Faith and Tuberculosis: Experience and Opportunity

Tuberculosis (TB) is attracting new international interest, reflecting concern for high mortality from TB, the public health challenges it presents, and TB’s special impact on poor and vulnerable populations. The WHO’s End TB Strategy lays out ambitious goals that cannot be achieved without broad mobilization, and there are large opportunities for stronger partnerships with faith-inspired organizations (FIOs) at global and country levels. An often underestimated menace, TB shares features with HIV and AIDS and other diseases that demand active community understanding and support, both to ensure sustained and quality care and to combat stigma. Various FIOs currently play significant roles in both program execution and advocacy at global, national, and community levels, but an aggregate view of their roles and assessment of performance are lacking. Different faith-linked institutions—both transnational FIOs and congregational structures—could play more active roles in both international and national partnerships, and there is wide scope for engagement at community level. A useful next step would be to document actual and potential roles of faith-inspired actors in two or three high burden countries with the goal of outlining practical action strategies that could enhance program impact there and refine lessons for global efforts.

THE CHALLENGE

Faith actors at global and local levels can more effectively engage in global health strategies generally, and in combatting tuberculosis more specifically. Distinctive contributions of faith actors center on their omnipresence and community knowledge as well as direct engagement in healthcare. Community understanding and support are vital to successful public health approaches and to patient care for TB. To enhance action and improve coordination, better knowledge of ongoing interventions, successful and less so, is needed. Lessons should be drawn from comparable public health challenges (notably on HIV and AIDS and malaria), and new approaches should be explored.

This brief highlights critical roles that faith-inspired actors play in addressing TB challenges in poorer countries, drawing on a 2009 Berkley Center/World Faiths Development Dialogue report, Experiences and Issues at the Intersection of Faith and Tuberculosis, and on more recent research and experience. The brief highlights obstacles that have tended to limit engagement, including poor coordination, lack of funding, and weak organizational capacity. It presents some instances of successful engagement and suggests areas to explore to enhance future efforts. We offer several options that religious leaders can implement and ideas for new and expanded partnerships.

Table 1. High Burden TB Countries by Region and Incidence as of 2013.

These 22 countries, separated by region of the world, account for 80 percent of the total TB cases in the world. They are listed in descending order of incidence, or the WHO’s best estimates of the number of new cases per 100,000 population per year. Numbers are listed in thousands.

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<thead>
<tr>
<th>Asia</th>
<th>Africa</th>
<th>Other</th>
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<tr>
<td>India (2,100)</td>
<td>Nigeria (590)</td>
<td>Brazil (93)</td>
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<tr>
<td>China (980)</td>
<td>South Africa (450)</td>
<td>Afghanistan (58)</td>
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<td>Pakistan (500)</td>
<td>DR Congo (220)</td>
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<tr>
<td>Indonesia (460)</td>
<td>Ethiopia (210)</td>
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<tr>
<td>Bangladesh (350)</td>
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WHY FOCUS ON TUBERCULOSIS?

Alongside HIV/AIDS and malaria, TB—airborne and highly contagious—is one of the “big three” infectious diseases that are leading causes of death in the world’s poorest countries. In 2013 an estimated 9.0 million people developed TB and 1.5 million died from the disease; 360,000 of those who died were HIV-positive.\(^2,3\) As seen in the high prevalence rates in Table 1, the Asia and Western Pacific regions experience over half of the global TB burden (56 percent); India and China accounted for 24 percent and 11 percent of all global cases, respectively. Africa has one quarter of the global TB burden, but relative to population the continent had the highest rates of cases and deaths.

Several features of TB have made it difficult to tackle; they suggest potential areas where faith communities might be engaged. TB is difficult to diagnose and has lengthy and exacting treatment regimes. Many people with HIV also develop TB, which is by far the single biggest killer of people living with HIV and poses a major risk even after starting anti-retroviral therapy. Most TB-related deaths—as illustrated in Figure 1—occur in the world’s poorer countries where treatment is either unavailable or costly. Even in many rich Western countries, localized TB hotspots still exist in poor areas—for example, Hackney, a neighborhood in London, has a TB prevalence of 60 cases per 100,000 people, a rate higher than some low and middle income countries. Diagnosis rates plunge and treatment abandonment rates skyrocket in places where damaging stigma is highest. Thus there are strong links between TB and poverty, weak health systems, distrust of public authorities, and other infectious diseases.

Effective antibiotics and changing health behaviors have led to the near disappearance of TB in wealthier countries, which has led to a declining interest in research and development of better treatment options. The resurgence of TB and issues around co-infection and drug-resistant TB strains have, however, spurred new interest in the disease.

The result is a new global focus on TB, and dedicated international partnerships, notably the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) and the Stop TB Partnership,\(^4\) which was founded in 2001 and today has 1,300 public and private member organizations.

Figure 1. Estimated TB mortality rates excluding TB deaths among HIV-positive people, 2013.\(^5\)
The international goal of addressing TB is reflected in the third UN Sustainable Development Goal (SDG), which is to “ensure healthy lives and promote well-being for all at all ages.” The Rio+20 Open Working Group Proposal highlights this goal’s relation to TB, specifically proposing: “by 2030 [to] end the epidemics of AIDS, tuberculosis, malaria, and…other communicable diseases.” WHO adopted the “End TB Strategy” in 2015, which aims to accelerate the decline of TB incidence and reduce mortality by 75 percent by 2025.

Success has been mixed. In several countries, South Africa among them, TB incidence has doubled and mortality (not including cases of HIV+TB) has declined only marginally since 2000. There is far to go, but a roadmap is taking clearer form with an emphasis on community outreach. The Stop TB Partnership’s Global Plan to End TB 2016-2020 will set out actions needed to accelerate the reduction and shift from a medical approach to TB focused on control and management, to a model focused on active community outreach and patient centered approaches to reducing TB.

Specific TB control efforts are underway in more than 102 countries, launched between 2002 and 2013. Domestic funding accounts for most TB control efforts, rising from an estimated US$1.5 billion in 2002 to US$3.5 billion per year in 2011; Brazil, Russia, India, China, and South Africa (BRICS) accounted for 95 percent of this increase. International donor funding, mostly coming from GFATM, rose from US$0.2 billion to US$0.5 billion in 2011, which is over US$1 billion short of what both the WHO and the Global TB Programme have estimated to be a full response to the disease. Markedly, GFATM approved proposals for over US$4.5 billion for TB control efforts over the course of 11 years.

WHAT ARE THE PRIORITIES FOR TUBERCULOSIS CONTROL?

Non-drug resistant tuberculosis requires meticulous treatment where patients are put on a regimented, six to eight-month antibiotic plan. Outpatient treatment predominates largely due to limited hospital and clinic capacity and cost. An incomplete drug sequence can potentially lead to dangerous multidrug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB). Directly Observed Therapy (DOT, or DOTS if short course) programs respond to these features. Effective implementation of DOTS requires consistent contact with and surveillance of TB-infected communities. The World Bank calculated that the marginal benefit of implementing DOTS was 15 times greater than its cost in the 22 TB high-burden countries (HBCs) seen in Table 1.

For MDR or XDR-TB cases, or when sufficient resources are available, isolation is sometimes employed. But, inpatient centers can be costly to run and become breeding grounds for even more dangerous drug-resistant strains. Médecins Sans Frontières (MSF) states that, instead, community-based care has been shown to be safe, practical, and extremely effective for DR-TB.

International partners are deeply involved in advocacy, financial mobilization, and research related to TB. As seen in Figure 2, national governments fund (often through international donors) most anti-TB efforts, and they are responsible for the planning and execution of tuberculosis programs at the country level. The WHO Stop TB Strategy works through these national tuberculosis programs (NTPs).

The search for new, more effective anti-TB drugs and better diagnostic tools is ongoing. Organizations and researchers associated with the Global Alliance for TB Drug Development and Aeras are working to develop new ways to treat, prevent, and vaccinate against the disease. Research into new vaccines has a high priority as a complement to drug development efforts, and is an essential component of the fight against TB, especially as TB/HIV co-infection rates increase. Access to drugs and reliable supplies are serious challenges in many situations. As an example of the type of research occurring, Partners in Health (PIH), working with MSF and Interactive R&D, has a US$60 million grant for the “endTB” project to expand drug access in 17 countries, as part of efforts to develop more effective drug/treatment strategies.

WHY IS RELIGION RELEVANT?

The most common current engagement of faith communities in the effort to combat TB centers on DOTS care because of their extensive community links, trust, and respect in society. Various faith-related organizations are involved in DOTS programs in high TB-burden countries, including Zambia, Cambodia, and Peru. Broadly, notwithstanding imperfect evidence related
Figure 2. Funding for Tuberculosis Care and Control from Domestic Sources, International Donors, and the Global Fund Specifically.\textsuperscript{15}  
\textit{Graph G does not include South Africa and Graph H does include India and China.}

![Graph showing funding over years and regions for tuberculosis care and control.]

specifically to faith health delivery and performance, faith institutions deliver substantial shares of healthcare in many countries, and many services are high quality and reach very poor communities.\textsuperscript{16}

Like malaria and HIV/AIDS, no overarching data documents existing work or pinpoints specific roles for either generic or specific faith community actors in TB prevention or treatment. However, informed observers’ logical hypotheses suggest that the distinguishing characteristics of faith-supported health actors—close community links, broad networks of health outlets, healthcare experience, and faith leaders’ influence in their communities—support exploration of more systematic engagement. Establishing national networks that monitor and evaluate the work of faith-based groups is one way to advance knowledge and research in this area.\textsuperscript{17}

**WHAT DISTINCTIVE FEATURES CHARACTERIZE FAITH INVOLVEMENT IN TUBERCULOSIS TREATMENT AND PREVENTION?**

Faith and health are closely linked in many world regions, including countries with high TB incidence.\textsuperscript{18} The following noteworthy characteristics of faith health “assets” have special relevance for discussions about TB:

The substantial demands of home-based care and follow up for people living in communities for TB. Faith-inspired health institutions commonly have close community ties and
infrastructure (health and non-health related), and therefore may be positioned to facilitate the intensive, community-level work required for current TB treatments to be effective. DOTS, the most used treatment regimen for TB, requires strict adherence to cure and minimize the rate of emergence of drug-resistant TB strains. The experience of Socios en Salud (an NGO founded by a Catholic priest working in the slums of Lima, Peru) has shown the effectiveness of using networks of volunteers trained by churches. Existing community groups formed within, or associated with, congregational structures could undertake, in a systematic way, DOTS programming in some communities.

Stigma is a large challenge for TB, affecting those infected and dampening desire to seek treatment. By combating stigma, faith leaders can influence and have influenced community attitudes and thus contribute to addressing this aspect of TB. For example, together with the Integrated Provincial Health Office, Catholic Relief Services (CRS) initiated the Maguindanao TB project in the Philippines in 2005. CRS informed Maguindanao’s religious leaders, primarily Muslims, about the disease. The leaders participated in information, education, and communication (IEC) campaigns and encouraged TB-inflicted individuals to seek medical care. After the program was introduced, one municipality reported a 14 percent increase in case detection rates. Other studies indicate that involving religious leaders in raising TB awareness has beneficial effects on health-seeking behavior and case detection rates.

TB disproportionately affects poor and vulnerable populations, such as migrants and those in prisons. Faith actors—who often engage directly with marginalized populations—can be instrumental in identifying and serving these groups. World Vision Foundation in Thailand implemented the GFATM-funded TB Reduction Among Non-Thai Migrants (TB-RAM) Project. Working with Thailand’s Ministry of Public Health, the TB-RAM project covered 271,000 people and identified and referred 27,037 non-Thai migrants for diagnosis and treatment. The project’s treatment success rate was comparable to national rates across all populations for smear-positive TB and performed seven percent better for all forms of TB.

Faith institutions often run health and other operations during conflict situations or in failing states, when government service provision is limited or nonexistent yet continuity of service provision is crucial. In North Korea, for example, the Christian Friends of Korea worked with Stanford University’s North Korea Tuberculosis Project and the Global Fund on a US$1.7 million renovation of a national TB reference laboratory, decreasing post-operative infections by 50 to 70 percent. The Global Fund reported that the project “exceeded expectations,” and their efforts have detected and treated 107,000 new smear-positive TB cases.

INTERFAITH PARTNERSHIPS

Few cases of interfaith partnerships focused specifically on TB are documented, but such partnerships deserve priority attention. Interfaith cooperation in some situations might achieve the dual goals of addressing public health goals and fostering positive relations between different faith communities. Given the emphasis on coordination in global plans, cooperation within and among faith communities could further overall progress on TB. Blanket treatment is crucial to TB eradication, as inconsistent efforts lead to drug resistance; thus, in areas where faith-inspired health providers constitute a substantial percentage of available healthcare, interfaith coordination could help complete a network of coverage.

Promising national-scale initiatives in Nigeria and Mozambique have engaged interreligious partnerships on malaria programs. Data on interfaith efforts to address other diseases, however, are poor. Nonetheless the potential benefits of interfaith approaches suggest that further exploration is warranted and TB could be a good focus. Important to consider in the planning stages of interfaith development programming are the diversity of local and national religious communities and their leadership, local tensions between faith communities, and the extent to which interfaith work could add value to development initiatives.

BARRIERS TO FUTURE SUCCESS

Three priority areas in relation to potential faith-linked action on TB deserve attention: capacity, funding mechanisms, and coordination.

Various functions (procurement, proper accounting, monitoring and evaluation, etc.) are critical to successful implementation of TB programs. Thus the capacity demands of potential cooperation among faith entities needs to be explicitly examined. Large transnational faith organizations (for example CRS and Islamic Relief) benefit from high caliber professional management, but local faith communities have been described as “organic and chaotic,” and they have
rarely developed the capacities expected by international financing and technical partners. Solutions need to be developed country by country, balancing the advantages of working with embedded, local faith actors and the demands of taking programs to scale.

Like other organizations, faith actors struggle to mobilize the financing needed for TB, among other healthcare needs, especially when a TB program is part of an integrated health system (many TB programs tend to be vertical). But there are important advantages to integrating TB programs within broader healthcare strategies and systems. Furthermore, many faith-inspired actors are disadvantaged by a history of dependence on denominational donations and lack a track record with secular development actors (including business). As seen in Figure 3, fewer faith actors receive grants toward TB projects than toward projects addressing HIV or malaria. Given that the GFATM spends 16 percent of its total funds on TB (compared to 54 percent for HIV and 28 percent for malaria), the disbursement to faith actors for TB is a small percentage of the overall funding.

Coordination among development actors—so that they work smoothly together within the local context, with a common strategy, and with similar processes—is notoriously challenging. Coordination could be much better among faith actors, and exclusion of or marginal engagement by most faith actors in country level coordination mechanisms compound most problems with coordination. The National Tuberculosis Control Program in Timor Leste, in contrast, showed that a faith-based actor can act as the leading organization of a national tuberculosis campaign. This model offers the advantage of the state's legitimacy—which can create and enforce policy—as well as the flexibility and local understanding of various, coordinated, cooperative, and collaborative NGOs and private actors. The challenge going forward with TB is to encourage the organic, often locally-driven approaches by faith actors who address TB,
while “getting a grip” on disparate approaches, ensuring that all efforts are within and supported by national and global TB control structures.

**PROPOSALS TO ENGAGE RELIGIOUS LEADERS**

1. **Focus on faith gatherings for well elaborated public health messaging that addresses TB.** Efforts by faith leaders can reduce stigma and encourage treatment-seeking behavior. Religious leaders can disseminate educational messages provided for them by their National TB campaign or government program during worship services and other congregating events. A prerequisite (to avoid “instrumentalization”) is to engage faith communities in planning and design.

2. **Cooperate with religious leaders of the same and different faiths in order to develop best practices of faith-sensitive messaging and service delivery through networks of religious actors.** Muslim and Christian communities may approach TB treatment differently and achieve different results, suggesting that different religious groups have lessons that can be shared and learned. Holding meetings and shared gatherings can boost interfaith understanding and shared prosperity.

**BOTTOM LINE**

Engagement of faith communities along with public, private, and other faith communities needs to be a part of tuberculosis interventions. With support from public and private partners, places of worship could present a training ground for DOTS community health workers, support a network and infrastructure, serve as a locus for drug supply, and provide intimate knowledge of the community. FIOs in many situations can be a significant part of a broad, holistic fight against the disease.

Strategic coordination and networking are key to future success. Solid information is crucial to advance. Faith-linked institutions often work in remote regions where others will not, but tend to be underrepresented in official statistical analyses of health services. Poor information sharing and coordination make their insights hard to quantify and redundant. One answer is to ensure that religious networks and faith-linked institutions are included in any mapping of resources to address tuberculosis responses. With this information, secular development organizations can pool resources with faith actors and ministries of health in order to build a comprehensive tuberculosis strategy.
NOTES

9. Ibid.
22. Ibid.
26. Ibid.