Scientific Research Publishing

Advances in Applied Sociology, 2025, 15(6), 451-461
https://www.scirp.org/journal/aasoci
ISSN Online: 2165-4336
ISSN Print: 2165-4328

Reclaiming the Breath: A Decolonial Lens on Tuberculosis Control in the Global South

Isabelle Munyangaju[1,2]

[1]ISGlobal, Barcelona, Spain
[2]Facultat de Medicina i Ciències de la Salut, Universitat de Barcelona (UB), Barcelona, Spain
Email: imunyangaju@gmail.com

How to cite this paper: Munyangaju, I. (2025). Reclaiming the Breath: A Decolonial Lens on Tuberculosis Control in the Global South. *Advances in Applied Sociology, 15,* 451-461.
https://doi.org/10.4236/aasoci.2025.156026

Received: May 26, 2025
Accepted: June 27, 2025
Published: June 30, 2025

Abstract

Background: Tuberculosis (TB) remains a leading cause of death in the Global South, where the burden of disease is compounded by structural inequalities. Despite decades of biomedical interventions, TB control efforts have often failed to address the deeper socio-political and historical factors that sustain the epidemic. **Aim:** This literature review aims to examine how colonial legacies continue to shape TB control and to explore how decolonial frameworks can reimagine TB care by centering indigenous knowledge, community agency, and health sovereignty. **Methods:** A narrative literature review was conducted using interdisciplinary sources from public health, global health governance, medical anthropology, and decolonial theory. Key themes were identified through a review of peer-reviewed articles, reports, and grey literature related to TB, colonialism, indigenous knowledge, and community participation. **Discussion:** Findings highlight enduring power asymmetries in global TB governance, with institutions based in the Global North often dictating priorities that may not align with community needs. The marginalization of indigenous epistemologies further weakens the cultural relevance of TB interventions. However, documented examples of community-led initiatives and integrated traditional practices demonstrate alternative models rooted in relational, participatory approaches. These approaches underscore the importance of ethical collaboration, epistemic pluralism, and local leadership. **Conclusion:** Decolonising TB control means more than changing tools; it means changing relationships. By centering indigenous knowledge, dismantling power hierarchies, and fostering true community leadership, TB strategies can become more just and effective. In reclaiming the breath, we restore the right to heal on one's own terms.

Keywords

Tuberculosis, Decoloniality, Health Sovereignty, Health Governance, Indigenous Knowledge

1. Introduction

TB disproportionately affects low- and middle-income countries (LMICs), with the Global South bearing the brunt of the disease burden (WHO, 2024). Despite advancements in diagnostics and treatment, TB continues to claim millions of lives annually (WHO, 2024; Suvvari, 2025; Baquero-Artigao, del Rosal, Falcón-Neyra, Ferreras-Antolín, Gómez-Pastrana, Hernanz-Lobo et al., 2023). The persistence of TB in these regions underscores the need to examine not only the well-documented barriers—such as inadequate funding, weak healthcare infrastructure, and social determinants like poverty and malnutrition (WHO, 2024; Suvvari, 2025; Barter, Agboola, Murray, & Bärnighausen, 2012)—but also the deeper socio-political and historical forces, including colonial legacies and global power asymmetries, that continue to shape its endemicity.

Historically, TB control strategies have been heavily influenced by colonial legacies. During colonial times, health interventions were often designed to protect colonial interests rather than address the health needs of indigenous populations. These interventions were characterized by top-down approaches that disregarded local knowledge and practices (Moffatt, Mayan, & Long, 2013; Moralina, 2009; Mant, Abonyi, & Hackett, 2023).

In the postcolonial era, many TB programs continue to reflect these colonial structures. International donors and organizations often dictate health priorities and strategies, leading to a mismatch between global agendas and local needs. This dynamic perpetuates a form of neo-colonialism in global health governance (Neelakantan, 2018; Yanga, 2025; Sen, Qadeer, & Missoni, 2022).

This literature review explores TB control through a decolonial lens. It examines how historical legacies, indigenous knowledge, and community-led interventions can inform more equitable, effective, and culturally grounded TB strategies in the Global South.

2. Methodology

This is a narrative literature review. We conducted a structured search of databases including PubMed, Scopus, Google Scholar, and Web of Science using the search terms: “tuberculosis”, “sanatoriums”, “colonialism”, “decoloniality”, “traditional healers”, “indigenous knowledge”, and “global health governance”. We included peer-reviewed articles, book chapters, and grey literature published up to date. Literature was selected based on relevance to the decolonial framing of TB control.

2.1. Colonial Legacies in TB Control

Under colonial administrations, tuberculosis control strategies frequently reflected broader systems of social stratification, with the establishment of sanatoriums and isolation policies that prioritized the health and safety of colonial settlers, often at the expense of equitable care for indigenous populations. In South Africa, facilities like the Nelsproot Farm Sanatorium and Durban Sanatorium exemplify this model, often placing black patients in under-resourced wards (McCulloch & Miller, 2023a). Colonial-era tuberculosis control was shaped by racialized public health ideologies that portrayed indigenous peoples as inherently vulnerable to the disease. This perception led to dismissive and controlling health interventions that excluded indigenous perspectives and contributed to long-standing distrust and systemic disparities in TB care (McMillen, 2021; Shariati, 2023).

The modern structure of TB programs in many LMICs mirrors these colonial patterns. Reliance on vertical programming, centralized authority, and externally imposed protocols often limits local agency. Historical and genetic evidence indicates that European colonization played a role in the introduction and spread of tuberculosis in various regions, often through trade, military activity, and migration. The Euro-American strain of Mycobacterium tuberculosis (Lineage 4) expanded into Africa, Asia, and the Americas alongside European movements (Brynildsrud, Pepperell, Suffys, Grandjean, Monteserin, Debech et al., 2018; McCulloch & Miller, 2023b; Packard, 1987). Understanding this historical context helps explain current disparities in TB burden and highlights the importance of more inclusive and equitable health strategies.

2.2. Decolonial Theory in Global Health

Decolonial approaches in global health critique the dominance of Western knowledge systems and advocate for the inclusion of diverse epistemologies rooted in local and Indigenous contexts. Recent studies emphasize the need for epistemic justice by challenging the historical marginalization of non-Western ways of knowing and promoting more pluralistic, relational frameworks for understanding health and knowledge production (Affun-Adegbulu & Adegbulu, 2020; Büyüm, Kenney, Koris, Mkumba, & Raveendran, 2020; Chandanabhumma & Narasimhan, 2020; Kwete, Tang, Chen, Ren, Chen, Wu et al., 2022).

In global health, this involves questioning who sets the agenda, whose knowledge counts, and how systems of care are structured. For TB, this could mean integrating traditional healing into diagnostics and care, involving communities in policy design, and re-centering health sovereignty.

A decolonial TB response embraces pluralism, equity, and participatory governance. It requires recognizing the limitations of one-size-fits-all biomedical models and building partnerships with communities to co-create solutions that reflect their lived realities (Chandanabhumma & Narasimhan, 2020; Munyangaju, 2024; Yanou, Ros-Tonen, Reed, Moombe, & Sunderland, 2023; Hindmarch & Hillier, 2023).

2.3. Power Asymmetries in TB Governance

Global TB governance is dominated by institutions based in the Global North, such as the WHO, Global Fund, and donor governments (WHO, 2024). These actors often set priorities and funding conditions without full alignment with community contexts. This creates power asymmetries that marginalize national programs and local knowledge (Abimbola, Asthana, Montenegro, Guinto, Jumbam, Louskieter et al., 2021; Vivek, 2025). These asymmetries have led to recurrent failures within TB programs—such as community resistance, low adherence, or unsustainable interventions—particularly when vertical, donor-driven approaches are implemented without adequate local input. In countries like Kenya, Mozambique, and Nigeria, standardized protocols have often clashed with local beliefs or lacked adaptability to rural health systems, undermining both effectiveness and long-term trust in TB services (Kenya, 2024; Mbuthia, Nyamogoba, Chiang, & McGarvey, 2020; Otieno, Luciani, Lumumba, Gikunda, Kiilu, Ogutu et al., 2024; Oladimeji, Tsoka-Gwegweni, & Udoh, 2017; Oga-Omenka, Tseja-Akinrin, Sen, Mac-Seing, Agbaje, Menzies et al., 2020; Biesma, Brugha, Harmer, Walsh, Spicer, & Walt, 2009; Nhassengo, Yoshino, Zandamela, De Carmo, Burström, Lönnroth et al., 2024; Nhassengo, Yoshino, Zandamela, De Carmo, Burström, Khosa et al., 2023). Empowering local stakeholders through participatory mechanisms, transparent funding models, and localized metrics of success is essential to balance these asymmetries and improve TB outcomes.

2.4. Indigenous Knowledge and Beliefs about TB

Across many cultures, TB is not only a biomedical disease but a condition imbued with social and spiritual meaning. In parts of Mozambique and South Africa, TB is interpreted as a curse or result of ancestral displeasure. Traditional treatments include herbal medicine, cleansing rituals, and sacrifices (Give, Morris, Murray, José, Machava, & Wayal, 2024; Mindu, López-Varela, Alonso-Menendez, Mausse, Augusto, Gondo et al., 2017; Matakanye, Tshitangano, Mabunda, & Maluleke, 2021; Edginton, Sekatane, & Goldstein, 2002).

In East Africa, TB may be seen as the result of social transgressions or inherited from the ancestors (Juma, Nzioki, Kibiti, & Shaikh, 2022; Msoka, Orina, Sanga, Miheso, Mwanyonga, Meme et al., 2021; Adaw, 2012). Herbalists use local plants for respiratory symptoms, and spiritual healers perform rituals. Similar beliefs exist among India's tribal communities, where TB is linked to sexual experience or punishment and treated by village healers (Phutane, Sawant, Randive, Hulsurkar, Mahajan, & Kudale, 2024; Atre, Kudale, Morankar, Rangan, & Weiss, 2004). These interpretations may either delay or strengthen engagement with biomedical care depending on how health systems respond. Understanding and integrating these worldviews is crucial for culturally responsive TB care.

2.5. Community Participation and the Integration of Indigenous Knowledge: Pathways to Health Sovereignty in TB Control

Community participation can improve TB outcomes by fostering trust and ensur-

ing relevance. In Meghalaya, India, health teams used boats and mobile X-rays to reach remote villages, working with traditional healers and community leaders to identify cases (Tribune, 2025; The Shillong Times, 2025; Highland Post, 2025). In Delhi, the "TB-Free Slums" initiative mobilized communities to screen and treat residents (Singh, Rade, Rao, Kumar, Mattoo, Nair et al., 2025; Jaiswal, 2025).

When TB control includes traditional authorities and community-based workers, interventions are more accepted and adhered to. For instance in Uganda, Tanzania and other African countries, traditional healers and community members were trained to refer TB cases and provide DOTS, leading to reduced defaults (Colvin, Mugyabuso, Munuo, Lyimo, Oren, Mkomwa et al., 2014; Apangu, Candini, Abaru, Candia, Okoth, Atiku et al., 2023; Schausberger, Mmema, Dlamini, Dube, Aung, Kerschberger et al., 2021; Makabayi-Mugabe, Musaazi, Zawedde-Muyanja, Kizito, Fatta, Namwanje-Kaweesi et al., 2023; Amare, Alene, & Ambaw, 2024). This improved understanding and reduced stigma.

These examples show that community ownership and co-production are key to sustainable TB control. Respectful integration, not assimilation, of indigenous systems can create effective, community-rooted TB strategies. To balance potential conflicts between biomedical protocols and indigenous practices, structured collaborations—such as dual-referral systems and co-designed care models—can enable respectful integration while maintaining scientific integrity and treatment outcomes. Health sovereignty means giving communities the power to define their own health priorities. In this context, health sovereignty refers both to national-level policy autonomy and to the grassroots capacity of communities to define, lead, and govern their own health responses—two interlinked scales necessary for genuine decolonization.

2.6. Towards a Decolonial TB Response

A decolonial TB strategy demands structural transformation grounded in health sovereignty, where communities do not merely participate but take the lead in shaping interventions that affect their lives. Central to this approach is epistemic pluralism—the recognition that indigenous and biomedical knowledge systems can and should coexist within models of care. Furthermore, it calls for ethical collaboration that prioritizes reciprocity over extraction, ensuring that partnerships are rooted in mutual respect, transparency, and shared benefit. This means moving away from models where external actors (including foreign donors, non-governmental organizations, research institutions, and even central government authorities operating without local input) collect data, impose solutions, or extract knowledge without giving back; and instead fostering long-term, equitable relationships in which communities are recognized as co-creators of knowledge and co-owners of outcomes. Such collaborations must be attentive to power imbalances and designed to build capacity, redistribute resources, and affirm the dignity and agency of local actors. This vision disrupts the prevailing technocratic status quo, instead placing justice, cultural respect, and community agency at the core

of effective and equitable TB control.

To translate a decolonial TB strategy into practice, several concrete actions must be undertaken by national TB programs, donors, researchers, and implementing partners. First, community leadership must be ensured in program design and governance by establishing formal advisory boards with decision-making authority, allocating budgets for community-led planning and monitoring, and training TB survivors and local leaders to co-lead projects. Indigenous knowledge should be meaningfully integrated into care pathways through respectful dialogue with traditional healers, community-based documentation of local health practices, and the creation of culturally grounded health education materials using local languages and metaphors. Partnerships must be redesigned around equity and reciprocity by mandating local co-leads in externally funded projects, shared authorship in publications, and transparent benefit-sharing agreements.

Decision-making and funding mechanisms should be decentralized, shifting resources directly to community organizations and local governments, using flexible grant procedures and locally defined success indicators. Investment in transformative research is also key—this includes funding participatory action research, training local actors in data collection and analysis, and adopting monitoring systems that capture power dynamics and qualitative outcomes. This could involve the use of participatory tools such as community-led audits, critical incident narratives, and reflective storytelling, which complement conventional indicators by highlighting the lived experience of power relations within TB care.

Finally, ethical accountability must be institutionalized through the development of decolonial ethics frameworks, cultural humility training for all partners, and community-led oversight mechanisms. These steps will help shift the TB response from one of top-down technocratic control to a model rooted in justice, dignity, and community agency. To address potential concerns about financial accountability, such decentralization must be paired with capacity strengthening, participatory budgeting processes, and community-led oversight structures, ensuring transparency without undermining local agency.

3. Gaps and Future Directions

Despite the growing recognition of decolonial approaches in global health, research that explicitly applies this lens to tuberculosis remains limited. There is a pressing need to expand the evidence base through rigorous and context-sensitive studies that foreground local agency and knowledge. Future priorities should include the evaluation of co-designed, community-led TB programs to understand their effectiveness, sustainability, and impact on health equity. Additionally, more effort is needed to document indigenous TB treatment frameworks—not only to preserve valuable cultural practices but also to explore how they can be meaningfully integrated into broader care models. Research should also interrogate the structures of global and national TB funding and policymaking, with a focus on promoting more equitable governance, transparency, and accountability. Cru-

cially, research must be conducted with, not merely about, communities. This calls for participatory and transformative methodologies that prioritize collaboration, shared ownership, and the capacity-building of local actors. In doing so, TB research can move from extraction toward empowerment, reinforcing a truly decolonial public health agenda.

4. Conclusion

Decolonising TB control requires structural transformation—shifting power, resources, and knowledge back to communities. Future research should prioritize participatory methodologies, the validation of indigenous frameworks, and the development of equitable governance models. A decolonial TB response is both an ethical imperative and a strategic pathway toward more just and effective public health systems.

Conflicts of Interest

The author has no competing interests to declare.

References

Abimbola, S., Asthana, S., Montenegro, C., Guinto, R. R., Jumbam, D. T., Louskieter, L. et al. (2021). Addressing Power Asymmetries in Global Health: Imperatives in the Wake of the COVID-19 Pandemic. *PLOS Medicine, 18,* e1003604. https://doi.org/10.1371/journal.pmed.1003604

Adaw, S. A. (2012). *Socio-Cultural and Operational Factors Affecting Tuberculosis Control among the Nomads of Northern Kenya.* http://ir-library.ku.ac.ke/handle/123456789/4870

Affun-Adegbulu, C., & Adegbulu, O. (2020). Decolonising Global (public) Health: From Western Universalism to Global Pluriversalities. *BMJ Global Health, 5,* e002947. https://doi.org/10.1136/bmjgh-2020-002947

Amare, D., Alene, K. A., & Ambaw, F. (2024). Impact of Integrating Traditional Care with the Modern Healthcare System in Reducing Tuberculosis Diagnosis Delays in Ethiopia: A Clustered Randomized Controlled Study. *Tropical Medicine and Health, 52,* Article No. 83. https://doi.org/10.1186/s41182-024-00641-0

Apangu, T., Candini, G., Abaru, J., Candia, B., Okoth, F. J., Atiku, L. A. et al. (2023). Engagement with Traditional Healers for Early Detection of Plague in Uganda. *The American Journal of Tropical Medicine and Hygiene, 109,* 1129-1136. https://doi.org/10.4269/ajtmh.23-0101

Atre, S. R., Kudale, A. M., Morankar, S. N., Rangan, S. G., & Weiss, M. G. (2004). Cultural Concepts of Tuberculosis and Gender among the General Population without Tuberculosis in Rural Maharashtra, India. *Tropical Medicine & International Health, 9,* 1228-1238. https://doi.org/10.1111/j.1365-3156.2004.01321.x

Baquero-Artigao, F., del Rosal, T., Falcón-Neyra, L., Ferreras-Antolín, L., Gómez-Pastrana, D., Hernanz-Lobo, A. et al. (2023). Update on the Diagnosis and Treatment of Tuberculosis. *Anales de Pediatría (English Edition), 98,* 460-469. https://doi.org/10.1016/j.anpede.2023.03.009

Barter, D. M., Agboola, S. O., Murray, M. B., & Bärnighausen, T. (2012). Tuberculosis and Poverty: The Contribution of Patient Costs in Sub-Saharan Africa—A Systematic Review. *BMC Public Health, 12,* Article No. 980. https://doi.org/10.1186/1471-2458-12-980

Biesma, R. G., Brugha, R., Harmer, A., Walsh, A., Spicer, N., & Walt, G. (2009). The Effects of Global Health Initiatives on Country Health Systems: A Review of the Evidence from HIV/AIDS Control. *Health Policy and Planning, 24,* 239-252. https://doi.org/10.1093/heapol/czp025

Brynildsrud, O. B., Pepperell, C. S., Suffys, P., Grandjean, L., Monteserin, J., Debech, N. et al. (2018). Global Expansion of *Mycobacterium tuberculosis* Lineage 4 Shaped by Colonial Migration and Local Adaptation. *Science Advances, 4,* eaat5869. https://doi.org/10.1126/sciadv.aat5869

Büyüm, A. M., Kenney, C., Koris, A., Mkumba, L., & Raveendran, Y. (2020). Decolonising Global Health: If Not Now, When? *BMJ Global Health, 5,* e003394. https://doi.org/10.1136/bmjgh-2020-003394

Chandanabhumma, P. P., & Narasimhan, S. (2020). Towards Health Equity and Social Justice: An Applied Framework of Decolonization in Health Promotion. *Health Promotion International, 35,* 831-840. https://doi.org/10.1093/heapro/daz053

Colvin, C., Mugyabuso, J., Munuo, G., Lyimo, J., Oren, E., Mkomwa, Z. et al. (2014). Evaluation of Community-Based Interventions to Improve TB Case Detection in a Rural District of Tanzania. *Global Health: Science and Practice, 2,* 219-225. https://doi.org/10.9745/ghsp-d-14-00026

Edginton, M. E., Sekatane, C. S., & Goldstein, S. J. (2002). Patients' Beliefs: Do They Affect Tuberculosis Control? A Study in a Rural District of South Africa. *The International Journal of Tuberculosis and Lung Disease, 6,* 1075-1082.

Give, C., Morris, C., Murray, J., José, B., Machava, R., & Wayal, S. (2024). Sociocultural Understanding of Tuberculosis and Implications for Care-Seeking among Adults in the Province of Zambezia, Mozambique: Qualitative Research. *PLOS ONE, 19,* e0289928. https://doi.org/10.1371/journal.pone.0289928

Highland Post (2025). *NTEP Meghalaya on Rugged Path to Break TB Chain.* Highland Post. https://highlandpost.com/ntep-meghalaya-on-rugged-path-to-break-tb-chain/

Hindmarch, S., & Hillier, S. (2023). Reimagining Global Health: From Decolonisation to Indigenization. *Global Public Health, 18,* Article ID: 2092183. https://doi.org/10.1080/17441692.2022.2092183

Jaiswal, A. (2025). *City Goes All Out to Eradicate TB, Focus on Slums. The Times of India.* https://timesofindia.indiatimes.com/city/delhi/city-goes-all-out-to-eradicate-tb-focus-on-slums/articleshow/121299069.cms

Juma, B. M., Nzioki, J. M., Kibiti, C., & Shaikh, M. (2022). Socio-Cultural Factors Associated with Patient Delay in Commencement of Anti-TB Drugs among TB Patients in Kwale County, Kenya. *African Journal of Health Sciences, 35,* 469-474. https://www.ajol.info/index.php/ajhs/article/view/237703

Kenya, K. (2024). *Barriers to Accessing HIV and TB Medicines in Kenya.* KELIN Kenya. https://www.kelinkenya.org/barriers-to-accessing-hiv-and-tb-medicines-in-kenya/

Kwete, X., Tang, K., Chen, L., Ren, R., Chen, Q., Wu, Z. et al. (2022). Decolonizing Global Health: What Should Be the Target of This Movement and Where Does It Lead Us?. *Global Health Research and Policy, 7,* Article No. 3. https://doi.org/10.1186/s41256-022-00237-3

Makabayi-Mugabe, R., Musaazi, J., Zawedde-Muyanja, S., Kizito, E., Fatta, K., Namwanje-Kaweesi, H. et al. (2023). Community-Based Directly Observed Therapy Is Effective and Results in Better Treatment Outcomes for Patients with Multi-Drug Resistant Tuberculosis in Uganda. *BMC Health Services Research, 23,* Article No. 1248. https://doi.org/10.1186/s12913-023-10120-7

Mant, M., Abonyi, S., & Hackett, P. (2023). Colonial Tuberculosis Legacies and the Dynevor Indian Hospital (1908-1934). *Canadian Medical Association Journal, 195,* E278-E280. https://doi.org/10.1503/cmaj.221284

Matakanye, H., Tshitangano, T. G., Mabunda, J. T., & Maluleke, T. X. (2021). Knowledge, Beliefs, and Perceptions of TB and Its Treatment Amongst TB Patients in the Limpopo Province, South Africa. *International Journal of Environmental Research and Public Health, 18,* Article 10404. https://doi.org/10.3390/ijerph181910404

Mbuthia, G. W., Nyamogoba, H. D. N., Chiang, S. S., & McGarvey, S. T. (2020). Burden of Stigma among Tuberculosis Patients in a Pastoralist Community in Kenya: A Mixed Methods Study. *PLOS ONE, 15,* e0240457. https://doi.org/10.1371/journal.pone.0240457

McCulloch, J., & Miller, P. (2023a). Tuberculosis and Migrant Labour in the High Commission Territories: Bechuanaland: 1885-1998. In J. McCulloch, & P. Miller (Eds.), *Mining Gold and Manufacturing Ignorance* (pp. 197-229). Springer Nature Singapore. https://doi.org/10.1007/978-981-19-8327-6_8

McCulloch, J., & Miller, P. (2023b). Tuberculosis, Malnutrition and Mining in South Africa: 1903-1960. In J. McCulloch, & P. Miller (Eds.), *Mining Gold and Manufacturing Ignorance* (pp. 169-196). Springer Nature Singapore. https://doi.org/10.1007/978-981-19-8327-6_7

McMillen, C. (2021). Indigenous Peoples, Tuberculosis Research and Changing Ideas about Race in the 1930s. *Canadian Medical Association Journal, 193,* E1666-E1668. https://doi.org/10.1503/cmaj.210613

Mindu, C., López-Varela, E., Alonso-Menendez, Y., Mausse, Y., Augusto, O. J., Gondo, K. et al. (2017). Caretakers' Perspectives of Paediatric TB and Implications for Care-Seeking Behaviours in Southern Mozambique. *PLOS ONE, 12,* e0182213. https://doi.org/10.1371/journal.pone.0182213

Moffatt, J., Mayan, M., & Long, R. (2013). Sanitoriums and the Canadian Colonial Legacy: The Untold Experiences of Tuberculosis Treatment. *Qualitative Health Research, 23,* 1591-1599. https://doi.org/10.1177/1049732313508843

Moralina, A. R. (2009). State, Society, and Sickness: Tuberculosis Control in the American Philippines, 1910-1918. *Philippine Studies: Historical and Ethnographic Viewpoints, 57,* 179-218. https://doi.org/10.13185/2244-1638.4980

Msoka, E. F., Orina, F., Sanga, E. S., Miheso, B., Mwanyonga, S., Meme, H. et al. (2021). Qualitative Assessment of the Impact of Socioeconomic and Cultural Barriers on Uptake and Utilisation of Tuberculosis Diagnostic and Treatment Tools in East Africa: A Cross-Sectional Study. *BMJ Open, 11,* e050911. https://doi.org/10.1136/bmjopen-2021-050911

Munyangaju, I. (2024). Beyond Decoloniality: Toward a Framework of Global Equity. *Advances in Applied Sociology, 14,* 728-739. https://doi.org/10.4236/aasoci.2024.1412047

Neelakantan, V. (2018). Tuberculosis Control in Postcolonial South India and Southeast Asia: Fractured Sovereignties in International Health, 1948-1960. *Wellcome Open Research, 2,* Article 4. https://doi.org/10.12688/wellcomeopenres.10544.2

Nhassengo, P., Yoshino, C., Zandamela, A., De Carmo, V., Burström, B., Khosa, C. et al. (2023). Perspectives of Healthcare and Social Support Sector Policymakers on Potential Solutions to Mitigate Financial Impact among People with TB in Mozambique: A Qualitative Study. *BMJ Open, 13,* e073234. https://doi.org/10.1136/bmjopen-2023-073234

Nhassengo, P., Yoshino, C., Zandamela, A., De Carmo, V., Burström, B., Lönnroth, K. et al. (2024). "They Didn't Look at Me with Good Eyes"—Experiences of the Socioeconomic Impact of Tuberculosis and Support Needs among Adults in a Semi-Rural Area

in Mozambique: A Qualitative Study. *Global Public Health, 19,* Article ID: 2311682. https://doi.org/10.1080/17441692.2024.2311682

Oga-Omenka, C., Tseja-Akinrin, A., Sen, P., Mac-Seing, M., Agbaje, A., Menzies, D. et al. (2020). Factors Influencing Diagnosis and Treatment Initiation for Multidrug-Resistant/Rifampicin-Resistant Tuberculosis in Six Sub-Saharan African Countries: A Mixed-Methods Systematic Review. *BMJ Global Health, 5,* e002280. https://doi.org/10.1136/bmjgh-2019-002280

Oladimeji, O., Tsoka-Gwegweni, J., & Udoh, E. (2017). *Barriers and Strategies to Improve Tuberculosis Care Services in Resource-Constrained Setting: A Qualitative Analysis of Opinions from Stake-Holders in Oyo State South West Nigeria.* SMGgroup.

Otieno, J., Luciani, A., Lumumba, S., Gikunda, G., Kiilu, C., Ogutu, N. et al. (2024). Mental Health Issues Associated with the Management of Tuberculosis in Homabay, Busia and Kakamega Counties, Kenya. *PLOS ONE, 19,* e0298268. https://doi.org/10.1371/journal.pone.0298268

Packard, R. M. (1987). Tuberculosis and the Development of Industrial Health Policies on the Witwatersrand, 1902-1932. *Journal of Southern African Studies, 13,* 187-209. https://doi.org/10.1080/03057078708708141

Phutane, M. S., Sawant, P. A., Randive, A. P., Hulsurkar, Y. P., Mahajan, U. S., & Kudale, A. M. (2024). Sociocultural Aspects of Delays in Diagnosis among Tuberculosis-Diabetes Comorbid Patients in Satara, India: Its Implications for the Implementation of the National Framework for Joint Tuberculosis-Diabetes Collaborative Activities. *Indian Journal of Tuberculosis, 71,* 250-261. https://doi.org/10.1016/j.ijtb.2023.05.001

Schausberger, B., Mmema, N., Dlamini, V., Dube, L., Aung, A., Kerschberger, B. et al. (2021). "We Have to Learn to Cooperate with Each Other": A Qualitative Study to Explore Integration of Traditional Healers into the Provision of HIV Self-Testing and Tuberculosis Screening in Eswatini. *BMC Health Services Research, 21,* Article No. 1314. https://doi.org/10.1186/s12913-021-07323-1

Sen, K., Qadeer, I., & Missoni, E. (2022). Understanding the Context of Global Health Policies: Their Post-Colonial Legacies and Impacts on Health Service Systems. *World Review of Political Economy, 13,* 322-343. https://doi.org/10.13169/worlrevipoliecon.13.3.0322

Shariati, S. (2023). *Hidden Wounds: Tuberculosis, Colonialism, and the Unsettling Story of Indian Hospitals.* IMS Magazine. https://imsmagazine.com/2023/11/06/hidden-wounds-tuberculosis-colonialism-and-the-unsettling-story-of-indian-hospitals/

Singh, U. B., Rade, K., Rao, R., Kumar, N., Mattoo, S. K., Nair, S. et al. (2025). *Lessons and Updates from India's National TB Elimination Program—Bold Decisions and Innovative Ways of Fast-Tracking Progress towards Ending TB. IJID Regions.* https://regions.ijidonline.org/article/S2772-7076(25)00034-7/fulltext

Suvvari, T. K. (2025). The Persistent Threat of Tuberculosis—Why Ending TB Remains Elusive? *Journal of Clinical Tuberculosis and Other Mycobacterial Diseases, 38,* Article ID: 100510. https://doi.org/10.1016/j.jctube.2025.100510

The Shillong Times (2025). *Meghalaya Leverages Cutting-Edge Technology to Combat Tuberculosis.* https://theshillongtimes.com/2025/03/22/meghalaya-leverages-cutting-edge-technology-to-combat-tuberculosis/

Tribune, T. A. (2025). *Meghalaya Integrates Traditional Healers & Modern Technology to Combat TB.* https://assamtribune.com/north-east/meghalaya-integrates-traditional-healers-mod-

ern-technology-to-combat-tb-1571757

Vivek (2025). *Power Asymmetries in Global Health Governance: Challenges and Local Struggles in Africa.* ROAPE. https://roape.net/2025/03/05/power-asymmetries-in-global-health-governance-challenges-and-local-struggles-in-africa/

WHO (2024). *Global Tuberculosis Report 2024.* World Health Organization. https://www.who.int/teams/global-tuberculosis-programme/tb-reports/global-tuberculosis-report-2024

Yanga, N. (2025). Missed Nuances in Tuberculosis Research: Reflections from a Tibetan Scholar. *International Journal of Social Determinants of Health and Health Services, 55,* 330-337. https://doi.org/10.1177/27551938251314654

Yanou, M. P., Ros-Tonen, M. A. F., Reed, J., Moombe, K., & Sunderland, T. (2023). Integrating Local and Scientific Knowledge: The Need for Decolonising Knowledge for Conservation and Natural Resource Management. *Heliyon, 9,* e21785. https://doi.org/10.1016/j.heliyon.2023.e21785