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POLICY BRIEF

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Faith and Tuberculosis:
Experience and Opportunity in Nigeria

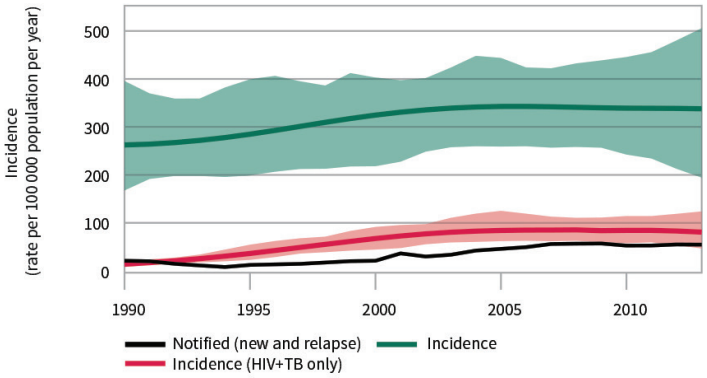
HIGHLIGHTS

Engaging faith actors systematically in Nigeria's national tuberculosis (TB) programs is feasible and deserves high priority. Community outreach should be the main focus, particularly to reach vulnerable populations and build sustainable networks that deliver well-integrated health solutions. Faith communities can play positive roles in addressing stigma and supporting individuals and families. An interreligious approach can offer additional advantages. Interreligious groups currently support malaria and HIV and AIDS programs, thus extending such efforts to TB makes eminent sense. Inter-religious approaches that address common challenges and enhance collaboration can also strengthen social cohesion.

THE CHALLENGE

Systematic efforts to engage faith actors in combatting tuberculosis are not yet an integral part of global or national TB efforts. Nigeria is an excellent case in point. There are urgent calls for action, and the government has pledged to increase budget allocations to address TB. With the world's fourth largest population affected by TB, Nigeria faces the general challenges that this complex disease presents as well as specific challenges related to a large population and TB's interactions with other public health problems. Faith actors in Nigeria provide healthcare services and have intimate community knowledge and trust; they influence community and policy attitudes in significant ways. Community understanding and support are especially important in the case of TB. A first step toward planning for specific faith or interfaith engagement on TB would be a systematic mapping of ongoing interventions, evaluating their strengths and weaknesses. Broader lessons of effective interfaith cooperation on health could inform this effort. In short, there are significant opportunities to enhance TB response by engaging faith communities.

Increasing TB Incidence Since 1990

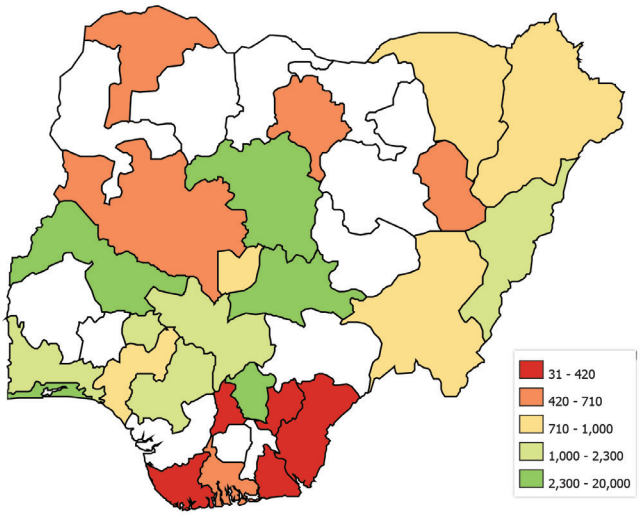


Each line represents the best estimate of TB incidence in each year. The shaded green and red above and below the respective lines represent the upper and lower bounds of uncertainty for each measurement. Source: Global Tuberculosis Report 2015, Annex 2: Country Profiles, 137.

WHY FOCUS ON TB IN NIGERIA?

Nigeria has a high TB prevalence—about 600,000 cases (more than any other African country)—with peak prevalence in younger groups.[1] TB mortality, resulting in an estimated 170,000 deaths in 2014, is equal to or greater than that of HIV. Nigeria is one of five countries with the highest number of missed cases (the difference between the estimated number of incident cases and notified cases), accounting for 15 percent of globally missed cases. Figure 1 shows that incidence rates have increased from 1990 levels, highlighting the need to prevent new cases. As the result of a significantly improved national survey system, 92 percent of Nigerian patients with TB know their HIV status, and 75 percent of those patients co-infected with TB and HIV (19 percent of all TB patients) have started on ART.[2] Drug susceptibility coverage is, however, abysmal, with just 0.2 percent of every 5 million patients in Nigeria tested for drug susceptibility. Nigeria did not meet MDG target reductions in incidence, prevalence, or mortality.

Reported Cases of Tuberculosis in 2008



Source: National Bureau of Statistics Nigeria, Socio-Economic Indicators, 2012.

Nearly 59 percent of the 2015 TB Program budget was funded by international partners. With rising numbers of patients on treatment, there is still a considerable funding gap; over 68 percent of the funding needs for the response was notification[5] and access to diagnosis and treatment. Led by the National TB and Leprosy Control Programme (NTLCP), Nigeria has improved data collection and completed a first ever TB prevalence survey in 2012. Although 100 percent of the patients with MDR-TB are hospitalized, the number of missed cases and high TB deaths suggests that priority should go to improving diagnostic treatment and access. Case notification is largely the result of singular efforts; as it stands, TB case notification as the result of partnerships—public-private and public-public mix (PPM)—is at 24 percent.[6] TB case notification as the result of private sector care providers is 14 percent.[7]

HOW ARE RELIGIOUS ACTORS RELEVANT?

Faith institutions manage a significant share of Nigeria's health infrastructure, shape many health behaviors in communities (including stigma and support), and influence aspects of national health policies.[8] Researchers in Nigeria advocate for increased collaboration on TB between the public sector and the private, not-for-profit sector, which includes faith-based services.[9] Some evidence suggests that patients who receive TB treatment at faith-based healthcare facilities have better treatment outcomes than those seen at public healthcare facilities.[10] However, more analysis of faith community involvement and its role in TB diagnosis and treatment in Nigeria is needed to support more systematic policy interventions. Robust, systematic studies could provide better information on specific faith roles in relation to TB and related diseases.[11]

Given recognized gaps in TB diagnosis and treatment, the underutilized potential engagement of faith communities—both formal, such as the largely Christian health infrastructure, and informal, such as the national, regional, and local community networks across various faith traditions—is particularly relevant. Decentralizing TB care by harnessing the power of communities could increase access to and effectiveness of TB treatment.[12] However, evidence for or against faith-based treatment plans is fragmented. The Civil Society for the Eradication of Tuberculosis in Nigeria's commitment in 2015 to support Nigeria's National TB Strategic Plan highlights the importance of better understanding actual and potential faith-actor contributions.

WHAT DISTINCTIVE FEATURES CHARACTERIZE FAITH INVOLVEMENT IN TB TREATMENT AND PREVENTION?

Faith-inspired health institutions commonly have close community ties and infrastructure (health and non-health related). This positions them well to facilitate the intensive, community-level work required for TB treatments to be effective. For example, the Christian Health Association of Nigeria (CHAN), which promotes best practices, information sharing, and cooperation among its 358 member church-based health services, has been a leader in providing TB treatment. CHAN trained several thousand workers, exceeding its goal in training private sector workers but failing to meet its goal in training public sector

Religious Demographics, weighted percentage

	Women	Men	Total
Catholic	11.5	11.6	11.6
Other Christian	42.1	42.1	42.1
Muslim	44.4	44.7	44.6
Traditionalist	1.3	1	1.2
Other	0.2	0.4	0.3
Missing	0.5	0.2	0.4

Source: Percent distribution of women and men age 15-49, Nigeria DHS 2008.

workers, with Global Fund support.[13] This illustrates the potential and need for clearer and stronger public-private partnerships.

With close community ties and infrastructure, religious leaders measure high in **surveys of trust at the community level.** They can thus act as information deliverers to their congregations. Nigerian government officials acknowledge that citizens listen to faith leaders more than government officials.[14] Training faith leaders on appropriate practices and treatment seeking could bolster TB campaign efforts in important ways. In relation to TB treatment, trained faith community health workers could utilize TB mHealth innovations, which track drug adherence and collect data that can be aggregated and analyzed. Initial results suggest that building on the trust that communities have in religious leaders could strengthen such innovations.[15]

Nigerian faith leaders have a history of **interfaith cooperation.** Better coordination of TB plans (a common priority globally), and specifically more cooperation between and within faith communities, could further overall progress. Nigerian Minister of State for Health, Dr. Khaliru Alhassan, at a UN meeting, stated recently that "interfaith is working and yielding a lot of positive results; what we need to do is to strengthen our partnership with these organizations."[16] Work by such groups as the Nigerian Inter-faith Action Association (NIFAA) is promising. Interfaith coordination, especially in regions where faith-inspired health providers deliver a substantial share of available healthcare, should be explored.

The 2013 Nigeria Demographic and Health Survey (NDHS) data indicate that fewer than half of married women in Nigeria are empowered to make decisions about their healthcare.[17] This underscores the **critical need to target men—the current decision makers—with persuasive and culturally appropriate messaging** that builds support for women's health and care-seeking behaviors. Organizations like NIFAA have trained faith leaders in the use of Qur'anic and Biblical verses to demonstrate that gender equality is consistent with religious doctrines and to disseminate female supportive messaging through their sermons.[18] By empowering women to become faith community health workers, faith communities can encourage them to feel more invested in making their own health decisions.

BARRIERS TO FUTURE SUCCESS

Two priority areas for action are improving coordination among development actors and investing in community systems. Working smoothly together within the local context, with a common strategy, and with similar processes is notoriously challenging. Given gaps in partnerships between the public and private sectors in case notifications, coordination needs attention, focused especially on integrating diagnosis and treatment across public-private lines, connecting faith-based healthcare providers, and promoting interfaith work among faith leaders. This means moving beyond parallel structures and ad hoc engagement of faith leaders or local faith-based groups, toward a more systematic engagement with an entity such as the NIFAA, in coordination with the National Primary Health Care Development Agency. Faith groups' commitment to behavior change and community mobilization needs to part of the larger national strategy.

BOTTOM LINE

Engagement of faith communities alongside other public, private, and other civil society actors can and should be an integral part of TB interventions. The National Strategic Plan for Tuberculosis Control 2015-2020 (NSP) highlights first-points-of-contact like religious leaders in identification and referral of people with TB symptoms; it outlines training sessions, formal agreements like Memoranda of Understanding (MOUs), and field visits by public officials to use the assets of these actors more effectively. Faith-inspired providers can deliver excellent patient outcomes, but there is room to improve faith actor coordination with the public sector. The NSP outlines areas where the government can better support the various faith-inspired organizations and private health facilities in establishing TB diagnostic services and drug susceptibility testing. Sharing lessons learned and coordinating interventions is an important path to improving health outcomes for TB patients.

Strategic coordination and networking are key to future success. Solid information is crucial to move in this direction. Connected through organizations like CHAN and NIFAA, the extensive Nigerian faith-linked institutions can be more effective, notably by strengthening interfaith and public-private coordination. Networks mobilized for polio and malaria can and should also address TB, drawing on their community knowledge and healthcare capacity.

ENDNOTES

1. World Health Organization (2015) Global Tuberculosis Report 2015, Nigeria Country Profile. http://apps.who.int/iris/bitstream/10665/191102/1/9789241565059_eng.pdf
2. Ibid.
3. This graph was originally printed in World Health Organization (2015) Global Tuberculosis Report 2015, Annex 2: Country Profiles, 137. http://www.who.int/tb/publications/global_report/gtbr14_annex2_country_profiles.pdf
4. Ogundipe S (2015) "Nigeria: Hope Rekindles for 500 MDR-TB Patients." Vanguard. http://allafrica.com/stories/201504150369.html
5. The term "notification" means that TB is diagnosed in a patient and is reported within the national surveillance system, and then on to the World Health Organization (WHO).
6. World Health Organization (2014) Global Tuberculosis Report, Table 4.3. http://apps.who.int/iris/bitstream/10665/137094/1/9789241564809_eng.pdf?ua=1
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16. Ibid.
17. National Population Commission [Nigeria] and ICF International (2014) Nigeria Demographic and Health Survey Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International, page 288. https://dhsprogram.com/pubs/pdf/FR293/FR293.pdf
18. Ibid.

This brief's main author is Katherine Marshall, senior fellow at the Berkley Center for Religion, Peace, and World Affairs and executive director of WFDD; Spencer Crawford, a student at Georgetown University, provided substantial support. It builds on WFDD's Policy Brief, *Faith and Tuberculosis: Experience and Opportunity*, and draws from the research report published in 2009, written by Thomas Bohnett and Claudia Zambra.

THE WORLD FAITHS DEVELOPMENT DIALOGUE (WFDD) is a not-for-profit organization working at the intersection of religion and global development. Housed within the Berkley Center in Washington, D.C., WFDD documents the work of faith-inspired organizations and explores the importance of religious ideas and actors in development contexts. WFDD supports dialogue between religious and development communities and promotes innovative partnerships, at national and international levels, with the goal of contributing to positive and inclusive development outcomes.

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