The Green Light Committee
Progress Report

Karin Weyer
Rationale for the GLC

- 425,000 MDR-TB cases emerge every year
- Without appropriate treatment MDR-TB continues to spread
- With inadequate treatment or poor quality drugs incurable TB strains can develop and spread
- GLC a unique mechanism for access to affordable, quality-assured treatment
Objectives of the GLC Initiative

- To ensure effective treatment of patients with drug-resistant TB, following WHO guidelines
- To increase access to high-quality, affordable second-line anti-TB drugs for the treatment of DR-TB in well-organized programmes
- To prevent the amplification of resistance to second-line anti-TB drugs by ensuring rational drug use
- To increase access to technical assistance to facilitate rapid scale-up of DR-TB management
- To advise WHO on policy issues to effectively prevent and control DR-TB based on the best available scientific evidence
The GLC Initiative

ACCESS
(Quality & Price)

RATIONAL USE

POLICY

GLC Initiative

Pre-qualification

Pooled procurement

Operational research

Guideline development

Application review

Technical assistance

Monitoring & evaluation

Operational research
GLC Initiative

- GLC Secretariat
  - Country and partner liaison

- GLC Committee
  - Expert review and WHO advisory body

- GDF drug procurement & management
  - IDA as procurement agent
GLC Initiative

Diagram 1: The GLC Initiative
GLC membership

- Multi-institutional partnership (principal and alternate institutional members)
  - CDC, USA
  - Hospital FJ Műniz, Argentina
  - KNCV
  - Latvia NTP
  - Medical Research Council, South Africa
  - Partners in Health
  - The Union (IUATLD)
  - World Care Council
  - WHO

- GLC secretariat provided by WHO
Internal GLC reform

- Membership expanded (including community representation)
- Operating procedures standardised and streamlined
- Bi-monthly structured meetings plus *ad hoc* consultation if necessary
- Off-cycle, fast-track review process
- System for pre-application needs assessment and technical assistance to facilitate application process
- Rapid communication of estimated drug needs of approved projects to GDF
GLC action cycle

Pre-application
- Needs assessment
- Gap analysis

GLC secretariat
- Application completeness
- Supporting documentation

WHO Partners

Country application
- DR situation defined
- WHO Guidelines framework in place
- Stakeholders & funding identified
- Laboratory capacity established

GLC committee
- Technical review
- Approval

Drug regulatory issues

Drug procurement

Technical support / M&E

Supply chain management

WHO Partners

GDF
Advantages of GLC mechanism

- Access to DR-TB management expertise, best evidence and collective experience
- Access to high-quality, affordable second-line drugs
- Technical assistance through broad partnership network
- Peer support and knowledge sharing
- Independent external monitoring and evaluation
- Dedicated funding through GF, UNITAID
- Increased rational use of drugs
- Input into operational research and growing evidence base for policy development
Summary of GLC Applications
June 2000 – August 2007

- Meetings: 44
- Applications reviewed: 116
- Project sites: 68
- Countries: 48
- Applications approved: 90
- GF sites approved: 27
- Cohort expansion sites approved: 19
- Patients in approved projects: 29,824
MDR-TB Projects approved by GLC
September 2007

1. Bangladesh
2. India
3. Nepal
4. Timor-Leste

1. Burkina Faso
2. DR Congo
3. Guinea
4. Kenya
5. Lesotho
6. Rwanda
7. Uganda

1. Egypt
2. Jordan
3. Lebanon
4. Syria
5. Tunisia

1. Cambodia
2. China
3. Mongolia
4. Philippines
5. Vietnam
# 48 countries: 27 with GF support

### GF support

1. Azerbaijan  
2. Bangladesh  
3. Bolivia  
4. Burkina Faso  
5. China  
6. DR Congo  
7. Dominican Republic  
8. Ecuador  
9. Egypt  
10. Georgia  
11. Guatemala  
12. Honduras  
13. India  
14. Kenya  
15. Kazakhstan  
16. Kyrgyzstan  
17. Mongolia  
18. Moldova  
19. Nicaragua  
20. Peru  
21. Philippines  
22. Paraguay  
23. Romania  
24. Russia  
25. El Salvador  
26. Timor-Leste  
27. Uzbekistan

### Domestic or other donor support

- Armenia  
- Belize  
- Costa Rica  
- Estonia  
- Guinea  
- Haiti  
- Jordan  
- Cambodia  
- Lebanon  
- Lesotho  
- Lithuania  
- Latvia  
- Mexico  
- Nepal  
- Rwanda  
- Syria  
- Tunisia  
- Vietnam  
- Ukraine  
- Uganda  
- Uruguay
Gap between requests to GLC and Global Response Plan

<table>
<thead>
<tr>
<th>Year</th>
<th>GLC</th>
<th>Response Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>30,000</td>
<td>1,600,000</td>
</tr>
<tr>
<td>2001</td>
<td>1,600</td>
<td>1,600</td>
</tr>
<tr>
<td>2002</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2003</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2004</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2005</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2006</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2007</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2008</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2009</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2010</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2011</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2012</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2013</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2014</td>
<td>30,000</td>
<td>1,600</td>
</tr>
<tr>
<td>2015</td>
<td>30,000</td>
<td>1,600</td>
</tr>
</tbody>
</table>

Thousands

Request to GLC vs. Global Response Plan

- **GLC**: Graph shows a steady increase from 30,000 in 2000 to 1,582 in 2015.
- **Response Plan**: Graph shows a steady increase from 1,600 in 2000 to 1,600,000 in 2015.

The gap between GLC requests and the response plan exceeds 1,600,000 in 2015.
Barriers to MDR-TB scale-up: GLC perspectives

1. Diagnostic capacity
2. Drug supply
3. Training and Technical assistance
Diagnostic capacity

- Less than 5% of estimated MDR-TB cases detected due to lack of appropriate laboratory infrastructure
  - Urgent and massive scale-up of adequately funded, appropriate, safe, quality-assured laboratory networks
  - Emergency plans for staff training and retention
  - Active promotion of rapid R testing
  - Standardization of SLD DST
Building laboratory capacity

- Policy guidance on SLD DST
- Technical manual on SLD DST
- Expansion of SRL Network
- SLCS business plan
- SLCS resource mobilization plan
- Model-based approach (FIND-Lesotho)
- Interim use of excess laboratory capacity in resource-rich settings
Uninterrupted access to quality-assured second-line drugs

- Global shortages in supply of capreomycin, cycloserine, PAS - even for 30,000 patients currently eligible
- Lack of enough pre-qualified suppliers
- Lack of accredited laboratories to ensure drug quality and compliance with WHO-GMP practices
- Absent or neglected country-specific drug regulatory aspects
Uninterrupted access to quality-assured second-line drugs

- Subgroup on Drug Management
- Models for reliable drug forecasting and supply chain management
- Strategic stockpile and mechanisms for rapid response
- Accelerated list of pre-qualified suppliers
- Network of laboratories for drug quality assessment (stability, dissolution, bio-availability and bio-equivalence testing)
- Early country-specific intervention on drug regulatory issues
Training and Technical Assistance

- Cadre of trained MDR-TB consultants not adequately utilized or effectively deployed due to budget constraints
- Training capacity limited to a few academic institutions and WHO collaborating centres
- Training materials in need of adaptation for high-burden HIV settings
- Infection control demands
Training and Technical Assistance

- Coordinated, broad-based, accelerated partnerships to meet demand for MDR-TB scale-up
- Network of regional training centres specific to epidemiological, clinical, programmatic needs
- Improvement in infection control strategies and interventions
Contacts

- Assistance with programmes
  WHO regional or country offices

- Monitoring & evaluation
  glc_secretariat@who.int

- Technical assistance
  WHO regional or country offices

- Drug procurement
  gdf@who.int
# Green Light Committee 2007

<table>
<thead>
<tr>
<th>Organization</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDC</td>
<td>Tim Holtz (Charles Nolan), Chuck Daley</td>
</tr>
<tr>
<td>Latvia NTP</td>
<td>Vaira Lemaine, Gunta Dravniece</td>
</tr>
<tr>
<td>Hospital FJ Muniz, Argentina</td>
<td>Domingo Palmero, Maria Brian</td>
</tr>
<tr>
<td>KNCV</td>
<td>Kitty Lambregts, Agnes Gebbard</td>
</tr>
<tr>
<td>PIH</td>
<td>Salmaan Keshavee (Michael Rich), Jaime Bayona</td>
</tr>
<tr>
<td>SAMRC</td>
<td>Karin Weyer, Martie van der Walt</td>
</tr>
<tr>
<td>Union</td>
<td>Jose Caminero, Arnaud Trébucq</td>
</tr>
<tr>
<td>WHO</td>
<td>Fuad Mirzayev, Ernesto Jaramillo</td>
</tr>
<tr>
<td>WHO-GLC Secretariat</td>
<td>Irina Sahakyan</td>
</tr>
<tr>
<td>World Care Council</td>
<td>Case Gordon, Alberto Colorado</td>
</tr>
</tbody>
</table>
Announcements

• GLC call for nominations

• New GLC chair – Salmaan Keshavee, PIH

Congratulations!