Tuberculosis in First Nations, Métis and Inuit in Canada

Speaking Notes

- TB in First Nations and Inuit Communities -

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The Lung Association presentation to the House of Commons Standing Committee on Health on April 20, 2010 is found on pages 2 - 4.

In response to a request for recommendations, a letter was sent on April 23, 2010 which is found on pages 5 - 6.
Madam Chair and Members of the Committee,

I am pleased to be here today on behalf of The Canadian Lung Association, to speak about the high rates of tuberculosis among First Nations and Inuit communities. At the outset, I wish to thank the Committee for holding today’s hearing which recognise that this is a serious issue that deserves the attention of Parliament.

Madam Chair, as you know, the Public Health Agency of Canada (PHAC) reports cases of tuberculosis (TB) in three subdivisions: Canadian-born Aboriginals, Canadian-born Non-aboriginals and Foreign-born. PHAC further divides the Aboriginal segment into “Status Indian”, “Non-Status”, “Métis” and “Inuit”.

In 2008, there were 28.2 TB cases per 100,000 Canadian-born Aboriginals, 0.8 TB cases per 100,000 Canadian-born Non-aboriginals and 13.3 TB cases per 100,000 foreign-born persons.

If we focus on the Canadian-born segment of the population, the rates of tuberculosis are 35 times higher in the Aboriginal population with the highest TB rates in the Inuit.

The long term trend has been that overall TB rates are slowly declining in Canada. In absolute terms, the total number of TB cases in Canadian-born Non-aboriginals declined from 720 cases in 1987 to 209 cases in 2008. However, in Canadian-born Aboriginals, TB remains at much the same caseload: 384 cases in 1987 and 341 cases in 2008.

Why has the TB rate failed to decrease in the Aboriginal population while there has been a steady decline in the Non-aboriginal population and also in the foreign born?

In 1902, Sir William Osler, Canada’s most celebrated physician, noted that, “Tuberculosis is a social disease with a medical aspect.”

Worldwide, tuberculosis tracks poverty better than any other disease. Dr. Osler’s observation in 1902 still holds true today.

How do people become infected with TB? The most common way that TB infection is spread is by breathing the same indoor air as someone who has an infectious case of TB. People usually become infected without being aware of it. TB is thus a disease of crowding. When many people are living together TB spreads more quickly.

Tuberculosis is a very opportunistic disease. Many people are infected with TB germs but do not have a case of tuberculosis because the TB germs are dormant - lying in wait for the person’s immune system to become compromised before making its assault on the body.

Low socio-economic living conditions contribute to high rates of TB in various ways. First of all crowding aids the transmission of the infection. According to the Canada Mortgage and Housing Corporation (CMHC), 50% of First Nations housing on reserve fall below CMHC housing standards for suitability and adequacy.
Low socio-economic living conditions lead to poorer nutrition which in turn leads to a weaker immune system and a reduced ability to fight TB germs. This is especially true in remote northern communities where food prices tend to be extremely high. Poor water quality leads to poor health in general, a weaker immune system and yet another opportunity for tuberculosis to flourish.

People living in low socio-economic conditions are more likely to be smokers or to be living in a home with second-hand tobacco smoke. World Health Organisation studies have shown that both smokers and children exposed to tobacco smoke are at greater risk for TB.

To our shame, the rates of TB in some of our First Nations, Métis and Inuit communities rival the rates of TB seen in developing countries. We can and must do better.

Firstly, we need to maintain top quality TB control programs across Canada. We have to be able to find and treat people with active TB; to find people infected with the TB germs and treat them before they develop the disease; to ensure that everyone who starts a course of TB medication finishes it to minimise the risk of developing a drug-resistant case of TB; to have laboratories for diagnosing TB; and to maintain surveillance of TB cases so that outbreaks are quickly identified and decisions on programs are based on evidence.

But for our First Nations, Métis and Inuit communities we have to do more.

We have to address the social determinants of health such as inadequate housing, lack of access to nutritious food and clean water, lack of access to health care and high smoking rates. When we treat TB we are treating a symptom of an underlying social disorder.

Change will not happen quickly but we still must act quickly.

Some diseases like cholera for example, are dangerous because the germs grow very rapidly and can overcome a person within days. TB is dangerous because it progresses slowly but surely. Tuberculosis germs grow so slowly that it takes a couple of weeks to grow enough germs in a cell culture under ideal growing conditions to be able to diagnose the disease. It takes six months or more of taking a combination of drugs to cure a case of TB. Without interventions, a tuberculosis epidemic can take about 200-300 years to run its course.

The Lung Association has been fighting TB for 110 years. We are here for the long term. Solutions to the TB problem in First Nations, Métis and Inuit communities will require long-term programs with long-term indicators for success and long-term funding.

It took over 30 years for TB rates in the Non-aboriginal population to fall from where Aboriginal rates are now to below 1 per 100,000. We have better tools now and a much quicker decline in TB rates in the Aboriginal population can be achieved, but we need to build capacity and work with First Nations, Métis and Inuit community leaders and champions to make effective TB control a reality. Although TB rates are high, other
pressing matters often push TB down the priority list in many communities. TB still carries a stigma. The SCRAP-TB program showed us how to build TB capacity in First Nations and the PAL Project shows promise.

A successful TB program requires close collaboration of federal and provincial health agencies as well inter-tribal health authorities, individual First Nations and Métis and Inuit organisations. TB programs must provide seamless care for on- or off-reserve treatment. The TB germ does not respect jurisdictional borders and Canada’s TB control programs must not be hindered by jurisdictional constraints.

The cost of inaction is high, both in terms of human suffering and health care dollars. An effective TB program is our best defence against drug-resistant strains of TB. One multi-drug resistant case of TB can cost hundreds of thousands of dollars to cure and an extensively resistant case can cost over a million dollars.

We have the tools. We have the expertise. We have the experience. We need to collaborate with First Nations, Métis and Inuit communities to build sustainable community-led and community-driven initiatives working in harmony with provincial and national TB control measures to eliminate the gap in TB rates compared to the rest of Canada.

Submitted on behalf of the Canadian Lung Association by

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TO: Members of the House of Commons Standing Committee on Health

Dear Committee Members:

As requested at the hearings on Tuesday, April 20, 2010, I submit the following specific recommendations on tuberculosis in First Nations, Inuit and Métis for consideration in your report to parliament.

Recommendations:

1. Métis must be included in programs that address TB in Aboriginals. The TB case load is high and has not decreased in the past 10 years. There were 32 cases of TB in Métis in 1997 and in 2007 there were still 32 cases. Most cases are in Saskatchewan where the TB rate for Métis is 33 per 100,000.

2. There must be a long-term approach to this issue with long-term funding and long-term performance indicators. Funding levels must be sufficient to make a positive impact and must be committed for sufficient time to sustain a long-term program.

3. Absolute numbers of TB cases in each group should be used to set goals and performance indicators to alleviate uncertainty in the denominator. Even though the population is growing, we must see a decline in the number of TB cases. Furthermore a three-year or even a five-year average should be used when evaluating changes in the number of TB cases to smooth the effect of the timing of breakouts of TB which cause fluctuations in the year-to-year figures. A TB control program which becomes more effective in finding TB cases will likely show an increase in the number of TB cases in its initial stages, which once again stresses the need for long-term indicators.

4. People living in high-burden TB communities should be trained in the management of TB and directly observed therapy and included in the TB Control Team. Some aspects of TB control do not require a health care professional. Community members can provide continuity in the TB control program that is sometimes lost due to high turnover rates of health care professionals.
5. Grass-roots programs, such as SCRAP-TB and PAL (Practical Approach against Lung disease) should be supported to involve individual First Nations, Métis and Inuit communities in building capacity for community-led programs in TB. Such programs complement TB control programs by educating and raising awareness about TB and addressing the stigma of TB.

6. The reduction of tuberculosis among the First Nations, Inuit and Métis must be clearly identified as a priority for Federal, Provincial and Territorial governments. There must be clear lines of responsibility for medical TB treatment for all Aboriginal people.

7. Jurisdictional constraints to providing optimal TB care to First Nations, Inuit and Métis people must be removed. There must be seamless care for TB patients travelling on- or off-reserve, from one health region to another or from one province or territory to another. A successful TB program requires close collaboration of federal and provincial health agencies as well inter-tribal health authorities, individual First Nations and Métis and Inuit organisations. All levels of government and all agencies must be committed and accountable to working together to meet clear goals for reduction in TB cases.

8. There must be a firm commitment to simultaneously address the social determinants of health that precipitate and perpetuate high rates of TB among First Nations, Inuit and Métis peoples.

These recommendations are submitted on behalf of the Canadian Lung Association.

Please feel free to contact me if you require any further information.

Sincerely,

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President and CEO
Lung Association of Saskatchewan