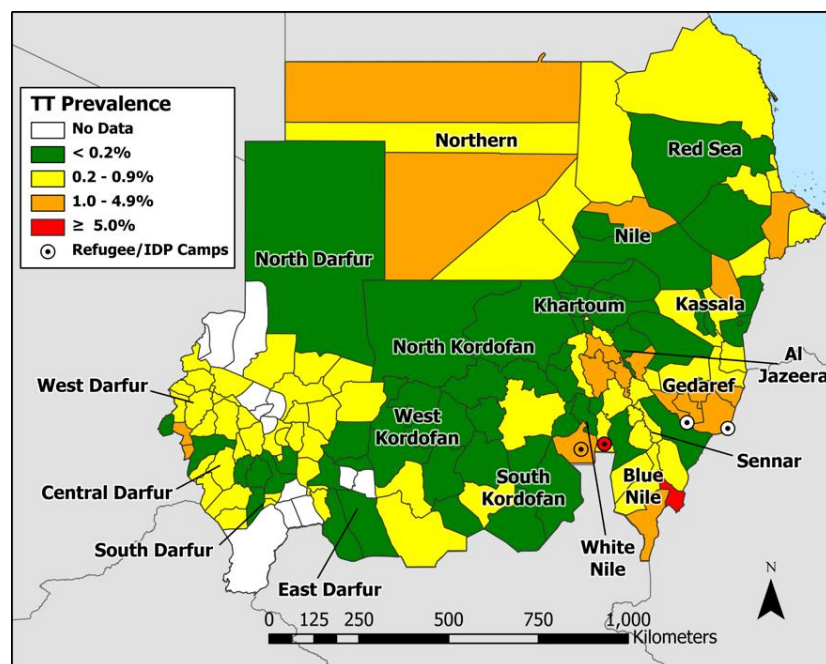


Figure 1 – Estimated TT prevalence at baseline

2025

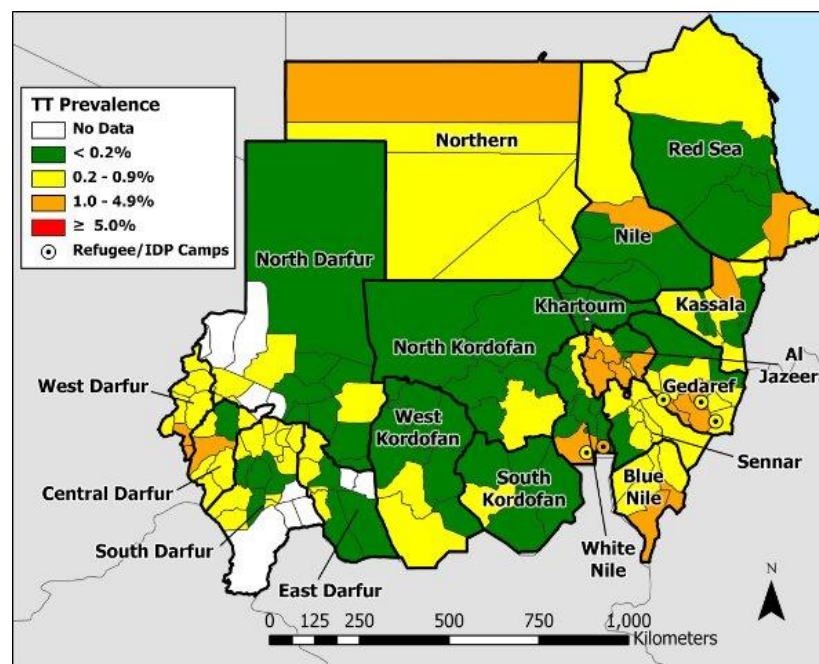


Figure 2 – Estimated TT prevalence through 2025

Sudan – TF Prevalence: Children 1–9 Years

Baseline (2022)

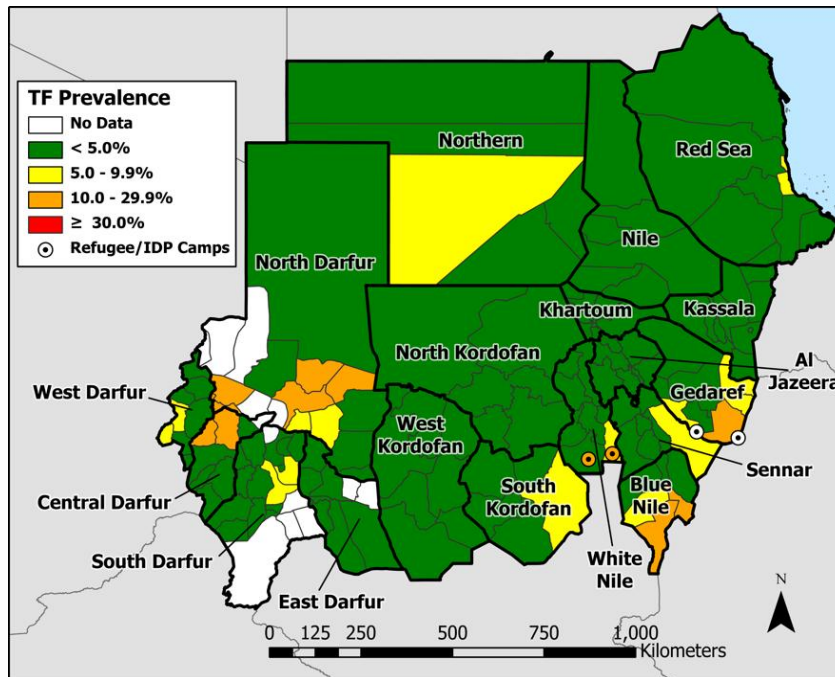


Figure 3 – Estimated TF prevalence at baseline

2025

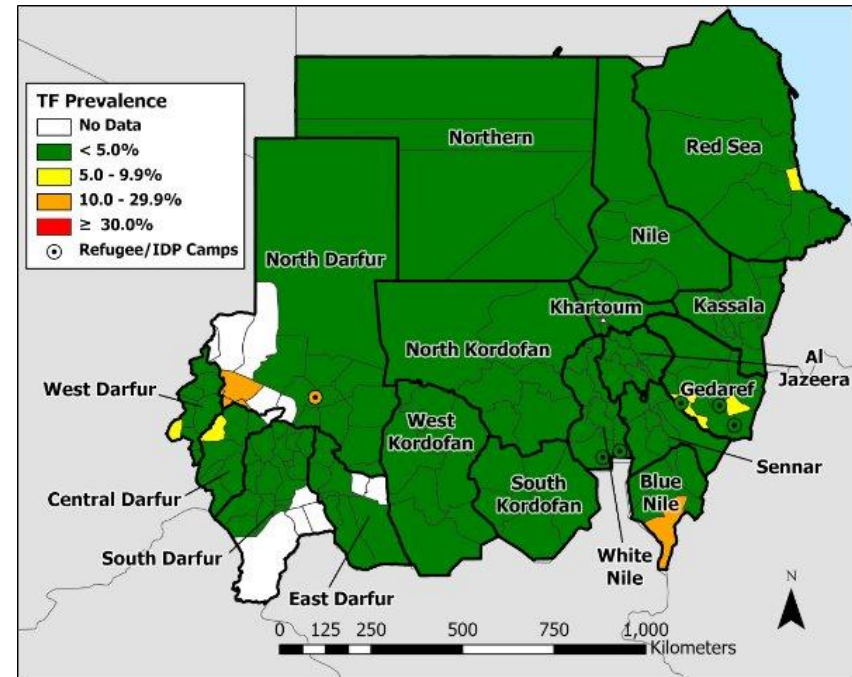


Figure 4 – Estimated TF prevalence through 2025

Table 1. Summary of National Data from Trachoma Control Programs (Carter Center-Assisted Areas)					
<i>National Data as Reported for 2025</i>					
Indicators	Ethiopia	Niger	South Sudan	Sudan	Total*
Surgery					
Surgeries	79,586	2,290	4,403	38	86,317
2025 Target	90,190	4,000	6,000	400	100,590
Percent Coverage	88.2%	57.3%	73.4%	9.5%	85.8%
Antibiotics					
<i>Azithromycin</i>					
Doses	39,048,687	N/A	894,289	544,216	40,487,192
2025 Target	46,485,899	N/A	1,042,975	591,224	48,120,098
Percent Coverage	119.0%	N/A	116.6%	92.0%	84.1%
<i>Tetracycline Eye Ointment</i>					
Doses	887,179	N/A	73,492	8,194	81,686
2025 Target	N/R	N/A	66,060	12,000	78,060
Percent Coverage	N/A	N/A	111.3%	68.3%	104.6%
Facial Cleanliness and Health Education					
Villages with Health Education	N/R	N/A	2,044	288	2,332
2025 Target	N/R	N/A	3,900	288	4,188
Percent Coverage	N/R	N/A	52.4%	100.0%	55.7%
Environmental Improvements					
Latrines	N/R	3,905	4	N/A	3,909
2025 Target	N/R	2,500	7	N/A	2,507
Percent Coverage	N/R	156.2%	57.1%	N/A	155.9%
Surveys					
Achieved	105	0	10	0	115
Target	145	6	13	1	165
Percent Coverage	72.4%	0%	76.9%	0%	69.7%
N/R=Not Reported					
N/A=Not Applicable					
*Totals based on available national data. Ethiopia TEO doses not included in total as target was NR					

Table 2. Carter Center-Assisted Implementation of SAFE (Carter Center-Assisted Areas Output)					
<i>Summary of Interventions per Country, January - December 2025</i>					
Indicators	Ethiopia-Amhara	Niger	South Sudan	Sudan	Total*
Surgery					
Persons operated for TT	28,239	1,575	1,233	38	31,085
2025 Target	19,599	2,000	3,300	400	25,299
Percentage	144.1%	78.8%	37.4%	9.5%	122.9%
Antibiotics					
Doses of antibiotics distributed	12,251,471	N/A	556,034	552,410	13,359,915
2025 Target	14,696,156	N/A	818,056	603,224	16,117,436
Percentage	83.4%	N/A	68.0%	91.6%	82.9%
Facial cleanliness and health education					
Villages with ongoing health education	N/R	N/A	2,044	288	2,332
2025 Target	N/R	N/A	3,900	288	4,188
Percent Coverage	N/R	N/A	52.4%	100.0%	55.7%
Environmental improvement					
Household latrines constructed	N/A	3,905	0	N/A	3,905
2025 Target	N/A	2,500	5	N/A	2,505
Percentage	N/A	156.2%	0%	N/A	155.9%
Surveys					
Trachoma Prevalence Surveys	6	0	1	0	7
2025 Target	47	6	3	1	57
Percentage	12.8%	0.0%	33.3%	0.0%	12.3%
N/A=Not Applicable					
N/R=Not Reported					
*Totals based on available data in TCC-assisted areas					

Table 3. National Trachoma Control Program Annual Targets 2026 (Carter Center-Assisted Areas)						
<i>Targets§ as Reported, March 2026</i>						
Indicators	Ethiopia-Amhara*	Ethiopia	Niger	South Sudan	Sudan	Total**
Surgery						
Persons to operate for TT	18,091	N/R	4,000	5,000	400	27,491
Antibiotics						
Doses of azithromycin to distribute during MDA†	16,273,383	N/R	N/A	1,911,757	0	18,185,140
Doses of TEO to distribute during MDA	306,299	N/R	N/A	113,499	0	419,798
Facial cleanliness						
Villages to reach through health education	N/A	N/R	N/A	N/A	0	0
Environmental improvement						
Household latrines to construct	N/A	N/R	1,500	17	N/A	1,517
Surveys						
Surveys to conduct	N/R	N/R	22	11	7	40
N/A = Not Applicable						
N/R = Not Reported						
§All targets are subject to change						
†Antibiotic targets do not reflect ITI-approved allocations of azithromycin						
*Includes doses to be distributed during child MDA in 8 woredas						
**Totals based on available data in TCC-assisted areas						

Table 4. Cumulative Carter Center-Assisted Implementation of SAFE					
<i>Cumulative Interventions per Country, 1999-2025</i>					
Indicators	Ethiopia-Amhara	Niger	South Sudan	Sudan	Total*
Persons operated for TT	837,584	93,599	15,909	13,089	960,181
Doses of antibiotic distributed (MDA)	231,167,550	4,331,365	6,185,204	9,605,539	251,289,658
Villages with ongoing health education	N/R	N/R	2,044	244	2,288
Household latrines constructed	3,336,513	199,548	646	0	3,536,707
N/R = Not Reported					
*Totals based on available data in TCC-assisted areas					

Table 5. Summary of Carter Center-Assisted Programs Activity Plans, Accomplishments, and Challenges 2025-2026

Country	2025 Plans	2025 Accomplishments	Challenges	2026 Plans
Ethiopia (Amhara)	•19,599 TT surgeries •Train 56 new TT surgeons •Retrain 47 TT surgeons •Train 467 IECWs on epilation •Distribute 14,417,527 doses of azithromycin •Distribute 278,629 doses of TEO •100% F&E schools reporting quarterly •Construct 20 water points	•28,239 TT surgeries •Operated 17,972 women •Trained 8 TT surgeons •Retrained 190 TT surgeons •Distributed 12,009,187 doses of azithromycin •Distributed 242,284 doses of TEO •MDA in 80 districts including child MDA in 8 districts •Conducted 6 prevalence surveys •Completed 7 water points	•Insecurity •Persistent and recrudescing districts	•18,091 TT surgeries •Train 46 new TT surgeons •Retrain 78 TT surgeons •Distribute 16,273,383 doses of azithromycin •Distribute 306,299 doses of TEO •Train 29,206 school personnel on STP •Construct 16 water points
Niger	•2,000 TT surgeries •Finish ratissage in 11 EUs •Construct 2,500 latrines •Conduct 6 prevalence surveys	•1,575 TT surgeries •Operated 1,084 women •Ratissage started in 6 EUs •Finished ratissage in 4 EUs •Retrained 44 surgeons •Constructed 3,905 latrines	•Insecurity •IDPs •Climate change •Implementation of field activities and stakeholder coordination •Loss of funding	•2,000 TT surgeries •Finish ratissage in 9 EUs •Construct 1,500 latrines
South Sudan	•7,906 TT surgeries •Distribute 1,762,691 doses of azithromycin •Distribute 35,254 doses of TEO •Health education in 3,900 villages •Construct 5 latrines •Conduct 13 prevalence surveys	•1,233 TT surgeries •Operated 977 women •Distributed 516,320 doses of azithromycin •Distributed 39,714 doses of TEO •Health education in 2,044 villages •Constructed 5 latrines •Conducted 1 prevalence surveys	•Insecurity •Reverse logistics of MDA drugs •Climate change •Pediatric TT •Unsatisfactory TF prevalence results •Loss of funding	•2,000 TT surgeries •Distribute 715,241 doses of azithromycin •Distribute 14,305 doses of TEO •Health education in 2,500 villages •Construct 15 latrines •Conduct 8 prevalence surveys
Sudan	•400 TT surgeries •Distribute 591,224 doses of azithromycin •Distribute 12,000 doses of TEO •Health education in 400 villages •Conduct 1 prevalence survey	•38 TT surgeries •Operated 26 women •Distributed 544,216 doses of azithromycin •Distributed 8,194 doses of TEO •288 villages with health education	•Insecurity •Shortage of medical supplies in local markets •Hyper inflation increasing program costs	•400 TT surgeries •Conduct 7 prevalence survey

Figure 1. Persons Operated for TT, Carter Center-Assisted Areas

National Program data as presented for January - December 2025

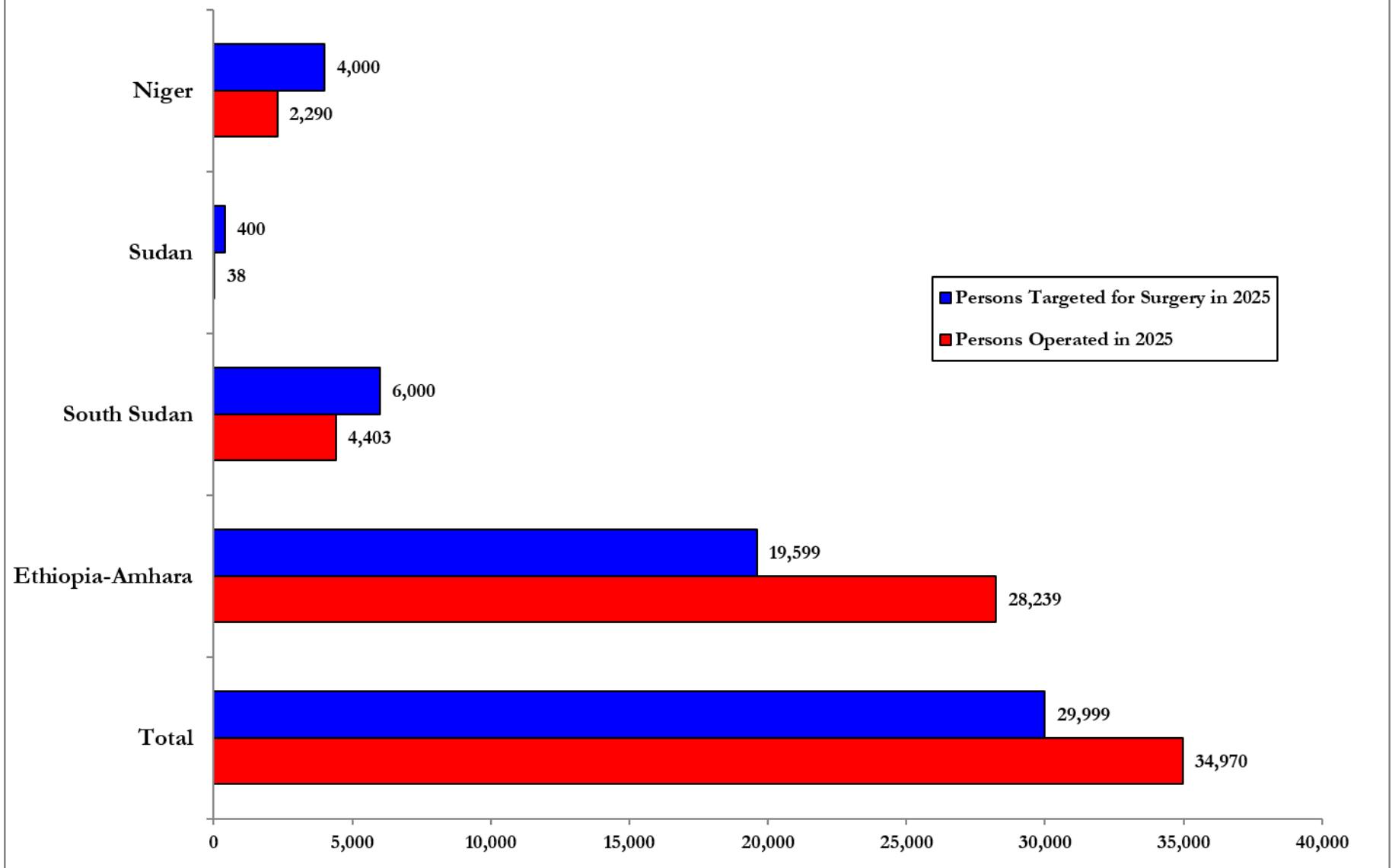
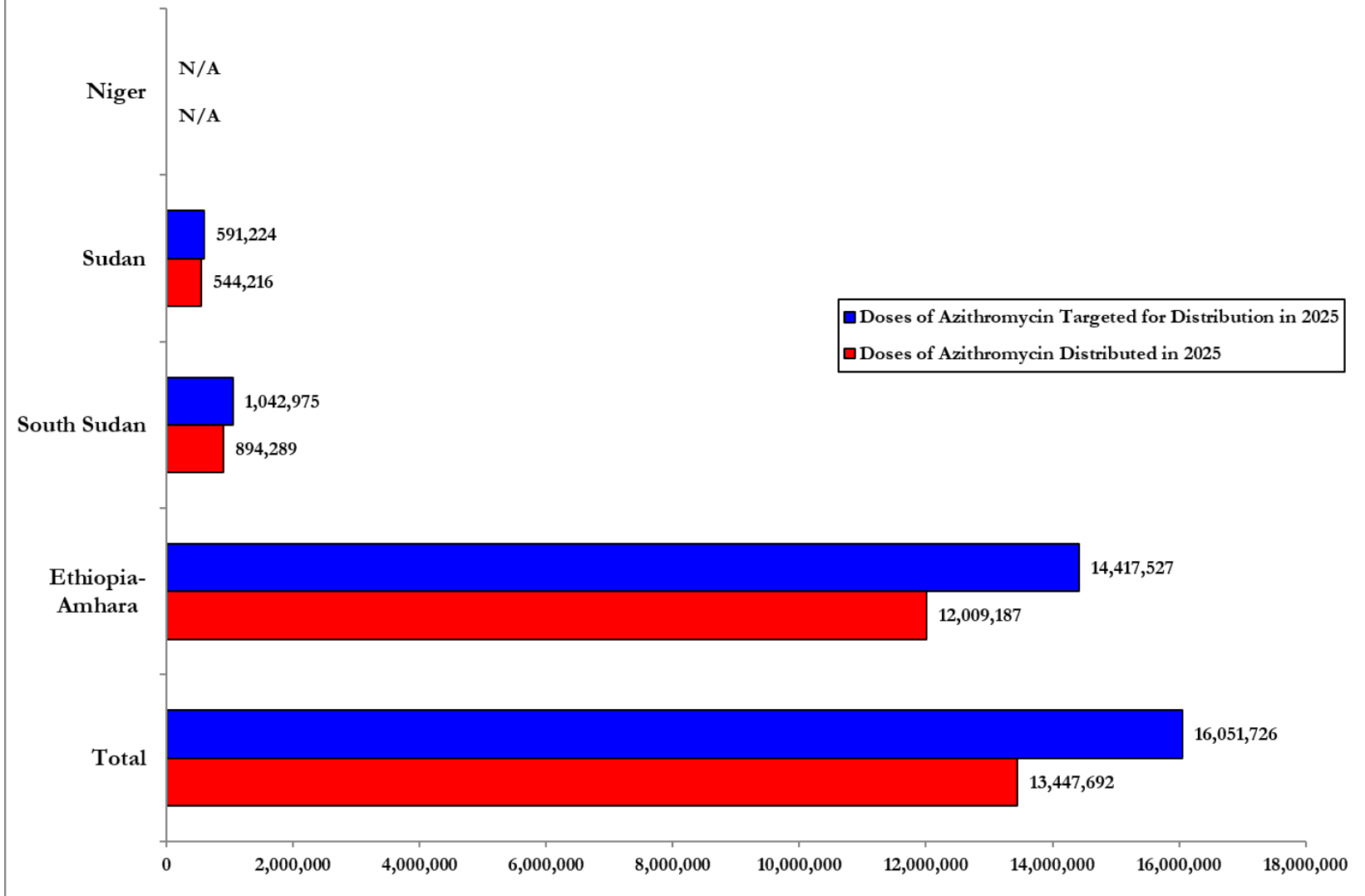


Figure 2. Azithromycin Distribution, Carter Center-Assisted Areas

National Program data as presented for January - December 2025



WASH Upgrades for Health in Amhara (WUHA) Study

Presented by Dr. Solomon Aragie, Researcher, The Carter Center – Ethiopia

Background

The WHO promotes the SAFE strategy for the elimination of trachoma as a public health problem. Although the S and A components are supported by strong evidence, there is limited availability of randomized trial data on the effectiveness of interventions targeting the F & E components. This study aimed to determine whether an integrated WASH intervention could prevent trachoma transmission, with and without MDA.

Methods

The WASH Upgrades for Health in Amhara (WUHA) trial was a two-arm, parallel group, cluster randomized study conducted in 40 rural communities in Wag Hemra Zone, Amhara Region, Ethiopia (2015–2025). Communities were randomized 1:1 to receive the WASH intervention either immediately (intervention arm) or after the trial concluded (control arm). For the first three years, no MDA was provided to either group; for the subsequent six years, both arms received annual MDA. The primary outcome was the cluster-level prevalence of ocular *Ct* infection at year nine in children ages zero to five years. Analyses were conducted in an intention-to-treat manner.

Results

Program delivery records confirmed full provision of WASH hardware and supplies in intervention clusters. Survey data indicated higher uptake of WASH behaviors in intervention communities compared with controls. At baseline, ocular *Ct* prevalence among children ages zero to five years was 11% (95% CI: 6–16) in the intervention arm and 11% (95% CI: 5–18) in the control arm. After three years without MDA, prevalence increased in both groups, reaching 32% (95% CI: 24–41) in the intervention arm and 31% (95% CI: 21–41) in the control arm. The adjusted risk difference across the three annual monitoring visits was 3.7% (95% CI: -4.9–12.4; $p=0.40$). At year nine, ocular *Ct* prevalence among children ages zero to five years was 2.4% (95% CI: 0.7–4.6) in intervention clusters and 3.0% (95% CI: 1.2–5.1) in control clusters (risk difference -0.3 percentage points; $p=0.87$). No meaningful differences were observed in infection prevalence or bacterial load between intervention and control arms.

Conclusions

In this hyperendemic Ethiopian setting, an intensive WASH intervention did not meaningfully reduce ocular *Ct* infection or clinical trachoma, either in the absence of or when combined with annual MDA. Major external disruptions, including COVID-19 restrictions, the Tigray conflict, and ongoing insecurity in Amhara, likely hindered sustained behavior change and limited intervention impact. These findings may not be generalizable to lower transmission settings.

Stronger SAFE Study

Presented by Dr. Katie Greenland, Assistant Professor, London School of Hygiene and Tropical Medicine

Background

Trachoma is caused by the bacterium *Ct*. The WHO recommends the SAFE strategy for trachoma elimination. Multiple rounds of SAFE implementation have proven insufficient to eliminate trachoma in Ethiopia, where over 60% of the global trachoma burden remains. This study aimed to evaluate a package of interventions to reduce the prevalence of conjunctival *Ct* and accelerate trachoma elimination.

Methods

Enhanced A, F, & E (Stronger SAFE) was an open-label, cluster-randomized controlled trial conducted in rural communities in the trachoma-endemic region of Oromia, Ethiopia. Clusters, each of about 90 households, were randomly assigned (1:1:1:1) using Stata 17 to: 1) standard A plus standard F & E (Standard SAFE; control group); 2) standard A plus enhanced F & E; 3) enhanced A plus standard F & E; or 4) enhanced A plus enhanced F & E (Stronger SAFE group). Standard A consisted of annual, single-dose, MDA of azithromycin. Enhanced A included two height-based doses of oral azithromycin (equivalent to 20 mg/kg) given as single doses in two MDA campaigns, two weeks apart, annually. Standard F & E involved promotion of latrine construction and facial hygiene, whereas enhanced F & E used additional fly control measures (permethrin-treated headwear [PTH] and odor-baited traps) and a household-level, facial hygiene behavior change intervention. The interventions were implemented and reinforced over three years. Laboratory technicians and the trial statistician were masked. The primary outcome was the prevalence of conjunctival *Ct* by quantitative polymerase chain reaction (PCR) at three years in the control group versus the Stronger SAFE group, assessed on an intention-to-treat basis in a cross-sectional sample of 60 children ages one to nine years from each cluster. Key secondary behavioral outcomes were observed such as face-washing prevalence and soap use in the intention-to-treat population of 204 households with one or more child ages one to six years. Behavioral outcomes were assessed via structured observation and surveys at baseline, and three months and 24 months after the initial face-washing intervention was first delivered. Adverse events were monitored in all participants receiving MDA and/or PTH. The trial is registered with ISRCTN (ISRCTN40760473) and is complete.

Findings

Between March 6, 2021, and August 31, 2024, 68 clusters were enrolled and randomly assigned to an intervention. From these clusters we surveyed 4,419 children ages one to nine years at baseline (control group n=1,095; Stronger SAFE group n=1,203) and 3,480 (mean 50.7 [SD 9.9] per cluster) at endline (control group n=970; Stronger SAFE group n=862). At baseline, the cluster mean prevalence of conjunctival *Ct* was 14.6% [SD 15.5%] (range 0–53.3) in the control group and 13.3% [SD 11.8] (range 0–39.1) in the Stronger SAFE group. Following three years of intervention, the cluster-adjusted prevalence of conjunctival *Ct* was 2.7% (95% CI 1.3–5.0) in the control group and 2.2% (0.6–7.9) in the Stronger SAFE group (adjusted prevalence difference of –0.02% [–2.73 to 2.68], p=0.99). Azithromycin was well tolerated with only 13 mild, self-limiting adverse events (almost exclusively nausea, diarrhea, and headache) reported related to the MDA (eight in single-dose MDA communities and five in double-dose MDA communities). No serious adverse events were reported. The enhanced

face-washing intervention was associated with an increase across all key behavioral outcomes compared with the control group. Effects were more pronounced among children ages one to six years. Additionally, 87 (85%) of 102 control households were water-insecure 24 months after the intensive intervention was delivered compared with 85 (83%) of 102 intervention households (cluster-level means 9.5 L [10.8] per person vs 8.7 L [8.6]).

Interpretation

Stronger SAFE had no additional effect compared with the standard of care on reducing the prevalence of conjunctival *Ct* at three years in this setting. The enhanced intervention increased soap use during face washing but had a smaller effect on the overall face washing prevalence. Our findings highlight the challenge of achieving behavioral change in hygiene in water-scarce settings. It is unlikely that these enhanced intervention measures will accelerate trachoma elimination beyond well-implemented, high-coverage of single-dose MDA as part of standard SAFE.

Funding

Wellcome Trust and the Children's Investment Fund Foundation.

School Trachoma Program (STP) – Amhara

Presented by Mr. Ayenachew Kerie, Behavior Communication Officer, The Carter Center – Ethiopia

The STP has been implemented across the Amhara Region since 2017 and currently reaches more than 8,900 schools. Trachoma and hygiene education are integrated into the primary curriculum and, from the 2022/2023 academic year, into the preprimary school curriculum, ensuring children develop essential hygiene knowledge and life skills from an early age. The Program emphasizes F & E behaviors, key components of the SAFE strategy for trachoma elimination, reinforced through classroom lessons and extracurricular activities.

STP Training

The STP applies a cascade training approach at zonal, woreda, and school levels. Zonal level training of trainers workshops prepare education and health officers, who then train school principals, teachers, and cluster supervisors at woreda level. At school level, trained principals and environmental science teachers orient all teachers on trachoma prevention and hygiene. Between 2016 and 2023, over 60,000 people were trained through training sessions, and more than 200,000 teachers received school level orientation by trained teachers and principals.

Activities and School Engagement

From 2017 to 2025 the primary school program was delivered through a parallel curriculum, providing teaching guides, flipcharts, classroom radio lessons, and spot messages so teachers could incorporate trachoma lessons into the environmental science classes for grades one to four. Additional activity suggestions were also provided for the anti-trachoma clubs so activities could be conducted throughout the school compound and the surrounding communities. Due to the success of this program, the Amhara Bureau of Education incorporated trachoma lessons into the standard regional curriculum, ensuring sustainability of trachoma education; the success also led to the development of the trachoma parallel curriculum for the pre-primary students, which was piloted and will scale throughout the region in 2026.

WASH Support and Community Events

To enhance the STP, water points were constructed in select schools within endemic areas; to date a total of 55 water points have been constructed, benefiting 31,993 students and 1,328 teachers. Each school manages the water point through a WASH Committee, which is made up of students, teachers, and community members who receive training on monitoring of water point functionality and basic water point maintenance. In addition, Face Washing Week, celebrated annually under the motto “Clean Face, Healthy Eyes”, mobilizes schools and communities to promote facial cleanliness. The STP has expanded widely across the Amhara Region, reaching over 8,900 schools and continues to help the region progress toward trachoma elimination.

NTD Advocacy, Learning, Action (NALA) WASH Update

Presented by Ms. Nisan Z. Kesete, Country Director, NALA Foundation

Beyond Antibiotics: Why Prevention through WASH & Behavior Change is Non-Negotiable.

Ethiopia has conducted MDA since 2003, delivering tens of millions of azithromycin doses. While MDA is highly effective at rapidly reducing infection—especially in high-prevalence settings—it does not stop transmission. The core issue is rebound: once treatment stops, infection returns in high-transmission environments. This is illustrated by the Lakew et al. (2009) study, in which infection dropped to 2.5% after intensive treatment but rebounded to 25.2% within two years.

The reason is straightforward: antibiotics treat infection but do not interrupt transmission pathways. Transmission continues through eye discharge, hands, flies, and contaminated environments. Evidence shows that interventions targeting these pathways are effective—clean faces, fly control, sanitation, and improved water access all significantly reduce infection. This reframes trachoma not as a failure of antibiotics, but as a behavioral and environmental challenge that requires a broader response.

Globally, elimination success follows the same pattern. All 28 countries that have eliminated trachoma initially used MDA though succeeded by strengthening WASH and behavior change alongside treatment. No country has eliminated trachoma through MDA alone. Historical examples from Europe and North America, as well as recent successes like Senegal and Morocco, reinforce this.

The conclusion is that SAFE must be implemented as a complete system, not selectively. Ethiopia's national strategy aligns with this, targeting elimination by 2030 through integrated MDA, WASH, behavior change, surgery, and strengthened health systems.

Using Complementary Indicators in Programmatic Decision Making

Presented by Mr. Eshetu Sata, Trachoma Program Manager, The Carter Center – Ethiopia

Background

Since the beginning of the TCP, remarkable gains have been made in the fight against trachoma in the Amhara region. As of December 2025, 58 (35%) of districts achieved the TF elimination threshold, meaning an estimated seven million people do not require MDA for trachoma. To better understand endgame challenges such as persistent and recrudescent trachoma and tailoring interventions, the Amhara Program has been collecting complementary indicators (*Ct* and DBS). *Ct* infection monitoring was first included in Amhara surveys in 2011, and to date more than 72,000 *Ct* samples have been collected and analyzed from almost all districts in Amhara, thanks to the m2000 PCR system donated to the Amhara Public Health Institute (APHI) in 2013. Collection of DBS started in 2017, and samples have been collected from 24 districts so far. The Amhara Program collaborated with the United States Centers for Disease Control and Prevention (CDC) for testing samples for Placid gene protein 3 (Pgp3) antibodies. In January 2024, the CDC facilitated a remote lateral flow assay (LFA) training at the Trachoma Molecular Laboratory at APHI which ensured in-country capacity. As a result, samples no longer need to be sent abroad, and all serology data are generated at APHI.

Complementary Indicators – Use cases and decision making

Complementary indicators have been collected to describe epidemiology within hyperendemic persistent districts. In a highly endemic district such as Ebinat, *Ct* infection was observed across all ages, though TF was highest in the youngest children. The results also showed that seroprevalence increases quickly with age, while both TF and *Ct* remain fairly stable over time in such hyperendemic persistent districts. To address persistent trachoma, one strategy employed was the child MDA pilot study, which was conducted in the persistently hyperendemic districts of Lasta and Wadilla of North Wollo zone in 2023. Following completion of the MDAs, enhanced post-MDA coverage surveys were conducted, and children ages one to nine years were swabbed for *Ct* infection. The enhanced coverage survey showed that infection among those never treated was high (16%), while infection among those who received both doses was low (1.2%). The Program plans to scale-up *Ct* infection monitoring in the districts implementing child MDA as much as possible. Complementary indicator data were also gathered in districts with low trachoma prevalence, where results confirmed that districts at TSS maintained a low TF prevalence, and low *Ct* infection and seroconversion rates (SCR), despite having previously been more endemic and located adjacent to endemic districts.

Another use case is to understand recrudescent trachoma. Between 2011 and 2019, among the districts that had completed TSS, 34% were recrudescent. Restarting MDA in these districts would be costly, and looking at complementary indicators would help to better understand recrudescence and inform decision-making. The “Wait and Watch” approach was conducted in two districts—Metema and Woreta town—where TF prevalence was >5% at TSS in 2019. In 2021, a follow-up survey with complementary indicators was conducted, and both districts had a TF prevalence <5% after more than two years without MDA. Additionally, *Ct* infection and SCR among children were very low. The “Wait and Watch” approach demonstrated a surveillance strategy that could lead to fewer MDA campaigns and surveys, resulting in cost savings and reduced antibiotic usage.

Conclusion

The collection of complementary indicators at a programmatic level is possible. Monitoring complementary indicators helps to understand trachoma epidemiology and endgame challenges. Using complementary indicators can add confidence when deciding whether to stop or continue MDA and can lead to fewer unnecessary MDAs and surveys, resulting in cost savings. Having all three indicators—TF/clinical, *Ct* infection, and serological monitoring—is the most valuable combination for informed decision making.

A Longitudinal Study of Trachoma Infection Clearance and Re-Acquisition in a Persistently Hyperendemic Setting (ATIRA) Study

Presented by Mr. Mikiyas Gebremichael, Ph.D. Student and Research Project Manager, London School of Hygiene and Tropical Medicine, and Eyu-Ethiopia

Azithromycin-based MDA has substantially reduced trachoma prevalence in many settings; however, several districts in Ethiopia remain persistently endemic despite more than 11 annual MDA rounds. Understanding the dynamics of *Ct* infection in these areas is critical to achieving the global trachoma elimination target by 2030.

A Longitudinal Study of Trachoma Infection Clearance and Re-Acquisition in a Persistently Hyperendemic Setting (ATIRA) is an ongoing study in the Argobba district, South Wollo Zone, Amhara Region, to investigate *Ct* infection clearance, re-acquisition, and their behavioral, environmental, nutritional, and socio-cultural determinants. Specifically, the aim is to: 1) assess *Ct* infection clearance one month after the first and second community MDA and a child-targeted MDA; 2) measure *Ct* infection re-acquisition over a 14-month period; and 3) identify key contextual factors associated with *Ct* infection clearance and re-acquisition.

At baseline, 2,086 children ages one to nine years were enrolled from 52 clusters selected using a population-proportionate approach. Data collection was conducted in September 2024. Ocular examinations, conjunctival swabs, and DBS samples were obtained. Baseline *Ct* infection, TF, and seroprevalence were 10.6%, 36.4%, and 35.5%, respectively.

Self-reported MDA coverage during the first annual round was 92.7%. *Ct* infection prevalence declined to 2.6% one month post-MDA, with infection clearance significantly higher among treated participants (82.8%) than among untreated participants (11.8%). Coverage for the second annual MDA and child MDA was 92.9% and 89.0%, respectively, and TF prevalence decreased to 9.9% following the child MDA ($p < 0.001$).

Ongoing activities include infection testing for samples collected between months seven through 14, a mixed-methods behavioral study, observational qualitative research on behavioral factors influencing infection re-acquisition, quantitative serological assessments, and macronutrient analyses to explore potential nutritional influences on *Ct* infection dynamics.

The Duration of Active Trachoma and Viable *Chlamydia trachomatis* Infection in Ethiopia: A Cohort Study

Presented by Dr. Oumer Shafi, Consultant, Sightsavers

Ethiopia bears the highest global burden of trachoma, yet critical gaps remain in understanding the duration and viability of ocular *Ct* infection, particularly in settings with long-standing MDA. This longitudinal cohort study investigated the natural history and spatial distribution of *Ct* infection and active trachoma in a trachoma endemic rural community in Shashemene Woreda, Oromia, Ethiopia.

A total of 298 individuals from 68 adjacent households were followed for one year with fortnightly visits (22 timepoints). Clinical examination for TF and trachomatous inflammation–intense (TI) was conducted alongside conjunctival swabbing for *Ct* infection detection. *Ct* infection was defined by deoxyribonucleic acid (DNA) detection using quantitative PCR, and viability was assessed using *Ct* messenger ribonucleic acid (mRNA) assays. Spatial clustering was evaluated using Moran's I. Community-wide azithromycin MDA was delivered between timepoints 16 and 17 based on MOH's schedule.

Before MDA, the mean prevalence among children ages two to nine years was 17.6% for TF, 2.6% for TI, and 9.5% for *Ct* infection. Overall, 82% of *Ct* DNA-positive samples were also mRNA positive, indicating viable infection. The median duration of *Ct* infection was eight weeks, while viable infections persisted for a median of five weeks. TF episodes lasted a median of eight weeks, whereas TI resolved more rapidly, with a median duration of two weeks. Infection and disease were concentrated in young children, particularly those ages two to five years.

Ct infection showed strong and persistent spatial clustering, with 83% of infections occurring in just 10 households. Following MDA, the prevalence of TF and *Ct* infection declined significantly. Among individuals with viable *Ct* infection immediately before MDA who reported receiving treatment, 86% cleared viable infection at the subsequent visit.

These findings demonstrate that viable ocular *Ct* infections can persist for several weeks and cluster within households, sustaining transmission despite repeated control efforts. Targeted strategies to identify and address untreated foci may be critical for achieving trachoma elimination.

Use of Molecular Diagnostic Platforms for Trachoma Monitoring

Presented by Dr. Barbara Van Der Pol, Professor, University of Alabama at Birmingham

Defining populations at need based on the prevalence of follicular active trachoma in children, which requires a physical exam that is difficult to standardize and requires rigorous staff training. Thus, the detection of *Ct* infection provides an additional data point for consideration. This becomes even more relevant when treatment programs are mature, as determining the impact of such programs is difficult without a highly objective, standardized methodology.

Field work is expensive, time-consuming, and requires technical expertise. During these efforts, the collection of a swab for molecular diagnostics is a simple addition to the process. If collected in an appropriate transport buffer, DNA or ribonucleic acid (RNA) can be stabilized for transport to a central lab, and they can be stored for future research. Use of a portion of the material in which the swab is transported can enable molecular identification of *Ct* DNA/RNA using any one of a number of platforms that have been well evaluated for use with genital specimens and, in some cases, with ocular samples. The remainder of the original sample may then be stored, and a variety of techniques may be used to examine genotype distributions, antimicrobial resistance genetic markers, and other targets of the chlamydia genome. In the future, additional tests may be possible as technologies develop.

Confidence in the data generated by molecular testing relies on using a well-qualified lab with a strong emphasis on quality management. This is particularly important since the organism load in conjunctival samples is usually less than 100 organisms/mL, and therefore, the lab must be functioning at optimal levels. The Trachoma Molecular Laboratory at the APHI in Bahir Dar, Ethiopia, is an excellent example of such a resource.

Recent Serological and Infection Results in Amhara

Presented by Mr. Zebene Ayele, Monitoring & Evaluation Officer, The Carter Center – Ethiopia

Trachoma, caused by *Ct* infection, remains endemic in Ethiopia's Amhara region despite SAFE interventions since 2007. Districts with two TISs showing TF prevalence $\geq 5\%$ among children ages one to nine years are considered persistent. Because persistent trachoma is a key endgame challenge, the WHO encourages the collection of complementary indicators (*Ct* infection and serology) to better characterize transmission.

Nine persistent districts with elevated TF prevalence were surveyed in 2025 and included the collection of complementary indicators. All districts had received 10–15 years of MDA and had ≥ 2 TIS with TF prevalence $\geq 5\%$. Multi-level cluster random surveys were conducted using the Tropical Data service: 30 communities were selected proportional to estimated size, then segmented into groups of 30 households; one segment was sampled, and all households were included. Trained, certified graders assessed TF prevalence among children ages one to nine years. Children ages one to five years provided conjunctival swabs for *Ct* PCR testing (Abbott RealTime PCR on the m2000 platform) and DBS for serology using LFA; laboratory analyses were conducted in Amhara.

Overall, 13,072 children ages one to nine years were examined, and 5,251 children ages one to five years provided swabs and DBS. TF prevalence remained above the 5% threshold in eight of nine districts, ranging from 5.4% (Sahalla Seyment) to 37.1% (Dahanna). *Ct* infection was detected in all districts. Kombolcha, the only district below the TF threshold (TF=1.1%), had *Ct* infection prevalence of 0.3%. Among districts with TF prevalence $\geq 5\%$, *Ct* prevalence ranged from 0.5% (Sahalla Seyment) to 26.1% (Dahanna). Dahanna also had an SCR of 32.0 per 100 children per year, indicating intense transmission despite >10 years of annual MDA.

Persistent trachoma remains a major problem in Amhara; nearly all surveyed persistent districts stayed above the TF elimination threshold, and complementary indicators confirmed ongoing transmission, including hyper-endemicity in Dahanna. With the 2030 elimination goal, the Program should prioritize enhanced MDA strategies and use complementary indicators to target and monitor intensified interventions in persistent districts.

Niger – Ratissage

*Presented by Mr. Nassirou Baido Epidemiologist, National Eye Health Program &
Mr. Ilhyassou Issa, Ophthalmology Technical Advisor, The Carter Center – Niger*

As of early 2024, Niger had made considerable progress toward the elimination of trachoma as a public health problem, yet five regions remained endemic for TT. Identifying and managing TT cases has been challenged by the limited number of trained surgeons to conduct outreaches and the fluctuating prevalence estimates from surveys. In response, the PNSO adopted *ratissage* as the national elimination strategy for TT endemic EUs. This approach, developed by the PNSO with support from Helen Keller International and The Carter Center, utilizes *relais* to conduct house-to-house TT case finding. Suspect cases are referred to ophthalmological surgeons, who confirm the diagnosis and provide TT surgery.

Following a May 2024 pilot, *ratissage* was scaled up nationally, and initial results indicate the strategy is an effective method for Niger to achieve its TT elimination goals. As of February 2026, 78% (32/41) eligible EUs have started *ratissage*. Over 3.2 million people have been screened nationally, with 4,645 confirmed cases and nearly 3,900 TT surgeries performed. Among the six EUs which have completed *ratissage*, 95% of the eligible population has been screened, with 90% (889/991) of confirmed cases receiving TT surgery.

During the scale-up of *ratissage*, challenges have emerged, including longer-than-expected timelines, substantial data verification needs, and sociocultural barriers. The Program has responded by continuously evaluating and adapting its approach, yielding several key lessons. First, coordinated planning through frequent meetings with stakeholders has helped minimize delays and ensure implementation quality. Additionally, a dedicated database centralizes programmatic data and supports surgical planning, which will be key for the preparation of their elimination dossier. Finally, the supervision of surgeons and engagement of *relais* have helped ensure the quality of implementation and address patients' reluctance to surgery. Thanks to these efforts, all eligible TT endemic EUs in Niger are expected to complete *ratissage* by the end of 2026.

Preparing for Trachomatous Trichiasis Endgame – Amhara

Presented by Mr. Begashaw Hailemariam, Program Officer, The Carter Center – Ethiopia

At baseline in the Amhara region, every district was endemic for TT' (>0.2% in individuals 15 years and above), and many districts had a TT' prevalence that exceeded 5%. In response, the Amhara Program introduced an IECW-based approach in 2001, training general health workers to provide TT' surgery service through static and outreach modalities. Outreach has dominated service delivery, accounting for 97% of surgeries over the past decade, with case identification integrated into MDAs, cataract campaigns, and other community-based activities. Since 2001, more than 837,000 TT' surgeries have been performed in the region, reducing the estimated backlog to 53,484 cases in January 2026. Consequently, TT' prevalence has shifted dramatically, and by 2025 no districts remained above 3% TT' prevalence, compared to 102 districts in 2015.

As the Program enters the endgame, remaining TT' cases are fewer and harder to identify, requiring greater resources per case, while the high surgical volume has led to a growing number of PTT' cases. In response, the MOH and ARHB introduced national guidelines for PTT' management, epilation for TT' management, and FGC.

Following endorsement, PTT' and epilation guidelines were rolled out through IECW training, distribution of materials, and initiation of service provision. Most of the IECWs in the Amhara region received trained on these new guidelines in 2025 with the remaining IECWs to be trained in early 2026; all future IECW trainings will incorporate the newly-endorsed PTT' and epilation guidelines.

FGC is implemented through a structured process that includes detailed planning, training, and house-to-house screening of adults ages 15 years and older. Suspected TT' cases are mobilized for confirmation, counseling, and management by IECWs, with comprehensive documentation used to verify completion. FGC prioritization in Amhara focuses on: 1) districts with TT' prevalence above 0.2% despite TF prevalence levels below 5% at TSS; and 2) districts that achieved the TF prevalence threshold at TIS but failed to achieve the TT' indicator threshold.

Finally, districts meeting elimination criteria through surveys or FGC will transition from active outreach to routine eye health services, and incident cases will be managed through the existing health structure.

Surgeon Attrition and Productivity Study in Five Regions of Ethiopia

Presented by Dr. Michael Dejene, Consultant Epidemiologist, Sightsavers/Tropical Data

Background Information

Since 2003, more than 1,400 mid-level health workers (Clinical nurses, Health Officers, Ophthalmic Nurses, Optometrists, and Cataract Surgeons) have been trained, certified, and deployed in trachoma endemic districts across Ethiopia. Programmatic reports also showed that over 1.88 million people received TT surgery since then. Despite commendable progress made so far, an information gap regarding the productivity and functionality of the TT surgeons was identified as a programmatic challenge. Considering the identified programmatic gap, the ETAG recommended an assessment focusing on TT surgeons' productivity and attrition, as well as the factors associated with them.

Study Coordination and Study Area

The five high trachoma burden regions in the country, namely Amhara, Central Ethiopia, Oromia, South Ethiopia, and Tigray, were the study areas. The MOH led the process of the study, and Sightsavers provided the technical and financial support required for the study.

Study Progress

- A study protocol was prepared and received ethical approval from a national health research ethics committee.
- As part of the preparation for the study, a national study consultant was recruited, and a core survey team was formed, with representatives from MOH, Sightsavers, and Orbis Ethiopia.
- The study was launched during a national consultative planning workshop, which was conducted with the participation of all key stakeholders.
- A TT surgeons database was compiled and used as a sampling frame for random selection of the TT surgeons for the quantitative study.
- An electronic data collection platform was developed (using KoboCollect), pretested, and used to gather information from the study group using a self-administered questionnaire.
- The online data collection is planned to be completed by the end of March 2026, and the collection of the qualitative data through in-depth interviews with regional and partner program coordinators, supervisors, and focus group discussions with TT surgeons from the five study regions will be completed by the end of April 2026.
- Data analysis and report writing are scheduled to be completed by the end of May 2026.
- A draft report and national TT surgeons' database will be finalized and presented to the National Trachoma Task Force and shared with key program partners by the first week of June 2026.
- Feedback received from partners will be incorporated, and the final study report will be submitted to the MOH in the third week of June 2026.
- The study findings will be prepared for wider dissemination by the end of July 2026.

Monitoring Eye Health Indicators in Trachoma Surveys

Presented by Dr. Emma Harding-Esch, Associate Professor, London School of Hygiene and Tropical Medicine

This presentation highlighted the opportunity to integrate the collection of eye health indicators in routine trachoma prevalence surveys. This approach helps address current gaps in eye health indicator data, with benefits at global, national, and individual levels. Results from a feasibility study in Ethiopia and Nigeria were presented, including key eye health indicators, feasibility, acceptability, and cost data. Subsequent stakeholder engagement work has been conducted to discuss future opportunities and sustainable funding options for integrating Eye Health Indicator trachoma surveys. With over 2,000 trachoma surveys planned across 35 countries between now and 2032, the window of opportunity to maximize this integrated survey approach is now.

Pediatric Trachomatous Trichiasis Detection and Services in South Sudan

Presented by Dr. Pallavi Kache & Dr. Angelia Sanders on Behalf of Mr. Nicholas Presley, Epidemiologist & Senior Associate Director, Trachoma Control Program, The Carter Center – Atlanta

Repeated *Ct* infection can cause conjunctival scarring and progression to TT. Pediatric TT is rare globally and poorly characterized clinically and within surveillance systems. In South Sudan, the TCP has increasingly registered suspected pediatric TT during surgical outreach camps and therefore aimed to characterize cases among attending children. In July 2025 and February 2026, children ages one to 14 years presenting with suspected TT to two surgical camps in Pibor County were enrolled in a descriptive study. Participants were assessed using a questionnaire, capturing demographics and clinical history, graded for signs of trachoma and TT severity, with ocular photos and DBS collected from confirmed TT cases.

Children ages one to 14 years comprised 4.1% (239/5,702) of overall surgical camp attendees. Among all children, 32 (13%; 32/239; ages three to 14 years) were confirmed with TT. Major TT (>5 lashes touching the globe) was present in 30/32 (94%) children, and 29/32 (91%) had bilateral TT. Corneal opacity was observed in 21/32 (66%) children. Trachoma signs were common with TF in 21/32 (66%) children, TI in 21/32 (66%) children, and trachomatous scarring in 25/32 (78%) children. These results suggest an under-documented burden of pediatric TT with advanced disease, which will further be confirmed via serologic testing and photographic grading.

Providing surgery to confirmed pediatric TT cases presents considerable challenges. Among them, children under the age of 12 are not eligible for surgery at Carter Center-supported outreaches and require referral for general anesthesia. In November 2025, The Carter Center and partners coordinated a surgical pilot: nine children were transported to the MOH's Buluk Eye Center in Juba via charter flight for surgery and post-operative care. This pilot provided the framework for managing pediatric TT patients and was repeated successfully in March 2026. Moving forward, the Program will explore options to reduce the costs and delays between identification and surgery. Further, findings highlight the need to resume MDA in Pibor County and collect population-level data to guide interventions.

International Coalition for Trachoma Control New Publication – Hard to Reach Populations

*Presented by Dr. Angelia Sanders, Senior Program Associate, Trachoma Control Program,
The Carter Center – Atlanta*

According to the International Coalition for Trachoma Control’s (ICTC) special populations task team, “special populations” are those that, due to various factors, require programs to be tailored to ensure equitable access to trachoma interventions. This definition includes (but is not limited to): refugees, IDPs, indigenous and nomadic populations, people living with disabilities, and people who experience homelessness. These populations have been referred to as “statistically invisible” because disease prevalence among them is often obscured by the dominant population in population-based surveys.

To help document the knowledge gained by various ministries of health and supporting implementing partners working with these special populations, ICTC’s special populations task team developed a toolkit that was officially launched in September 2025. This toolkit can be used in several ways:

1. as a guiding resource for organizations with limited or no experience working with special populations;
2. as a step-by-step planning guide for organizations already engaged with these groups;
3. as a reference document outlining key planning components; and
4. as a tool to engage non-trachoma partners.

The toolkit outlines key considerations for stakeholders planning trachoma interventions targeting special populations, as well as those funding them. It includes guidance on conducting situational analyses and surveys, building strategic partnerships, planning for implementation, and advocating for inclusive approaches. In addition, it offers a collection of practical tools that can be used or adapted to enhance program efficiency and effectiveness.

The toolkit can be accessed at the below link. Funding is still being sought to translate the document into French and cover the costs of printing.

<https://www.trachomacoalition.org/resources/delivering-trachoma-interventions-to-special-populations-a-toolkit-for-program-managers>

Adaptive Programming: Implementing Trachoma Surveys and Mass Drug Administration in Insecure Districts, Amhara, Ethiopia

*Presented by Mr. Ayalew Shiferaw & Mohammed Feyisso, Senior Program Officer & Epidemiologist,
The Carter Center – Ethiopia*

For nearly two decades, the Amhara Program has implemented the SAFE strategy, achieving significant reductions in disease burden. However, since 2020, COVID-19 and escalating insecurity have delayed surveys and MDA, creating operational gaps in districts awaiting continuation.

To address these challenges, the Amhara Program has embraced adaptive strategies to sustain progress toward trachoma elimination in the face of insecurity and public health disruptions. Prior to surveys, structured security assessments were conducted with stakeholders at all levels to determine which districts were accessible. Operational adjustments included reducing survey teams to decrease the number of people moving around insecure areas, deploying two teams per cluster to minimize exposure, and using alternative transport such as public vehicles and motorbikes that were permitted to travel in the insecure areas. In areas where electronic devices were restricted, paper-based data collection was piloted. Additional measures such as enhanced training, local task force establishment, and strengthened cold chain support have improved feasibility and safety. Key lessons highlighted the importance of local survey teams, continuous security monitoring, stakeholder collaboration, and methodological flexibility.

Similarly, adaptive MDA programming ensured continued antibiotic distribution despite insecurity. Districts assessed transport, staff mobility, and safety, then adjusted delivery strategies with minibuses, motorbikes, carts, and even air transport. Local supervisors stepped in when regional staff could not travel, while training and supervision continued through regional centers and remote communication. Flexible scheduling allowed programs to adapt to changing conditions, and community mobilization was strengthened by engaging additional facilitators to support health extension workers in outreach and screening.

The Amhara experience demonstrates that MDA and surveys can be feasible in insecure settings when delivered by community-based teams. Success depends on thorough preparation, strong stakeholder collaboration, consistent communication, and adaptive risk mitigation. Decision gates allow districts to revise plans based on local realities, supported by zonal and regional health authorities. Ultimately, resilient, context-specific approaches ensure that trachoma elimination efforts remain on track, offering a global model for programs operating in conflict-affected regions.

Mass Drug Administration in Cattle Camps

*Presented by Mr. Stephen Ohidor, Trachoma Program Manager,
The Carter Center – South Sudan*

The TCP implements MDA campaigns at the village level to interrupt transmission and reduce disease burden. In South Sudan, where nomadic pastoralism is a central component of livelihoods and culture and an estimated 70% of the population engages in pastoralist activities, seasonal migration patterns present a major consideration for equitable delivery of health services. In Kapoeta East County and Kapoeta North County, South Sudan, pastoral communities frequently move with their cattle to temporary cattle camps, often traveling long distances in response to seasonal grazing conditions, insecurity, and environmental pressures.

To better understand the role of cattle camps in achieving high treatment coverage, the South Sudan TCP has incorporated temporary cattle camps into MDA planning. Ongoing data collection activities include routine MDA drug distribution records, GPS mapping of cattle camp locations (2023–2025), and in-depth questionnaires administered across three seasonal time points (2024–2025). Between September and November 2025, a team of 23 trained data recorders collected information from 146 cattle camps in Kapoeta North and East Counties. Preliminary analyses indicate that the age composition of cattle camps remained relatively stable across seasons, although gender composition varied over time. Communities were also found to remain in camps for moderate periods (one to two months at a time), emphasizing the importance of aligning outreach and MDA deployment schedules with migration timing. Across both counties, cattle management and access to grazing resources were identified as the primary drivers of cattle camp location, while social factors such as security and proximity to home villages appeared to play a more prominent role in Kapoeta North County.

Future work will explore how climate change may alter migration and cattle camp distribution, assess the burden of TF and TT among mobile populations, and continue development of targeted mitigation and outreach strategies to improve equitable service delivery for pastoralist communities living in fragile, climate-affected settings.

Reaching Mobile and Migrant Populations – Experience from Trachoma Surveys in Uganda

*Presented by Dr. Jeremiah Ngondi, Epidemiologist,
AFYAZEN Consulting*

Background

Uganda has made remarkable progress toward the elimination of trachoma as a public health problem, with 61 of 62 (99%) previously endemic districts having attained TF prevalence of <5%. However, trachoma has remained persistent or recrudescing in Karamoja Region (Eastern Uganda), where mobile and migrant populations (MMP) comprising nomadic pastoralists seasonally migrate across the porous Uganda/Kenya border. Following intervention with modified MFTA biannual MDA with azithromycin, enhanced trachoma impact surveys (TIS+) were undertaken to investigate: 1) prevalence of TF in children ages one to nine years; 2) prevalence of ocular *Ct* infection and Pgp3 serology in children ages one to nine years; and 3) prevalence of TT in people ages 15 years and above.

Methods

TIS+ were undertaken in two EUs comprising: 1) the villages in Moroto districts, and 2) MMPs within Moroto district. Surveys were conducted using tropical data methods. A total of 30 clusters were sampled for Moroto villages EU, while all 19 MMP settlements, mapped before the survey, were surveyed. Eligible participants were examined for trachoma and conjunctival swab and DBS samples were collected from children ages one to five years. Heads of households were interviewed on household characteristics, WASH, migration, and history of MDA.

Results

The surveys showed that, compared to Moroto villages EU, the MMP EU had: a higher proportion of households identifying as Kenyan nationals; fewer improved water facilities and no improved sanitation facilities; reported higher migration mainly for pastoralism; and a higher proportion reporting not having participated in MDA. In the Moroto villages EU, the prevalences of TF and TT were 1.9% and 0.3%, respectively. In contrast, prevalences of TF and TT in the MMP EU were 17.9% and 2.8%, respectively. Distribution of TF at the cluster level showed that 60% of the clusters had a proportion of TF in children one to nine years above 10%. Testing of ocular *Ct* infection and Pgp3 serology is underway.

Conclusion

Findings suggest that TF prevalence in the Moroto villages EU was below the elimination threshold. However, the MMP EU still had TF prevalence above the elimination threshold. The results of *Ct* infection and Pgp3 will provide important indicators for decision-making. Nonetheless, modified MDA should be considered in the MMP EU.

South Sudan Gender Equity & Social Inclusion Study

*Presented by Dr. Abuk Peter, Gender Equity & Social Inclusion Focal Person,
Ministry of Health – South Sudan*

Understanding Gender, Equity, and Social Inclusion (GESI) begins with understanding the key terminologies. Sex refers to the chromosomal makeup assigned at birth, while gender refers to the social norms, expectations, and responsibilities assigned to women and men. Equity is the means used to address different needs, while equality is the result we aim to achieve. Inclusion involves designing interventions that recognize people's diverse needs and tailoring services to accommodate them. Exclusion happens when needs are known but not considered—whether intentionally or unintentionally. In most cases, those excluded are vulnerable groups such as pregnant women, children, people living with disabilities, and mobile populations.

GESI aims to identify these excluded groups, understand their specific needs, and design solutions that are culturally appropriate and contextual to their realities.

Integrating GESI into NTD programming is essential for effective planning and service delivery. Despite the hard work of the MOH and partners, treatment coverage has remained low. The GESI approach was therefore introduced to ensure that no one is left behind.

This approach uses the iDARE (Identify, Design, Apply/Assess, Record, and Expand) methodology, adapted from WI HER (Women Influencing Health, Education and Rule of Law). It involves identifying root causes, designing solutions based on those gaps, applying the solutions, recording progress, assessing results, and expanding what works.

The approach has been piloted in four counties—Kapoeta North County, Awerial County, Kajo Keji County, and Budi County. Findings from these root cause analyses have directly informed the planning and implementation of MDAs in those counties.

Kebele Elimination of Trachoma for Ocular Health (KETFO) Study

*Presented by Dr. Anraris Hailu Bilchut, Associate Professor of Public Health,
School of Public Health – Debre Berhan University*

The *Kebele Elimination of Trachoma for Ocular Health (KETFO)* trial is a collaborative research effort involving the National Institute of Health, the Francis I. Proctor, Bahir Dar University, the APHI, Eyu-Ethiopia, and The Carter Center.

Azithromycin MDA has been highly effective in eliminating trachoma as a public health problem in many settings. However, trachoma persists in most parts of Ethiopia, despite more than 10 rounds of azithromycin in some districts.

We propose to evaluate whether quarterly, targeted azithromycin distribution to a core group of children is more effective than the current WHO-recommended annual MDA in eliminating trachoma after three years. The aim of this study is to assess the impact of intensive, targeted treatment at the kebele level compared with the standard annual MDA approach.

A four-arm cluster-randomized trial has been conducted in Merhabete District, Amhara Region, Ethiopia, since February 2022. Baseline, 12-month, and 36-month assessments include clinical examinations, conjunctival swabs, and serology, with the primary outcome being ocular *Ct* prevalence at 36 months.

Preliminary results reveal that at baseline, TF was observed in 47% of examined children, declining to 37% at 12 months and further to 11% at 36 months. Preliminary results also showed that at baseline, TI was present in 16% of examined children, decreasing to 10% at 12 months and further to 4% at 36 months. In addition, PCR prevalence was high at baseline; however, by 12 months, it declined by 50–70%, and the 36-month laboratory work is underway to provide definitive comparisons across the intervention arms.

The KETFO trial evaluates whether increased frequency and targeted azithromycin delivery can overcome persistent infection observed under annual MDA. While 12-month aggregated data indicate a reduction, substantial declines in TF and TI are consistently observed across time points, with the greatest reduction at 36 months. The analysis of the 36-month PCR results are currently underway and will provide definitive evidence for policy and are expected to determine whether intensified quarterly strategies are higher than annual MDA in reducing ocular *Ct* prevalence.

Promoting Resilience, Preparedness, Adaptation, and Response to Climate Change in Complex Crises (PREPARE-CC)

*Presented by Drs. Pallavi Kache & Angelia Sanders, Epidemiologist & Senior Program Associate,
The Carter Center – Atlanta*

Climate change is increasingly recognized as a major driver of global health and development challenges, with an estimated 3.6 billion people, nearly 44% of the world's population, living in settings highly vulnerable to climate-related risks. These impacts are disproportionately concentrated in low- and middle-income countries, where climate shocks intersect with economic instability, conflict, population displacement, water and food insecurity, and disease outbreaks to strain already fragile systems. Promoting Resilience, Preparedness, Adaptation, and Response to Climate Change in Complex Crises (PREPARE-CC) is a multi-country, mixed-methods research initiative designed to address the convergence of climate change, conflict, and community health and resilience. The project is centered around 10 highlighted country case studies in Africa, the Middle East, and Asia that provide diverse contextual settings for examining how climate and conflict-related pressures interact across different regions and health system environments.

A key strength of PREPARE-CC is its transdisciplinary and conflict-sensitive approach, which combines quantitative analyses with qualitative research to better capture the lived experiences of affected communities and institutional responses to climate and conflict-related health risks. Using geospatial and statistical analyses that integrate satellite imagery, climate change and extreme weather variables, ACLED and United Nations High Commissioner for Refugees conflict and displacement data, and WHO and the Department of Homeland Security health datasets, the project seeks to generate evidence on spatial and temporal associations between extreme climate events, conflict dynamics, displacement, and health outcomes across the case study countries. In partnership with The Carter Center's Peace Programs, the study includes conflict and contextual assessments, structured document reviews, stakeholder interviews, and focus group discussions to examine how climate and conflict pressures are shaping governance, livelihoods, migration, and health outcomes. Early findings suggest that while conflicts remain highly context-specific and heterogeneous, climate and health stressors frequently act as threat multipliers, intensifying existing vulnerabilities rather than serving as direct causes of conflict. Ultimately, PREPARE-CC seeks to generate actionable evidence and policy recommendations that support more resilient health systems, strengthen preparedness and adaptive capacity, and inform integrated responses to climate and conflict-related crises, including in settings where disease elimination programs such as trachoma control are operating.

WHO Global Elimination of Trachoma Alliance: Success and Remaining Challenges

Presented by Dr. Anthony Solomon, Chief Scientist, Neglected Tropical Diseases, World Health Organization

Trachoma programs are fortunate to benefit from Pfizer's donation of azithromycin, and ITT's careful stewardship of that donation; many partnerships; committed donors; and a robust data ecosystem. In 2024, 87,000 TT surgeries were performed, and 44 million people received antibiotics for trachoma elimination purposes. The number of people needing TT surgery globally was 1.2 million in April 2025, and the number of people qualifying for the A, F, and E components of the SAFE strategy stood at 97 million in November 2025. New data will be available soon. A total of 28 countries have been validated as having eliminated trachoma as a public health problem. Major remaining challenges include the phenomena of: 1) persistent and recrudescence active trachoma, and 2) post-operative TT; a vaccine against *Ct* could help to address the first of these.

Expanded Special Project for Elimination of Neglected Tropical Diseases Update

*Presented by Dr. Amir Bedri Kello, Medical Officer, Trachoma,
World Health Organization – Regional Office for Africa*

The Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN), established in 2016 by the WHO – Regional Office for Africa as a public–private partnership, supports African countries in reducing the burden of the five PC-NTDs amenable to preventive chemotherapy: lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis, and trachoma. These diseases represent nearly 90% of the NTD burden in the African Region. With its mandate extended to 2030, ESPEN developed its third strategic framework for 2026–2030, organized around four thematic pillars—country leadership and technical capacity, access to medicines and diagnostics, AI-driven data and innovation, and regional coordination—and two cross-cutting pillars on health-system integration and gender equity.

Trachoma remains the most significant PC-NTD in the region. As of April 2025, approximately 95.5 million people lived in trachoma-endemic areas in Africa, representing 93% of the global at-risk population. The region also bears 84% of global TT cases, with Ethiopia the most affected country worldwide, accounting for over 65% of the global at-risk population and over one-third of the global TT burden.

Despite the huge burden, the region has achieved notable progress. At present, 18 out of 47 countries remain endemic with trachoma being a public health problem, while six countries—Algeria, Botswana, Guinea, Guinea-Bissau, Namibia, and Sierra Leone—have officially submitted elimination dossiers for validation. Nine countries have already been validated by WHO as having eliminated trachoma as a public health problem between 2018 and 2025, including Ghana, Gambia, Togo, Malawi, Benin, Mali, Mauritania, Burundi, and Senegal.

ESPEN’s support for trachoma includes technical assistance, catalytic financial support for surveys and TT surgery, and guidance for elimination dossier development and finalization. Regional priorities focus on completing baseline mapping, addressing persistent and/or recrudescing areas, strengthening cross-border collaboration, supporting countries through the elimination dossier process and post-validation surveillance.

Pfizer Update

Presented by Miss Julie Jenson, Director, International Product Donations, Pfizer Inc.

Pfizer covered their latest activities in Ethiopia across four pillars. Azithromycin manufacturing remains on track, with production spanning facilities in India and Italy and approximately 50 million doses planned for 2026. The presentation introduces Pfizer's Global Health Investments leadership team, led by Darren Back. Through the Accord for a Healthier World, Pfizer is working to ensure that where people live does not determine the quality of their healthcare—reaching 448 million patients worldwide in 2025. The Pfizer Foundation is focused on improving breast cancer outcomes in Ethiopia by promoting earlier diagnosis, decentralizing care, and targeting 50% treatment completion—partnering with the Clinton Health Access Initiative. Product donations through the Max Foundation have provided oncology treatments to 350 patients at Tikur Anbessa Hospital since 2018, with 180 currently receiving holistic support services. Finally, Global Health Fellows are on the ground in Addis Ababa supporting the Ethiopian Pharmaceuticals Supply Service with supply chain digitization and barcoding integration.

International Trachoma Initiative Update

*Presented by Ms. PJ Hooper, Director, International Trachoma Initiative
& Immediate Past Chair, International Coalition for Trachoma Control*

Background

Since 1998, Pfizer has donated over 1.14 billion doses of azithromycin to 41 countries through ITI, a contribution valued at over \$27.8 billion. As of March 2026, the global population at risk has fallen to 94 million, down from historical highs.

The burden is now heavily concentrated:

- Ethiopia remains the primary focus, accounting for 68% of the global at-risk population and receiving 52% of all historical donated doses.
- Despite the high numbers, Ethiopia shows hidden progress, with a 38% reduction in endemicity from baseline to current levels.
- Other high-burden countries include the Democratic Republic of Congo, Nigeria, South Sudan, and the Central African Republic.

Strategic Challenges and Stewardship

With Pfizer's commitment set to conclude in 2030, ITI is emphasizing drug stewardship to maximize the impact of the donation in the remaining five years. In November 2025, the Trachoma Expert Committee noted that the 2026 supply does not meet current demand. Consequently, they have advised countries and ITI to implement a "Wait and Watch" strategy for districts with low prevalence (TF 5–9.9%) to prioritize resources for highly endemic areas, based on research indicating that districts in this prevalence range typically have very little to no active infection.

Expansion into Child Survival

A significant pivot is occurring as trachoma programs scale down. Following a 2024 Gates Foundation grant, ITI is now managing azithromycin distribution for the REACH (Resiliency through Azithromycin for Child Survival) Network to improve child survival.

In a historic shift, ITI forecasts that in 2026, it will ship more doses for child survival than for trachoma. This transition leverages 28 years of drug stewardship expertise to address broader public health challenges while continuing the push to eliminate trachoma by the 2030 deadline.

International Coalition for Trachoma Control Update

*Presented by Ms. Michaela Kelly, Director, Neglected Tropical Disease Program Delivery, Sightsavers
& Chair, International Coalition for Trachoma Control*

The ICTC brings together non-governmental organizations (NGOs), academia, donors and industry partners around a shared mission: achieving the global elimination of trachoma as a public health problem. Guided by its Strategic Plan 2022–2030, ICTC’s objectives are to mobilize advocacy efforts, increase investment, coordinate technical assistance, and ensure an effective coalition model. ICTC leads and contributes to several communications initiatives. Most recently, ICTC published a press release in collaboration with WHO and ITI highlighting that the number of people requiring interventions against trachoma has fallen below 100 million for the first time since records began. ICTC also publishes bi-monthly trachoma-related resource updates, along with a range of articles, case studies, blogs, infographics, and data sheets to support advocacy efforts and aligned communications among ICTC members. ICTC has recently published new resources to strengthen advocacy and enhance programming. These include a toolkit for delivering trachoma interventions to special populations and a costing analysis of investment gaps in the global trachoma program. ICTC has also updated two preferred practices relating to TT case-finding training and surgical outreach, with three further updates planned for 2026. Additionally, through its new task team, ICTC is working to better understand the challenges surrounding MDA coverage and the tools and approaches partners currently use. The aim is to generate a summary of findings and recommendations for tool use to improve the reliability of coverage estimation.

2026 Trachoma Control Program Review Recommendations

Ethiopia Recommendations:

- The National Program should continue and potentially expand the implementation of more frequent than annual MFTA MDA, with particular focus on persistent, highly endemic areas.
- Considering the burden of trachoma and the delays that have resulted from insecurity, the National Program should prioritize MDA treatments where there is the greatest burden and ensure flexibility in activities to allow for implementation in a region when the security situation allows.
- As insecurity will continue to impact programs, the National Program should consider continued adaptive implementation strategies for MDA and/or surveys, like those presented by the Amhara region of Ethiopia and South Sudan programs.
- Due to the drug shortage and considering evidence that there may be limited infection transmission in areas with TF <10%, programs should continue to implement the Wait & Watch strategy, whereby districts found to be TF <10% at survey will not restart/resume MDA but instead will conduct a trachoma impact survey (with complementary indicators) later.
- As TF is a subjective indicator which might overestimate trachoma transmission in a district, the National Program should consider collecting complementary indicators (*Ct* and/or serology) where it is feasible and could provide important support in the decision-making process.
- The increased use of complementary indicators requires the importation of testing materials, which often incur large customs fees, making the cost of testing more expensive. The National Program should seek and consider importation cost exemption or, at least, reduced fees for these program specific items.
- The National Program should expand the use of FGC into more areas, prioritizing districts that have fulfilled the TF 5% threshold at TSS (or TIS), and once completed, districts can be considered as having “finished” addressing TT as a public health problem.
- As Ethiopia moves closer toward elimination, with some areas having fulfilled the elimination criteria, there is a need to establish a plan for managing incident TT cases within the existing health system. The National Program should begin assessing the existing eyecare structure and determine whether additional human resources will be required to manage incident and PTT cases. As there are many experienced IECWs throughout the regions, the Program should consider whether a new curriculum / training program can be developed for select IECWs; this could establish a path for career advancement by leveraging their existing experience and providing additional training and may fill a potential gap resulting from the limited number of MLECWs available.

Niger Recommendations:

- To minimize loss to follow-up among suspected cases, the National Program should continue to explore ways to reduce the time between *relais* screening and ophthalmic technician confirmation during *ratissage*.
- In alignment with the third criteria for the elimination of trachoma as a public health problem, the National Program should continue to develop and operationalize its transition plan, including strengthening referral systems for incident cases and centralizing *ratissage* data to support the preparation of the elimination dossier.
- To support knowledge sharing across endemic settings, the National Program should document and disseminate lessons learned from the successful *ratissage* experience through publications and other appropriate channels.

South Sudan Recommendations:

- The National Program should implement MFTA MDA in high endemic counties of the country, such as those in Jonglei, Unity, and Upper Nile states.
- To better understand the observed increases in TF prevalence in Unity State, the National Program should conduct a root cause analysis of potential drivers, ideally using a mixed-methods approach that incorporates both programmatic data and key informant interviews.
- Based on the successful integration of complementary indicators into trachoma surveys in Eastern Equatoria State, the National Program should consider expanding their use to other endemic counties and strengthening in-country laboratory capacity for the testing of DBS and conjunctival swabs.
- To inform a national strategy for addressing TT burden, the National Program should pilot documenting FGC in one county, and apply lessons learned to guide national scale-up.
- In response to the phenomenon of pediatric TT observed in Jonglei State and Greater Pibor Administrative Area, the National Program should continue to expand operational research to better understand the population-level epidemiology of the disease, disseminate case studies to the global scientific community, and explore programmatic innovations to improve access to surgical services for confirmed pediatric cases.
- Upon finalization, the National Program should disseminate the National Eye Care Strategic Plan (2025-2030) to key stakeholders.
- The National Program should conduct coverage evaluation surveys in two to four counties each year to monitor the effectiveness of MDA activities. This will help assess treatment coverage, identify deviations from program standards, and enable timely corrective actions to achieve elimination targets.

Sudan Recommendations:

- The National Program should identify how to provide 'TT' surgical services in the states and localities where 'TT' surgeons are now living given significant displacement (from Khartoum).
- The National Program should consider including serology in the seven localities scheduled for trachoma prevalence surveys.
- The National Program should consider identifying local partners in the Darfur region to assist with an MDA that would utilize remaining azithromycin in country.
- The National Program should consider resuming MDA activities in Darfur.
- The National Program should review the 'TT' backlog in localities which have a high 'TT' prevalence and did not receive an MDA.
- The National Program should resume collecting 'TT' surgery monthly reports from eye hospitals.
- The National Program should conduct sensitization campaigns in localities that are recrudescant and persistent.

General Program Recommendations:

- National Programs should seek to promote country-led efforts to examine opportunities for domestic resource mobilization.
- National Programs should increase MDA to four times per year in high transmission settings to accelerate progress to eliminate trachoma as a public health problem to meet 2030 goals.
- National Programs should prioritize WASH interventions in at-risk areas, recognizing the central role of government in the required infrastructure development.
- National Programs should consider serological and *Ct* detection indicators, in targeted areas, to improve transmission assessments and inform focused intervention strategies.
 - Further, National Programs should leverage serological platforms and other disease program data to inform coordinated interventions and improve efficiency.

Trachoma: The Disease

Trachoma, the world's leading cause of infectious blindness, is caused by repeated infections of the conjunctiva (the lining of the eye and eyelid) by the bacterium *Ct*. As of March 2026, the WHO estimates that 1.2 million people, the majority of whom are women, are blind or visually impaired due to trachoma, and another 92 million people are at risk of blindness or severe visual impairment due to trachoma in 29 countries.¹ The early stage of the disease is called inflammatory trachoma and is most common among children. Inflammatory trachoma can present as either the formation of whitish follicles, on the conjunctiva under the upper lid or around the cornea, or as an intense painful or uncomfortable inflammation with thickening of the conjunctiva. Women are repeatedly exposed to inflammatory trachoma in their role as primary caretakers of children. It is therefore not surprising to find that women develop chronic trachoma twice as often as men. Trachoma is transmitted through discharge from the eyes and nose of infected individuals: 1) by contact with hands, towels, and clothing or 2) by flies, which are attracted to ocular and nasal discharge. As individuals are repeatedly infected with *Ct*, subsequent scarring of the conjunctiva deforms the eyelid margin, resulting in eyelashes turning inward and rubbing against the cornea. This condition, called trichiasis, causes disabling pain, physically abrades the cornea, and can lead to corneal opacity and blindness if not corrected.

In 1987, eye care experts and the WHO developed a simplified trachoma grading scale, which facilitated and standardized the diagnosis and identification of all stages of trachoma. In 1997, the WHO established the GET2020 Alliance, which brought international non-governmental development organizations, donors, and researchers together to work collectively in controlling trachoma. The World Health Assembly (WHA) adopted resolution WHA51.11 in 1998, targeting the global elimination of trachoma as a public health problem. In addition, with support from the Edna McConnell Clark Foundation and WHO, the SAFE strategy was created to control trachoma through community-based interventions. The SAFE strategy stands for: Surgery to correct TT, the advanced, blinding stage of the disease; Antibiotics to clear *Ct* infection; and Facial cleanliness as well as Environmental improvement to reduce transmission. In 2004, ICTC, a coalition of NGOs, donors, academic institutions, and other partners, was created to support the GET2020 Alliance and to advocate for the implementation of the SAFE strategy.

Another important development was the finding that the oral antibiotic, azithromycin, taken once or twice annually, is as effective in preventing chronic trachoma as six weeks of daily treatment with TEO, the previously recommended therapy. Pfizer Inc., manufacturer of azithromycin, maintains a commitment to supporting the GET2020 Alliance goal of eliminating trachoma as a public health problem by the year 2030. Since the beginning of the donation in 1998, more than one billion doses of azithromycin have been donated by Pfizer Inc. and managed by ITI. The existence of the donation program has served to invigorate national trachoma programs and reinforce global support for the elimination of trachoma. In 2016, WHO published the dossier template for the validation of the elimination of trachoma as a public health problem. 25 countries fulfilled the criteria to be validated by WHO to have eliminated trachoma as a public health problem.

¹WHO, Weekly Epidemiological Report, Published July 17, 2026.

TT and TF Thresholds for Disease Elimination

The achievement of the *elimination of trachoma as a public health problem* is defined as:

- 1) A prevalence of TT “unknown to the health system” of less than 0.2% among people aged 15 years and older in each formerly endemic district (approximately one case per 1,000 total population);
- 2) A prevalence of trichomatous inflammation-follicular (TF) of less than 5% among children aged one to nine years in each formerly endemic district, sustained for more than two years without mass drug administration (MDA); and
- 3) The existence of a functional system capable of identifying and managing incident TT cases using defined strategies, supported by evidence of appropriate financial resources to implement those strategies.

Through WHA resolution 51.11, trachoma can be eliminated as a public health problem through the implementation of the WHO-endorsed SAFE strategy. The surgery, or S component, should be offered to any individual who is diagnosed with TT to benefit from the surgical treatment. The surgery component also includes case-finding activities, which are recommended when the prevalence of TT is 0.2% or greater among individuals who are 15 years or older. The A, F, and E components of the strategy are recommended for areas in which TF prevalence is 5% or greater in children ages one to nine.

To meet the criteria mentioned above, population-based prevalence surveys, amongst other activities, must be conducted in districts (enumeration units) suspected of being endemic at baseline and then at specified intervals after the start of interventions. Below are the success indicators and procedures often used to determine whether a district or region has achieved thresholds for the elimination of trachoma as a public health problem:

TIS: Must be conducted at least six months after final implemented MDA. If the TF prevalence threshold has been met, the district enters a two-year hold period (no MDA required).

TT activities: If TF prevalence threshold is met, but not TT threshold, then the program must conduct case searching and management activities.

TSS: At the conclusion of the two-year hold period, after the final TIS, a TSS is undertaken. If TT and TF thresholds are met, then the district is considered “transitioned” and no longer warrants interventions. If thresholds are not met, then the district is re-enrolled in TT activities and MDA as appropriate.

Persistent Trachoma: According to the recent WHO-endorsed “Informal Consultation on Endgame Challenges for Trachoma Elimination (2021)”, persistent trachoma refers to an enumeration unit with at least two TISs at which TF prevalence in children aged one to nine is 5% or greater, without ever having recorded a prevalence below 5%.

Recrudescent Trachoma: According to the same endgame challenges report, recrudescent trachoma is defined as an enumeration unit with at least one TSS at which TF is 5% or greater.

The Endgame Challenges Informal Consultation included several recommendations to address the problems of persistence and recrudescence. These include the delivery of MFTA MDA, with the

possibility of additional MDA rounds being delivered only to demographic subgroups with the highest prevalence of conjunctival *Ct* infection. For districts with lower levels of trachoma, a “Wait and Watch” approach was recommended, whereby a program discontinues MDA and continues surveillance if there is a justifiable expectation that TF in children ages one to nine will regress to less than 5%. In terms of monitoring, the consultation recommended the inclusion of the collection of samples to monitor conjunctival *Ct* infection and exposure to *Ct* infection.

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Monday, March 30		
6:30 AM – 8:30 AM	Breakfast	Hub Restaurant
8:30 AM – 9:00 AM	Check-in & Registration	Ballroom A
9:00 AM – 9:15 AM	Meeting Management	MYT & Dr. Angelia Sanders
	Morning Chairperson Welcome & Introductions	Senior Associate Director, Trachoma Control Program The Carter Center – Atlanta
9:15 AM – 9:45 AM	Ministry of Health Opening Remarks	Dr. Dereje Duguma State Minister of Health Ministry of Health – Ethiopia
9:45 AM – 9:50 AM	World Health Organization Message	Dr. Tedros Adhanom Ghebreyesus Director-General World Health Organization
9:50 AM – 10:10 AM	Trachoma Control Program Overview	Ms. Kelly Callahan Director, Trachoma Control Program The Carter Center – Atlanta
10:10 AM – 10:55 AM	Ethiopia 2025 Program Update (Q&A)	Mr. Tesfahun Bishaw Neglected Tropical Diseases Program Manager Ministry of Health – Ethiopia
10:55 AM – 11:25 AM	Break	
11:25 AM – 12:10 PM	Amhara 2025 Program Update (Q&A)	Mr. Adisu Abebe Neglected Tropical Diseases Case Team Leader Amhara Regional Health Bureau
Water, Sanitation, and Hygiene (WASH)		
12:10 PM – 12:30 PM	WASH Upgrades for Health in Amhara (WUHA) Study	Dr. Solomon Aragie Researcher The Carter Center – Ethiopia
12:30 PM – 12:50 PM	Stronger SAFE Study	Dr. Katie Greenland Assistant Professor London School of Hygiene and Tropical Medicine
12:50 PM – 1:05 PM	School Trachoma Program - Amhara	Mr. Ayenachew Kerie Behavior Change Communication Officer The Carter Center – Ethiopia
1:05 PM – 1:20 PM	NTD Advocacy, Learning, Action (NALA) WASH Update	Ms. Nisan Z. Kesete Country Director NALA Foundation
1:20 PM – 1:35 PM	Q&A	
1:35 PM – 2:35 PM	Lunch	
2:35 PM – 2:40 PM	Afternoon Chairperson Welcome	Dr. Zenhun Tadesse Senior Country Representative The Carter Center – Ethiopia
Complementary Indicators		
2:40 PM – 3:00 PM	Using Complementary Indicators in Programmatic Decision Making	Mr. Eshetu Sata Trachoma Program Manager The Carter Center – Ethiopia

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3:00 PM – 3:15 PM	A Longitudinal Study of Trachoma Infection Clearance and Re-Acquisition in a Persistently Hyperendemic Setting (ATIRA) Study	Mr. Mikiyas Gebremichael Epidemiologist & Researcher London School of Hygiene and Tropical Medicine
3:15 PM – 3:30 PM	The Duration of Active Trachoma and Viable <i>Chlamydia trachomatis</i> Infection in Ethiopia: A Cohort Study	Dr. Oumer Shafi Consultant Sightsavers Researcher London School of Hygiene and Tropical Medicine
3:30 PM – 3:45 PM	Use of Molecular Diagnostic Platforms for Trachoma Monitoring	Dr. Barbara Van Der Pol Professor University of Alabama at Birmingham
3:45 PM – 4:00 PM	Recent Serological and Infection Results in Amhara	Mr. Zebene Ayele Monitoring & Evaluation Officer The Carter Center – Ethiopia
4:00 PM – 4:15 PM	Q&A	
4:15 PM – 4:45 PM	<u>Break</u>	
Global Trachoma Partners Updates		
4:45 PM – 4:55 PM	WHO Global Elimination of Trachoma Alliance: Success and Remaining Challenges	Dr. Anthony Solomon Medical Officer for the Control, Elimination and Eradication of Trachoma, Guinea Worm and Yaws World Health Organization
4:55 PM – 5:05 PM	ESPEN Update	Dr. Amir Bedri Kello Medical Officer, Trachoma World Health Organization - Regional Office for Africa
5:05 PM – 5:15 PM	Pfizer Update	Miss Julie Jenson Director, International Product Donations Pfizer, Inc.
5:15 PM – 5:25 PM	International Trachoma Initiative Update	Ms. PJ Hooper Director, International Trachoma Initiative & Immediate Past Chair, International Coalition for Trachoma Control
5:25 PM – 5:35 PM	International Coalition for Trachoma Control Update	Ms. Michaela Kelly Director, Neglected Tropical Disease Program Delivery Sightsavers Chair, International Coalition for Trachoma Control
5:35 PM – 5:50 PM	Q&A	
5:50 PM – 6:00 PM	Closing Remarks	Dr. Kashef Ijaz Vice President, Health Programs The Carter Center – Atlanta
6:00 PM – 8:00 PM	Reception	Ballroom C

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Tuesday, March 31		
6:30 AM – 8:30 AM	Breakfast	Hub Restaurant
8:30 AM – 9:00 AM	Check-in & Registration	Ballroom A
9:00 AM – 9:10 AM	Meeting Management & Morning Chairperson Welcome	MYT & Dr. Scott Nash Senior Associate Director, Trachoma Control Program The Carter Center – Atlanta
9:10 AM – 9:55 AM	Niger 2025 Program Update (Q&A)	Mr. Nassirou Baido for Dr. Ibrahim Almou Epidemiologist, National Eye Health Program & Director, National Eye Health Program Ministry of Health – Niger
Surgical/Eye Care		
9:55 AM – 10:10 AM	Niger - <i>Ratissage</i>	Mr. Nassirou Baido & Mr. Illyassou Issa Epidemiologist, National Eye Health Program & Ophthalmology Technical Advisor The Carter Center – Niger
10:10 AM – 10:25 AM	Preparing for the Trachomatous Trichiasis Endgame - Amhara	Mr. Begashaw Hailemariam Program Officer The Carter Center – Ethiopia
10:25 AM – 10:35 AM	Surgeon Attrition and Productivity Study in Five Regions of Ethiopia	Dr. Michael Dejene Consultant Epidemiologist Sightsavers/Tropical Data
10:35 AM – 10:45 AM	Monitoring Eye Health Indicators in Trachoma Surveys	Dr. Emma Harding-Esch Associate Professor London School of Hygiene and Tropical Medicine
10:45 AM – 11:00 AM	Q&A	
11:00 AM – 11:30 AM	Break	
11:30 AM – 12:15 PM	South Sudan 2025 Program Update (Q&A)	Mr. Yak Yak Bol National Coordinator Preventative Chemotherapy-Neglected Tropical Diseases Ministry of Health – South Sudan
12:15 PM – 12:35 PM	Pediatric Trachomatous Trichiasis Detection and Services in South Sudan	Dr. Pallavi Kache & Dr. Angelia Sanders Epidemiologist & Senior Associate Director Trachoma Control Program The Carter Center – Atlanta
12:35 PM – 12:50 PM	South Sudan Gender Equity and Social Inclusion Study	Dr. Abuk Peter Gender Equity & Social Inclusion Focal Person Ministry of Health – South Sudan
12:50 PM – 1:00 PM	Q&A	
1:00 PM – 2:00 PM	Group Photo & Lunch	
2:00 PM – 2:05 PM	Afternoon Chairperson Welcome	Dr. Sara Lavinia Senior Country Representative The Carter Center – Sudan

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Accessing Hard-to-Reach Populations		
2:05 PM – 2:15 PM	International Coalition for Trachoma Control New Publication - Hard to Reach Populations	Dr. Angelia Sanders Senior Associate Director, Trachoma Control Program The Carter Center – Atlanta
2:15 PM – 2:30 PM	Adaptive Programming: Implementing Trachoma Surveys and Mass Drug Administration (MDA) in Insecure Districts Amhara, Ethiopia	Mr. Ayalew Shiferaw & Mr. Mohammed Feyisso Senior Program Officer & Epidemiologist The Carter Center – Ethiopia
2:30 PM – 2:45 PM	Mass Drug Administration in Cattle Camps	Mr. Stephen Ohidor Trachoma Program Manager The Carter Center – South Sudan
2:45 PM – 3:00 PM	Reaching Mobile and Migrant Populations – Experience from Trachoma Surveys in Uganda	Dr. Jeremiah Ngondi Epidemiologist AFYAZEN Consulting
3:00 PM – 3:15 PM	Q&A	
3:15 PM – 3:45 PM	Break	
3:45 PM – 4:15 PM	Sudan 2025 Program Update (Q&A)	Dr. Sara Lavinia for Dr. Balgesa Elshafie Senior Country Representative, The Carter Center – Sudan & National Coordinator for Trachoma Control Program Federal Ministry of Health – Sudan
4:15 PM – 4:30 PM	Kebele Elimination of Trachoma for Ocular Health (KETFO) Study	Dr. Awraris Hailu Bilchut Associate Professor of Public Health School of Public Health – Debre Berhan University
4:30 PM – 4:45 PM	Promoting Resilience, Preparedness, Adaptation, and Response to Climate Change in Complex Crises (PREPARE-CC)	Dr. Pallavi Kache & Dr. Angelia Sanders Epidemiologist & Senior Associate Director Trachoma Control Program The Carter Center – Atlanta
4:45 PM – 4:55 PM	Q&A	
4:55 PM – 5:05 PM	Closing Remarks	Ms. Paige Alexander Chief Executive Officer The Carter Center – Atlanta