GREEN LIGHT COMMITTEE INITIATIVE

of the Working Group on Multidrug-Resistant Tuberculosis (MDR-TB) of the Stop TB Partnership

Green Light Committee Initiative

Scaling up the global fight against MDR-TB

ANNUAL REPORT 2009

World Health Organization

Stop TB Partnership

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of the Working Group on Multidrug-resistant Tuberculosis

of the Stop TB Partnership

Green Light Committee (GLC) of the Working Group on MDR-TB STOP TB PARTNERSHIP

Secretariat housed at WHO Geneva

Hospital Francisco J. Muñiz
Indus Hospital
International Union against Tuberculosis and Lung Diseases
KNCV Tuberculosis Foundation
Médecins Sans Frontières
State Agency Infectology Centre of Latvia Tuberculosis and Lung Diseases Clinic
Partners in Health
United States Centers for Disease Control and Prevention
World Health Organization

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Message from the GLC Chair

Since its inception in 2000, the Green Light Committee (GLC) Initiative has worked to ensure that patients receive appropriate treatment for drug-resistant tuberculosis (DR-TB) with quality-assured second-line drugs (SLDs) in programmatic settings that prevent the emergence of further drug resistance. By the end of 2009, more than 63 000 patients had been approved for treatment in 113 projects spanning 71 countries; to date, 29 000 patients have received or are currently receiving treatment for multidrug-resistant tuberculosis (MDR-TB).

As we mark the tenth anniversary of the GLC, the successes of this approach are clearly evident. On the policy level, the clinical and programmatic management of MDR-TB has been accepted as an integral part of national TB control strategies worldwide. A number of high-MDR-TB burden countries have created national plans for the scale-up of diagnostic and patient-management capacity; more countries now have plans for universal access to MDR-TB treatment than ever before.

Despite these successes, it is clear to all partners in this mechanism that in order to achieve global universal access to MDR-TB treatment in a timely fashion, we need to rethink our approaches to scale-up. Early diagnosis of drug resistance continues to be a major challenge. Since the beginning of 2008, the GLC Initiative has been working in close collaboration with the Global Laboratory Initiative (GLI) to ensure appropriate diagnostic capacity in countries. The GLI is on track to diagnose more than 130 000 DR-TB patients by 2011. While this is a major step forward, much more needs to be done by countries to ensure that they have the required diagnostic capacity to cope with this growing epidemic.

After diagnosis, it is essential that patients with drug-resistant TB be managed within programmes capable of monitoring adverse events and reliably delivering treatment over 18–24 months. This means access to both quality-assured second-line anti-TB drugs and strengthened programmatic capacity in countries. Innovative funding mechanisms, such as the Global Fund to fight AIDS, Tuberculosis and Malaria and UNITAID, put universal treatment for MDR-TB within reach for many countries. The task before the international TB community is to develop appropriate mechanisms that will ensure that countries are able to undertake this complex health intervention: not only will international partners have to change the way that technical assistance is provided to countries (over the spectrum of short, medium and long term, augmented by Technical Assistance Centres), but countries will have to adopt innovative approaches to care delivery. The World Health Assembly called for community-based approaches to care last year, in its resolution WHA62.15. Models for using networks of ambulatory care that extend into patient communities already exist. We are now at the critical juncture of ensuring that what we have learned globally over the last two decades is

disseminated and adapted to different country settings with the rapidity that befits this airborne epidemic.

The GLC, the Stop TB Partnership and the World Health Organization (WHO) are all currently involved in thinking about how best to achieve the goal of universal treatment for MDR-TB. As we look to the future, it is clear that the GLC mechanism will need to adapt to changing global circumstances and needs. As I approach the end of my term as Chair of the GLC, on behalf of the committee I should like to thank all our colleagues in the MDR-TB Working Group, the Global Drug Facility, the Stop TB Partnership, WHO and international partner organizations – and in the countries themselves – for their work in ensuring that this vision of universal access to MDR-TB treatment becomes a reality. We look forward to our continued work together.

Salmaan Keshavjee, MD, PhD
Chair
Green Light Committee

Message from the GLC Secretariat

The 10th anniversary of the GLC Initiative is approaching and with it the time to look back, celebrate achievements, draw lessons learned and review our approach to the problems encountered and challenges that remain to be tackled.

The GLC was established in 2000, recognizing that MDR-TB could not be managed without access to quality-assured SLDs against -tuberculosis. Furthermore, it was not known whether a complex health intervention such as MDR-TB management could effectively be implemented in resource-limited settings.

Since then, quality-assured SLDs have become much more widely available, and the GLC Initiative with all its partners was able to show that MDR-TB management is feasible and can be implemented according to international standards in resource-limited countries.

These achievements would not have been possible without the generous backing of donors, in particular the Global Fund, PEPFAR, UNITAID and Eli Lilly, all of which are deeply engaged and continue to extend their support to treat and care for people with MDR-TB.

The applications that programmes have submitted to the GLC during 2009 clearly show that there is a need to move from pilot projects to countrywide implementation plans, otherwise universal access will not become a reality. Indeed, while the GLC Initiative has been successful in demonstrating proof of principle and there have been year on year increases in the number of patients treated in GLC programmes, progress towards reaching universal access to MDR-TB diagnosis and treatment has been insufficient. Currently only 10% of estimated MDR-TB patients are being diagnosed, 30% of whom are being treated according to WHO standards, and thus only 3–4% of all estimated MDR-TB cases receive gold standard care.

The GLC Initiative will have to renew itself by taking into account the changing environment and circumstances in which it operates; it has started to do so with a global debate on how to best support scale-up of DR-TB management.

When analysing the reasons why scale-up has been so slow, while global agencies must take some responsibility, the main challenges are being faced at the country level. The development of in-country capacity through various mechanisms, while taking into account the respective local requirements, will be key for moving ahead over the coming years.

Programmes, partners and members need to join forces to make sure that universal access to DR-TB management by 2015 does not become an empty promise.

In 2009, partners and WHO started to review the current GLC mechanism in order to better meet the needs of programmes and countries scaling up DR-TB management under evolving circumstances and we will continue to do so in 2010.

We look forward to continuing working with you.

Dr Wieslaw Jakubowiak
Team Leader
Green Light Committee Secretariat