GREEN LIGHT COMMITTEE INITIATIVE

of the Working Group on MDR-TB
of the Stop TB Partnership

ANNUAL REPORT 2007

World Health Organization

Green Light Committee (GLC) of the
Working Group on MDR-TB
STOP TB PARTNERSHIP
Secretariat housed at WHO Geneva

US Centers for Disease Control and Prevention, Partners in Health (Harvard Medical School), International Union against Tuberculosis and Lung Diseases, National Tuberculosis Programme Latvia, KNCV Tuberculosis Foundation, Médicins Sans Frontières, Hospital Muniz, World Care Council and World Health Organization

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MESSAGE FROM THE CHAIR

As the global burden of drug resistant tuberculosis (DR-TB) continues to threaten TB control, the international community is faced with the challenge of how to deliver effective TB care to the many patients suffering from disease caused by highly-resistant strains such as multidrug-resistant TB (MDR-TB). Since its inception in 2000, the Green Light Committee (GLC) Initiative has worked to ensure that patients receive appropriate treatment for drug-resistant TB, that prevent the emergence of further drug resistance, with quality-assured second-line drugs. Since then, the GLC has approved over 30,000 patient treatments in 69 projects spanning 51 countries. Data from these projects has contributed to the evidence base for the programmatic management of DR-TB, and has played a significant role in shaping global policy on MDR-TB/XDR-TB. Much of this is reflected in the updated *Guidelines for the programmatic management of drug-resistant tuberculosis* released in April 2008.

Our achievements to date have been reached through broader awareness of the benefits of the GLC Initiative, ongoing outreach on the part of WHO Regional Offices, and countries' eagerness to include DR-TB treatment in their national strategies (as recommended in the Global STOP-TB strategy). Although the temptation is to congratulate ourselves on the progress that has been made in recent years, the challenges are still formidable. We in the global TB community must face the reality that the GLC Initiative enables access to treatment to less than 10,000 patients a year; a small number compared to the estimated 490,000 new MDR-TB cases occurring annually. For those outside of GLC programs, treatment is often with drugs of unknown quality under treatment regimens that do not conform to the current global standard of care. The majority of DR-TB patients in the world receive no treatment; they transmit the disease and often die.

The scourge of more severe forms of MDR-TB, such as XDR-TB, has underscored the danger of leaving MDR-TB untreated or poorly treated, especially in the face of HIV. We in the global TB community are at the cusp of a significant paradigm shift, with expectations that national programs must provide integrated universal care for TB and DR-TB. With innovative funding mechanisms such as the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM) and UNITAID, our primary challenge now is to build country-level capacity to make universal high-quality treatment of DR-TB a reality.

In 2008, the GLC Initiative will continue to work in close collaboration with the Global Laboratory Initiative (GLI), second-line anti-TB drug manufacturers, National Tuberculosis Programs, public-private TB partnerships, innovative funding mechanisms, and other key partners in the STOP-TB Partnership and the MDR-TB Working Group to ensure that high quality care with quality-assured second-line drugs are available to as many patients as possible.

On behalf of the GLC I want to thank all those who have worked to make MDR-TB treatment possible for so many patients, and look forward to working together as we face the challenges ahead.

Salmaan Keshavjee
MD, PhD
Chair
Green Light Committee

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EXECUTIVE SUMMARY

In 2007, the Green Light Committee (GLC) Initiative achieved yet another milestone by reaching **51** countries, including several in the most remote areas of the world where management of drug-resistant tuberculosis presents a real challenge.

The number of GLC approved programs has been consistently rising since the establishment of the GLC in 2000. At the end of 2007, the GLC Initiative included **69** program sites with **30,206** patients to treat.

Although most of the countries were still at the stage of establishing centres of excellence and implementing pilot programs, a significant number of countries began expanding their services nationally. In 2007 this included such countries as Peru, Russia, and the Philippines.

This year particularly marked an increase in donor support for the GLC approved programs. More than 70% of the GLC donor and partner contributions in 2007 were committed to the procurement of affordable quality-assured second-line anti-TB drugs (SLDs) (see diagram 7). This was made possible by UNITAID, an international drug purchasing facility that in 2007 provided over US$7 million for the delivery of SLDs to recipients in 10 low and lower middle income countries[1].

As the level of external funding has steadily increased over the last decade, countries also have made bigger political and financial commitments towards programs dealing with drug-resistant TB. External funding, however, remained the main source of income to fund GLC approved MDR-TB programs for many countries. One of the biggest funders of the GLC approved programs was The Global Fund, which supported treatment of **23,661** patients, or **78%** of all patients approved under the GLC Initiative since 2000.

Given that there are close to 500,000 new cases of multidrug-resistant tuberculosis (MDR-TB) emerging globally every year, countries must respond rapidly by integrating diagnostic, treatment and care facilities for MDR-TB in their national plans for TB and speed up the enrolment of patients into treatment programs.

As progress is being steadily made, the GLC will continue strengthening its services and partner network in order to help countries to offer quality treatment and care and reduce the impact of MDR-TB on patients and their communities.

[1] World Bank Classification, see www.worldbank.org

INTRODUCTION

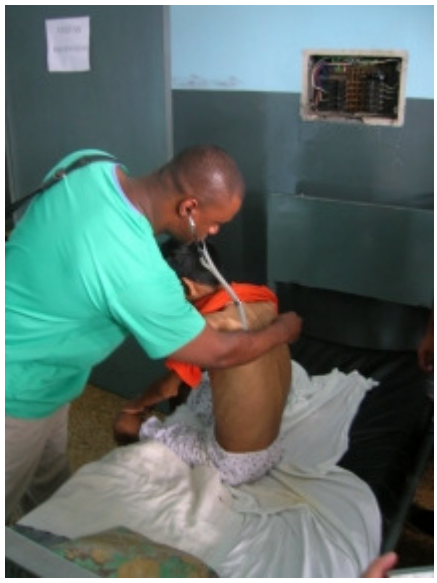
Component Two of the Stop TB Strategy calls for the control and prevention of multidrug-resistant tuberculosis (MDR-TB) through:

(i) increased access to quality-assured SLDs; and
(ii) prevention of development of resistance to anti-TB drugs.

The Green Light Committee (GLC) Initiative, together with the Working Group on MDR-TB, promotes implementation of this strategy in accordance with the Global Plan to Stop TB (2006–2015) and the Global MDR/XDR-TB Response plan (2007–2008).

Established in 2000 by WHO and partners, the **GLC Initiative** is the mechanism that enables effective control of MDR-TB and access to affordable, high-quality, SLDs for the treatment of MDR-TB. Its objectives are:

- *ensuring effective treatment of patients with MDR-TB in accordance with guidelines published by the World Health Organization (WHO) on the programmatic management of drug-resistant tuberculosis (WHO Guidelines);*
- *promoting access to technical assistance to facilitate rapid scale-up of MDR-TB management;*
- *increasing access to quality-assured, affordable, SLDs for the treatment of MDR-TB among well-performing programs;*
- *preventing the development of resistance to SLDs by ensuring drug use in accordance with the WHO Guidelines; and*
- *advising WHO on policy-related matters to effectively prevent and control MDR-TB based on the best available scientific evidence.*



Source: www.livinginperu.com

The core of the GLC Initiative is composed of the expert technical committee, the Secretariat, and the Global Drug Facility (GDF).

The Green Light Committee (GLC) reviews and approves applications for treatment of people with MDR-TB using affordable and quality-assured anti-TB drugs procured through the GLC Initiative.

The Initiative is coordinated by the **GLC Secretariat,** which is hosted and administered by the WHO.

The Global Drug Facility (GDF), an arm of the Stop TB Partnership, hosted and administered by WHO, carries out drug procurement for GLC-approved programs.

WHO and its technical partners provide technical assistance to GLC-approved MDR-TB programs.

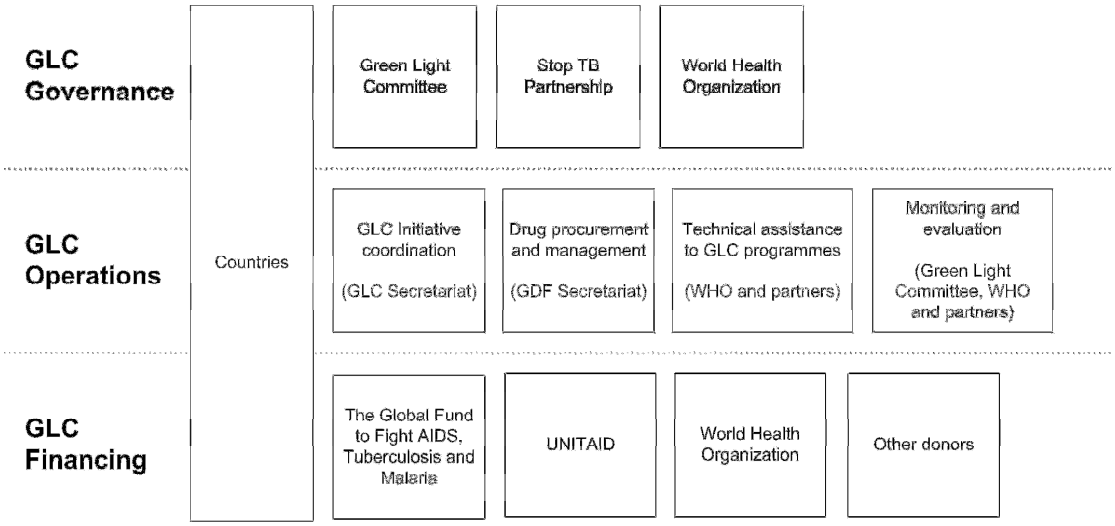


Diagram 1: The GLC Initiative

COMMITTEE MEMBERSHIP

The GLC is comprised of representatives from 9 institutions with specific programmatic, clinical, advocacy, scientific and managerial expertise. Its membership rests with institutions, not individuals. WHO is a permanent member of the Committee. All other institutions are normally drawn from the Stop TB Partnership Working Group on MDR-TB.

In February 2007, the Committee approved its Operating Procedures which govern the review, as well as the election process of new GLC members and the GLC Chair.

Key Changes

At the 44th GLC meeting in August 2007, Dr. Karin Weyer from the Medical Research Council for South Africa (MRC) stepped down from the chairmanship of the GLC. Dr. Salmaan Keshavjee from Partners in Health (PIH) was formally elected as the new Chair. At the same meeting, MRC announced its departure

As of December 2007, members of the GLC included (principal member listed first):

Partners In Health (PIH) -
Salmaan Keshavjee - Chair
Jaime Bayona

KNCV Tuberculosis Foundation
Kitty Lambregts
Agnes Gebhard

International Union Against Tuberculosis & Lung Disease (IUATLD)
Jose Caminero
Arnaud Trebucq

Hospital General de "Francisco J. Muniz"
Domingo Palmero
Cristina Brian

U.S. Centers for Disease Control and Prevention (CDC)
Timothy Holtz
Charles Daley

State Agency for TB & Lung Disease, Latvia
Vaira Leimane
Gunta Dravniece

Médecins sans Frontières (MSF)
Francis Varaine

World Care Council (WCC)
Case Gordon
Neichu Angami

World Health Organization (WHO)
standing member
Ernesto Jaramillo
Fuad Mirzayev