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Subcommittee on Africa, Global Health, Global Human Rights and International Organizations
"Drug Resistant TB: The Next Global Health Crisis"
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Mr. Chairman, Ranking Member Bass and members of the Subcommittee, it is a privilege to be with you today at this important hearing on drug resistant tuberculosis and its potential to turn into the next global health crisis.

TB is now the number one infectious disease killer in the world, surpassing HIV/AIDS according to the latest World Health Organization (WHO) report on TB. In this case, being number one is not an achievement – there is no trophy for taking more lives than any other disease. While major strides have been made in the effort to reduce the burden of TB the emergence of drug resistant organisms presents a major challenge to patients and doctors.

4,100 people a day die from TB. Of the estimated 9 million annual deaths from all infectious causes, 1.5 million are attributed to tuberculosis. That translates into one out of six deaths of all infectious diseases. An estimated 1 million children became ill with TB and 140,000 children died of TB in 2014.

Today, we can prevent, treat and cure TB. The world has joined together to set the goal to End TB by 2035 but we will not do so without radically changing the path we are on. At the current rate – reducing incidence by 1.5% per year it will take nearly 200 years to achieve this goal. Putting in place universal health coverage for an essential set of health-care interventions, including TB diagnosis and treatment, will be of great importance if we want to successfully combat TB.

TB is also the most common cause of death among people living with HIV in sub-Saharan Africa. More than 1,000 people infected with HIV die every day from TB. Tuberculosis and HIV/AIDS constitute a deadly combination that speeds the progression of illness and death. As the former US Global AIDS Coordinator and the current UN Special Envoy on TB, I can attest to the fact that HIV/AIDS and TB are true partners in crime.

The problem of TB is not evenly distributed around the world. Today there are 22 high burden countries that account for 83% percent of the cases. That said – the problem we have come to discuss, namely Multi Drug Resistant Tuberculosis (MDR-TB) varies dramatically by geography in terms of the concentration of cases and the severity of resistance.

Of the 480 000 cases of multidrug-resistant TB (MDR-TB) estimated to have occurred in 2014, only about a quarter of these – 123,000 – were detected and reported. In addition, treatment success rates are very low at less than 50%. Most cases come from previously treated TB patients who develop resistance, but this year the WHO reported a 50% increase in the percentage of patients that contract the disease directly from infected individuals. Remember this is an airborne disease.

Many countries that bear the largest burden of MDR-TB are important strategic partners to the U.S. More than half of the global burden of MDR-TB is borne by the BRICS countries and other emerging economies. The Russian Federation and Ukraine have the highest proportions among all new MDR-TB cases. India, China and the Russian Federation consist of over 45% of all the globally estimated numbers of MDR-TB cases. An estimated 9.7% of people with MDR-TB have XDR-TB and countries like India, Ukraine and South Africa reported the highest number of XDR-TB cases. With our current drugs regimens we only succeed in treating 20% of XDR patients.

Chairman Smith rightly warned in a press release last month that we must not allow multidrug-resistance to develop further, as the climb to successfully combatting TB becomes much steeper. Left unchecked, drug resistant TB alone could account for one in four deaths from antibiotic infections by 2050. Drug resistant TB services for addressing drug resistant TB in the U.S. and abroad must be scaled up immediately.

As one of the wealthiest countries in the world and the third most populous, we have a moral obligation to commit financial resources to this global health security threat. Serious detection and treatment gaps for drug resistant TB remain. Of the $13 billion in TB funding required in 2015, about two- thirds are for the detection and treatment of drug-susceptible TB and one-third for MDR-TB treatment. Today, only $6 million is funded and recent plans indicate that greater funding is required for MDR-TB globally as well as for capacity building for health care workers to provide high quality care. We need to find new resources to not only prevent this disease from shattering lives, but also invest in research that will enable us to save more lives.

It is imperative that we focus our efforts on calling out the tragedy which often strikes the voiceless. Those who suffer, do so in silence. We need to be their voice. We need to unleash the outrage. We need to accelerate the political backing and momentum to make the bold strides needed to drive down the epidemic.

While the call is urgent, there are signs of hope. Death rates from tuberculosis have dropped by nearly one half since 1990, with most of the improvement coming since 2000 and the establishment of the UN Millennium Development Goals. The MDG target calling for halting and reversing TB incidence by 2015 has been achieved globally. 43 million lives were saved between 2000 and 2014, thanks to effective TB diagnosis and treatment. In comparison – ART averted over 9 million deaths from AIDS between 1995 and 2014. Over 6.2 million malaria deaths have been averted between 2000 and 2015. In terms of lives saved, TB has had a tremendous impact – more than other current public health interventions have achieved.

I applaud the achievements of many governments worldwide that have large-scale and sustainable programs providing basic TB care in their primary health services, which are saving millions of lives each year. These programs provide solid foundations and models for others struggling to get ahead of this epidemic. But I must emphasize that the risks of not intensifying our TB efforts are real, with so many people needlessly missing out on care, and with truly menacing hot spots for drug-resistance.

Countries with high TB-HIV burdens are also mounting a solid response to the joint epidemics with prevention and care being scaled-up, but not yet with full coverage. Many countries have shown they can adopt new tools, innovate delivery, reach more patients, and contain drug-resistant TB at low levels.

TB interventions are cost effective and save lives. TB is the most effective health intervention bearing a $43 return for every $1 invested. We need revolutionary new technology and improved ways of delivering services. This will require intensifying basic and implementation research with innovation. This will be possible only through increased investments and effective engagements of both the public and private sectors.
I plan to continue conversations over the coming months with leaders on how we can truly activate that commitment. If we want to achieve an end to TB deaths and to the epidemic altogether, we'll need more investments. We'll also need progress on universal health coverage and poverty alleviation.

Some people remain undiagnosed. Some find the regimen too difficult to follow or, particularly in the developing world, too expensive. And others become resistant to the drugs they are using.

It is these people who drive me to work on this issue. Just as I'm sure they drive you.
The world owes a great deal of thanks to Congress and the Obama Administration for making global health a priority. I want to personally thank this Subcommittee for its efforts to provide generous resources in the fight against TB.

But this fight must also be a shared responsibility among all partners. Last week, at a Global Summit on TB in Cape Town, I challenged all of the global health players involved with TB to take a hard look at their resources and how they are being used. We need to better understand what is being spent on TB and match our funding against the unmet needs. By doing this, we not only can fill in the gaps, we can eliminate duplication and parallel systems and identify and engage synergies that ensure resources are truly additive.

We need a country-by-country analysis that does a deep dive on resources and on needs. When I was overseeing PEPFAR, we did exactly what I am calling upon the TB community to do. And the results speak for themselves. I was able to find millions of dollars that I could then strategically invest in countries with the greatest need. I was able to make decisions based on impact.

In other words, let's ensure that low-income and the most vulnerable communities worldwide are first, not last, in our efforts to fight TB.

Let's also ensure that we are not pitting one disease against another. It does not do any good to rob Peter to pay Paul. We can't save children from malaria and have them die from TB. We need investments across the board in global health. Investments bent the incidence curve on HIV. We can do the same for TB.

Finally, it is important to note that the United States is not immune to TB. According to the Centers for Disease Control and Prevention (CDC), a total of 9,421 TB cases were reported in

the U.S. in 2014, 66% of reported TB cases occurred among foreign-born persons. Furthermore, there were 96 cases of MDR-TB diagnosed in 2014.

Mr. Chairman, I'd like to leave you with a story. In last month's *Tampa Bay Times*, Dr. Jennifer Furin, a senior lecturer at Harvard Medical School, wrote an op-ed about her first-hand experience in dealing with children with TB in Lesotho. She writes, "I cannot forget seeing an 8-year-old boy as he crawled outside to play with his friends. Being on all fours was not part of the fun, but his only means of mobility. An infection in his knees, cause by multidrug-resistant TB, left him unable to walk or stand.

Resilient in the face of his illness, he looked to the sky with a shy grin as the other children shouted 'crab, crab, come and get us, crab.' But the playful laughter was soon replaced by silence: The young boy was killed by MDR-TB and his sister and mother are also ill with the disease."

Sadly, this story is heard all too often.

We can prevent, diagnose and cure drug sensitive TB, but MDR-TB increasingly presents a serious challenge.

We can do better. We must do better, but we need to act now.

Thank you.