The Fight Against First Nations Tuberculosis in Manitoba 1890-1950
Dr. Paul Hackett, Geography, University of Saskatchewan; Saskatchewan Population Health and Evaluation Research Unit

1 Introduction
From the 1880s to the 1950s tuberculosis was the dominant threat to the health of the First Nations of Manitoba. During that span, efforts to combat tuberculosis were funded only through charities and minimal contributions by the federal government, and as a consequence as the epidemic was beginning to emerge among the Plains people, whose main food source, the bison, had almost completely disappeared and who thereafter signed treaties with the Canadian government and were confined to reserves. Poor living conditions, overcrowding and other factors created an ideal situation for the disease, and the estimated TB mortality rates of the late nineteenth century were among the highest ever recorded. By the early twentieth century, the epidemic was beginning to emerge among the people of the parkland and forest, who faced similar hardships. Particularly hard hit were the children sent to the boarding schools. Throughout this era the federal government provided only minimal food and medical support, and most of this was given to the southern bands.

By the 1920s the province had begun to act on the epidemic out of concern for its own population. However, case-finding (through x-ray surveys) and treatment of these non-citizens were funded only through charities and minimal contributions by the federal government, and as a consequence assistance was limited to the accessible south and the communities along the settlement frontier. In 1937 the federal government held a conference in Ottawa which was to prove a turning point in the fight against TB. Thereafter, increasing funds were made available for treating First Nations TB. The first TB hospital for First Nations, St. Peters Dynevor (1939) was soon followed by others in Manitoba, including Clearwater (1945) and Brandon (1948). As of 1933 only 13 out of 127, or 10.2%, of TB deaths among Manitoba First Nations occurred in an institution (hospitals, mental hospitals and sanatoria). This was indicative of the lack of access to treatment on the part of the province's First Nations, which in turn helped to fuel much higher TB mortality rates than among the rest of the province's people.

By the end of the 1940s a far larger number was in treatment, and the proportion dying of TB in institutions was much higher (right). This meant that infectious cases were being removed from the community, breaking the chain of infection, and that they were more likely to receive treatment. Both contributed to the decline of TB in the province.

2 The Early Epidemic:
The TB epidemic among Manitoba’s First Nations began during the 1880s, a consequence of changing ecological, economic and political conditions. Initially it was confined to the plains peoples whose main food source, the bison, had almost completely disappeared and who thereafter signed treaties with the Canadian government and were confined to reserves. Poor living conditions, overcrowding and other factors created an ideal situation for the disease, and the estimated TB mortality rates of the late nineteenth century were among the highest ever recorded. By the early twentieth century, the epidemic was beginning to emerge among the people of the parkland and forest, who faced similar hardships. Particularly hard hit were the children sent to the boarding schools.

3 Increased Treatment: The 1940s
In 1937 the federal government held a conference in Ottawa which was to prove a turning point in the fight against TB. Thereafter, increasing funds were made available for treating First Nations TB. The first TB hospital for First Nations, St. Peters Dynevor (1939) was soon followed by others in Manitoba, including Clearwater (1945) and Brandon (1948). As of 1933 only 13 out of 127, or 10.2%, of TB deaths among Manitoba First Nations occurred in an institution (hospitals, mental hospitals and sanatoria). This was indicative of the lack of access to treatment on the part of the province’s First Nations, which in turn helped to fuel much higher TB mortality rates than among the rest of the province’s people.

By the end of the 1940s a far larger number was in treatment, and the proportion dying of TB in institutions was much higher (right). This meant that infectious cases were being removed from the community, breaking the chain of infection, and that they were more likely to receive treatment. Both contributed to the decline of TB in the province.

4 Decline
The combination of better case-finding and greater numbers of tuberculosis beds for First Nations people improved treatment, and it also led to the removal of ‘spreaders’ from the reserve populations. This decreased opportunities for new infections. The adoption of new surgical techniques and, in 1948, the first available antibiotic, streptomycin, greatly improved chances for survival. As a result, the TB death rate plummeted following 1937, with the exception of a brief period during the Second World War (right). By 1952 Manitoba’s First Nations rate was finally better than that of Saskatchewan, traditionally the leader among the Prairie Provinces.

Nevertheless, improvements in the First Nations experience with TB continued to lag behind that of the general population. As of 1952 the “Indian” TB death rate was still 13 times higher than the “non-Indian” rate (right). Later, as improvements continued and mortality became rare among all groups, First Nations TB morbidity in Manitoba continued to be five to six times higher than among the general population, a pattern that continues today.

In the present, TB remains a potential threat to the province’s First Nations people. While mortality is rarely, periodic outbreaks continue to occur, particularly on northern reserves where dense (and generally poor) living conditions, high stress levels and a lack of medical surveillance favour the disease. In this respect, the fight against tuberculosis among the First Nations of Manitoba remains incomplete.

Acknowledgements: Funding for this research was provided by the: Canadian Institutes for Health Research and Associated Medical Services, Toronto;

Paul Hackett, Geography, University of Saskatchewan, 266.3 Arts Building, 9 Campus Drive, Saskatoon, SK, S7N 0W0