March 1, 2016

The Honorable Roy Blunt
Chairman
Labor-HHS-Education Subcommittee
Committee on Appropriations
United States Senate
Washington, DC 20510

The Honorable Patty Murray
Ranking Member
Labor-HHS-Education Subcommittee
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Chairman Blunt and Ranking Member Murray:

The undersigned organizations — members of the United States global health community working on tuberculosis (TB) — are writing to express our gratitude. We appreciate your support for the critical infectious disease health research and development programs and efforts to combat antibiotic resistant bacteria and emerging infectious disease through the Biomedical Advanced Research and Development Authority (BARDA) at the Department of Health and Human Services. We recognize that you face many challenging decisions about expenditures but given the urgent need to address drug-resistant TB (DR-TB), we are writing to encourage you to prioritize anti-TB efforts. Specifically, we request that in any final version of Fiscal Year (FY) 2017 appropriations language, you strongly urge BARDA to include TB in their new emerging infectious disease efforts and invest in the development of new TB diagnostics, drugs and vaccines as part of the Combating Antibiotic Resistant Bacteria (CARB) initiative and the Emerging Infectious Disease program at BARDA.

TB causes more deaths than any other single infectious disease agent, with 9.6 million new illnesses and 1.5 million deaths in 2014. Approximately 480,000 of those cases were multidrug-resistant (MDR), including 9.7% that were extensively drug-resistant (XDR). Only about 10% of people with MDR-TB in 2014 were successfully treated, according to the World Health Organization. While these statistics are alarming, even more concerning is the lack of research funding going towards new, improved tools and treatments for one of humanity's oldest diseases.

While Zika and Ebola have captured headlines and funding commitments, TB's domestic and global health impact is much more costly and deadly. Because TB is airborne, TB can be contracted by inhaling the bacteria when a person with active TB disease of the lungs or throat coughs or sneezes -- it's only necessary to inhale a few of these germs to become infected. The only available vaccine for TB, Bacille Calmette-Guérin (BCG), is only moderately effective in preventing TB in infants and young children – and it doesn't adequately protect teens and adults who suffer most of the disease burden. Current treatment regimens are long, expensive, and difficult to implement. Treatment side effects are serious and long-lasting, including permanent hearing loss. Even our current diagnostics are inadequate, with rapid, accurate drug susceptibility testing only available for just one TB drug out of the several required for an effective regimen.

TB does not just impact the rest of the world. Every state in the U.S. continues to report cases of TB each year and cases of TB occasionally make the news when diagnosed, with recent examples in Sturgis, Michigan; Marion, Alabama, El Paso, Texas; or DeKalb County Georgia. In March 2015, 27 people tested positive for TB in a high school located in Olathe, Kansas, prompting the testing of more than 300 students and staff. Last year, an individual with XDR-TB was treated at the National Institutes of Health after traveling to and through the U.S. These travels included a long flight from India to Chicago, and then driving through Illinois, Tennessee, and Missouri, visiting friends and relatives, while infectious with a drug-resistant strain of this deadly airborne disease. We know that TB anywhere can be TB everywhere.

Although the medical community has made strides to combat TB, the threat of this epidemic is growing, in part because of the spread of dangerous strains of MDR-TB and XDR-TB around the world, which we are trying to fight with 20th century technologies. While MDR-TB is resistant to at least two of the key front-line drugs used to treat TB, XDR-TB is resistant to nearly all current drug options. The costs to treat MDR- and XDR-TB are enormous. In the U.S., a case of MDR-TB costs about 15 times the amount that is needed to treat drug sensitive TB, often requiring 20-26 months of treatment. And treating a single case of XDR-TB could cost more than half a million dollars -- enough to wipe out a city's total public health budget for a year. Underscoring the urgent need for new tools to combat this disease, the CDC cited MDR and XDR-TB as serious antibiotic resistant threats in its 2013 report on antibiotic resistance in the U.S.

Efforts at BARDA are currently underway to establish an Emerging Infectious Disease Division to focus on naturally occurring infectious diseases. Including TB in BARDA's new emerging infectious disease efforts to invest in the development of a TB vaccine and new TB drugs and diagnostics as part of the CARB initiative and the Emerging Infectious Disease program will be a critical step to ensuring that new vaccine, treatment and diagnostic options are developed and available for use.

Sincerely,

Aeras
American Thoracic Society
Friends of the Global Fight Against AIDS, Tuberculosis and Malaria
Georgia AIDS Coalition
Global Health Council
Health GAP
Infectious Disease Society of America
National Association of County and City Health Officials
RESULTS
Stop TB USA
Student Global AIDS Campaign
TB Alliance
Treatment Action Group
Universities Allied for Essential Medicine