Why the White Plague Reigns: A Nurse of European Background's Reflections on Tuberculosis Among Indigenous Peoples in Saskatchewan

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ABSTRACT

Tuberculosis is nearly eliminated in non-Indigenous Peoples in Canada yet remains a public health crisis for many Indigenous Peoples in this country. Nurses play a key role in TB elimination efforts for Indigenous Peoples in Canada and must do the work to learn how historical events and wrongdoings have led to the disproportionate TB burden many Indigenous Peoples face. We must understand the impact of these historical events and actively move towards truth and reconciliation if we hope to ever bridge the health equity gaps in this country and eliminate TB. Like many others, I did not know the truth until I began to ask the questions. As a tuberculosis registered nurse (TB RN) of European descent caring for the Indigenous population with TB in Saskatchewan, I have had some profound experiences. I will explore some of these encounters and the factors that affect TB elimination in Canada through my reflective journey.

Keywords: Indigenous, determinants of health, truth and reconciliation, inequities, stigma

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Tuberculosis (TB) has been a persistent public health challenge in Canada, with Indigenous communities bearing a disproportionate burden of the disease. Complex historical, political, and socioeconomic factors, including the determinants of health and Canadian colonialism and colonization have contributed to these health disparities. Once deemed the most significant health problem for all Canadians, TB rates decreased rapidly near the end of the twentieth century due to the availability of antibiotics and improved living conditions (Public Health Agency of Canada [PHAC], 2014). With modern medicine, TB is now easily diagnosed,

treated, and cured, making it exceedingly rare in the general population. Despite this, Indigenous Canadians continue to experience disparate rates of TB compared to non-Indigenous Canadians. Acknowledging the impact of historical events and wrongdoings towards First Nations, Inuit, and Métis Canadians with TB is the responsibility of all Canadians, but especially mine. As a registered nurse and a white settler mother who has worked for the federal government and provided care to the Indigenous population in Saskatchewan, I owe this to all the people who were taken to TB sanatoria, an Indian Hospital, or a residential school and never made it home.

As a Caucasian (white) tuberculosis registered nurse (TB RN), I have had some profound experiences caring for the Indigenous population with TB in Saskatchewan. I will explore some of the factors that affect TB elimination in Canada as I reflect on my journey to understand their experiences. At the time of writing this, I have found no literature specifically on my topic and note that there exists a gap in research reflecting the perspectives of a white nurse working with TB in Indigenous Peoples in Saskatchewan. I admit, I come from a place of white privilege and acknowledge that these experiences are my observed and heard experiences, but that they are not my own lived experiences. While sharing my first-person account of my experiences with TB in Indigenous Peoples, I explore the historical shadows cast by TB in Canada, including the dark histories of trauma, colonialism, residential schools, and TB sanatoria. By examining historical factors, reviewing relevant literature, and reflecting on personal experiences, I hope by writing this paper I will contribute to a comprehensive understanding of the challenges faced by Indigenous communities related to TB. The reflections will be critical to understanding the fear, stigma, and mistrust that exist today in Indigenous Peoples with TB. By sharing my experiences, and on a journey to cultural humility and allyship, I hope to create a safe space for other nurses to question their own knowing of factors that affect Indigenous health in Canada. This qualitative design will feature personal perspectives, storytelling, conversations, and photos.

This is a first-person perspective of my journey to truth, reconciliation, and allyship with Indigenous Peoples. My unique experiences and reflections as a white nurse working with TB in Indigenous Peoples in Saskatchewan is presented in this paper.

Background

Nearly eliminated in non-Indigenous Peoples in Canada, TB, or the White Plague, remains a public health crisis for many Indigenous Peoples in this country, where their overall incidence is 16.6/100,000, compared to 0.3/100,000 for non-Indigenous Canadians (Boffa et al., 2011; Dehghani et al., 2018; Jetty, 2021; Kulmann & Richmond, 2011; Mayan et al., 2019; Mounchili et al., 2022; PHAC, 2024; Richmond & Cook, 2016). Broken down further for Indigenous Peoples, Inuit see an incidence of 135.1 per 100,000, followed by First Nations at 16.1 per 100,00, and Métis at 2.1 per 100,000 (PHAC). Appearing below the overall Canadian incidence of 4.8/100,000, 90.0% of these cases were localized to specific areas of Saskatchewan, resulting in an adjusted incidence of 13.4 per 100,000 for Métis Peoples in Saskatchewan (PHAC). Perhaps most distressing, Boffa et al. report that in recent years, TB rates in some Prairie First Nations communities rival sub-Saharan African rates.

Despite these numbers, many are unaware that it remains an issue in Canada, let alone Saskatchewan. In fact, whenever I tell someone that I work with TB, they are often confused about what I mean, as most (in my predominantly European, privileged personal groups), believe that TB was eradicated many years ago. They are shocked to learn that not only is it still here, but that people are still getting sick and even dying from it. Even with provincial and federal TB prevention and control programming, the rate of TB in Saskatchewan continually exceeds the national average (PHAC, 2021). In 2021, Saskatchewan recorded the third highest rate of TB of our provinces and territories, at 10.3/100,000 (PHAC, 2024). In my undergraduate degree, we spent about five minutes of one class on TB. When I wrote the Canadian Registered Nurses Exam, there was one question related to TB, on the acronym for Directly Observed Therapy. One professor even said, "you will never see it (TB) in your career here, but we have to teach it." And yet here I am, and it has become my entire career.

To address the Truth and Reconciliation Commission (TRC) of Canada's *Calls to Action* and specifically health inequities, I have started to learn and understand the history of how the Indigenous Peoples of Canada were, and continue to be, treated (TRC: Government of Canada, 2015). On the road to cultural humility, I have had to face my own personal beliefs and biases that have been so deeply engrained in me as a middle-class, educated, and privileged white woman growing up and raising my children in rural Saskatchewan. This is my experience and perspective as a TB RN of European background for the Indigenous population in Saskatchewan.

My first day as a TB RN, a young European woman driving onto a First Nations reserve in southern Saskatchewan in a shiny silver Dodge Journey covered in Government of Canada decals, I expected that the community would be happy to see me. I thought, "Here I am. I have the knowledge and resources to help you." But my presence in the community was not well-received, and in fact, none of the clients I was expected to see that day would not see me. I drove back to the office, not understanding where I had gone wrong. When I asked my supervisor why nobody would see me, she asked me if I knew the history of treatment of Indigenous Peoples with TB in Canada. When I told her no, she said to me, "start there." Thus began my journey to learn everything I could about TB and Indigenous Canadians, some of which I will share here.

Implications for My Nursing Clinical Practice

I learned very quickly as a European TB RN serving the Indigenous population that you must have a strong knowledge and understanding of the history of Indigenous Peoples in this country. Despite being competent in public health and TB, my first day proved that my knowledge would only get me so far. If I had any hope of ever seeing a TB client in the First Nations communities that I was working in, I needed to bridge the gap between my textbook knowledge and the real lives of my clients and start to build trusting and reciprocal relationships. I never asked for it to happen, but my then-colleague, T, took me under her wing because she could tell that I genuinely cared. Through our work together, I had always admired T. As a beautiful Indigenous woman, the same age as me, she had real-world and lived

experience from her time as a TB RN in Nunavut and northern Saskatchewan, and a family history of TB, that shaped her into the nurse that she was. She took me with her to remote and isolated communities where I ate caribou and listened to stories of ancestors and survivors. We heard about hardships and triumphs. And once, when she was unable to share her personal stories at a TB conference, she asked that I present it on her behalf. As I choked back (most of) my tears telling her story, I felt closer to understanding her story, a story she had shared with me many times before. It was at this moment that I became an insider and not just the European TB RN that worked with T. My relationship with T made it so that I was seen as trustworthy and safe in the eyes of my clients. Suddenly, I was able to meet with and coordinate care for these clients that had previously closed their doors and blinds to me. T was my gatekeeper into her world.

I would love to be able to eliminate or contribute to ending TB for Indigenous Peoples in Canada in my lifetime, but it is much larger than I am. There exists trauma, socioeconomic factors, and a dark history that has led to the disproportionate TB burden for Indigenous Peoples in Canada (Jetty, 2021). Understanding the truth and historical treatment of Indigenous Canadians is necessary to address not only the disparate rates of TB in Indigenous Peoples in this country but is the crux of all health inequities experienced by this population. We, as Canadians, are responsible for the health and well-being of all Canadians, especially the First peoples. Implications for nurses and other healthcare providers, as well as all Canadians will be discussed in this paper so that we may begin to effectively address why the White Plague still reigns.

The *Canadian TB Standards* (Dunn et al., 2022) provides several detailed recommendations for health care workers serving Indigenous Peoples with TB, including reflection and acknowledgement of its history and the socioeconomic factors that prevent it from being eliminated. In order to look forward, we must first look to the past.

Historical Context of Tuberculosis (TB) in Canada

Tuberculosis, sometimes referred to as the White Plague due to the pallor of its victims, is rather aptly named when we consider what we, as non-Indigenous people, have done to perpetuate the disease in other populations. Several events in Indigenous history in Canada have created the perfect environment for tuberculosis to thrive in Indigenous Peoples. Some of these significant events will be discussed further.

Early Encounters: Arrival of European Settlers

The roots of TB in Canada are deeply intertwined with the arrival of European settlers. In what is now known as Canada, when the settlers from Britain and France stole the Indigenous land, it initiated a long history of both direct and indirect violence and dominance over Indigenous Peoples (Hick, 2019). One of the most known forms of indirect violence occurred as a result of the communicable diseases that the settlers brought to the Indigenous Peoples,

infecting them with smallpox and tuberculosis (Hick). Diseases introduced by these settlers, including TB, had devastating consequences for Indigenous populations, disrupting their traditional lifestyles, and leading to widespread health disparities. Notably, TB has been endemic in Canada since colonization (Hick).

The Role of Residential Schools

A significant chapter in the history of TB among Indigenous Peoples is the era of residential schools. A more direct form of violence in Canadian colonial history is the disturbing legacy of residential schools which saw the apprehension of Indigenous children from their homes with the goal of cultural genocide and to effectively "kill the Indian in the child" (Hick, 2019, Lancet, 2021, McDougall, 2018). These government-funded, church-run institutions, ostensibly established for education, became breeding grounds for TB due to overcrowded and unsanitary conditions (Bryce, 1922). With the intent of assimilation, the residential school policy resulted in loss of culture and intergenerational trauma from the spiritual, sexual, physical, and psychological abuse that the children experienced (Mahoney, 2019; TRC: Government of Canada, 2015). The residential school system is recognized as a major determinant in the overall identity, health, and wellbeing of Indigenous Canadians still today (Douglas, 2022; Government of Canada, 2019; TRC: Government of Canada; Mahoney).

Tuberculosis Sanatoria/Sanitoriums

Public health officials were granted authority by the government to abruptly remove individuals from their homes whether through coercion or force and take them to sanitoriums (Moffatt et al., 2013). Often required to stay for months or even years, former sanatoria patients describe feelings of loss and cultural disconnect, fear of illness, and painful memories of lost family members (Moffatt et al.). Many Indigenous patients died in sanatoria, and those who *did* survive, were often unable to find their way home (Moffatt et al.). Given the history of TB treatment for Indigenous Canadians, it is easy to understand why Indigenous Peoples face fear and stigma associated with TB investigation and diagnosis (Moffatt et al.).

Government Policies and Healthcare Disparities

Government policies, often well-intentioned but inadequately implemented, have played a pivotal role in perpetuating TB among Indigenous Peoples. Forced relocations, inadequate healthcare provision, systemic racism, and colonialism have contributed to the persistence of TB within Indigenous communities (McDougall, 2018). The resulting disparities in health outcomes reflect systematic issues that must be addressed to reach health equity in this country.

Determinants of Health and Socioeconomic Factors

The determinants of health, "the conditions in which peoples are born, grow, live, work and age" (World Health Organization [WHO], n.d., para 1), play an important role in the health

and wellness of all peoples, but are especially significant for Indigenous individuals (Reading & Wien, 2009; Wright et al., 2019). So significant, that simply *being* Indigenous is considered a determinant of health (Mikkonen & Raphael, 2010). Canada has consistently scored in the top five countries in the world when ranked by The Human Development Index (Marchildon et al., 2015). However, when the same methodology is applied to Indigenous Canadians, they rank much lower, at 63rd (Marchildon et al.). This issue of health inequity is not limited to the Indigenous peoples of Canada. In other "settler societies," such as the United States, Australia, and New Zealand, their Indigenous populations all maintain a lower health status and poorer health outcomes compared to the rest of their populations (Marchildon et al.). Addressing the determinants of health is essential for improving health and wellbeing and decreasing health inequities experienced by some populations (WHO).

The Indian Act

Developed in 1876 and still in existence today, the Indian Act is the only active national legislation that is specific to First Nations Peoples in Canada (Richmond & Cook, 2016). The Indian Act's original purpose of assimilation was bore out of the assumption that Indigenous Peoples were "inferior, unequal and uncivilized" (Richmond & Cook, 2016, para. 3). The effects of it are still felt today, as it has further perpetuated racism and health inequity in Canada (Richmond & Cook).

Truth and Reconciliation Commission (TRC) of Canada, 2015

In 2015, as a direct response to the Indian Residential Schools Settlement Agreement, the Truth and Reconciliation Commission of Canada (TRC) released its *Executive Summary*, findings and ninety-four *Calls to Action* to address the legacy of the residential school system (TRC: Government of Canada, 2015). Two relevant *Calls to Action* for nurses and other health care providers, #18 and #19, highlight acknowledging the current state of Indigenous health in Canada as a direct result of previous Canadian government policies, including residential schools, and on identifying and closing the gaps in health between Indigenous and non-Indigenous Canadians, including rates of chronic disease and shorter life expectancy (TRC: Government of Canada). The report and these *Calls to Action* urge us closer to knowing the truth and furthering reconciliation between Canadians and Indigenous peoples (TRC: Government of Canada). To learn the truth, we must turn to their stories.

The Stories

Undoubtedly, the most powerful and important piece of this project to me is the stories. My hope is that by sharing these stories, someone else may read them and find healing in knowing they are not alone.

My Friend, T

The story of T is not unlike many Indigenous Peoples's story in Canada. What began as a routine TB Skin Test (TST) for school, ultimately unraveled an elaborate TB history that has shaped T's family for generations and made her the advocate for Indigenous TB in Canada that she is today.

About 15 years ago, as a young woman living in Nunavut with her family, T decided to join the local nursing program there in hopes of becoming a nurse. As part of the routine Occupational Health and Safety screening with her nursing program, T had to have a TST performed. A TST is an intradermal injection of a small amount of protein derived from antigens of *M. tuberculosis* bacteria to determine if someone has been previously infected with TB or has been in close contact with someone with active TB (Campbell et al., 2022). The results of T's TST came back 'positive,' and she was diagnosed with latent TB infection. The findings, measured in millimeters, is read 48-72 hours after being 'planted', which, combined with a thorough history and reason for performing the TST, can be interpreted as 'positive' or 'negative'. Despite living in Nunavut at the time, T knew very little about TB, and like many Canadians, had not even realized it was still around. Once she began to speak to family and explore where she could have possibly been exposed to TB, she learned why TB was hardly ever spoken about in her home, and how TB was deeply intertwined in her own family's history. T's kookum, or grandmother, had been sent twice to the Fort Qu'Appelle, Saskatchewan TB sanitorium in the 1950's. She was told that there, the adults and children were forbidden to interact, even if related. T's aunt, less than ten years old at the time, was sent to live at the same sanitorium where her mother was, though they never saw each other there. Experiences of abuse, force-feeding, medical experimentation, and isolation were shared with T. She was told about how when physicians visited Indigenous communities to screen/test for TB, people with TB were not given the opportunity to collect their belongings or say goodbye to their families before being taken away.

Some Never Seen Again

The usual Canadian Government policy for Inuit Peoples in Nunavut was to be sent for medical services to the south in Ontario, and for those from the North-West Territories to be sent to the Prairie provinces for medical services. I have been told that this was also customary practice for First Nations or Inuit Canadians after a TB diagnosis. In fact, it is reported that Hamilton's Mountain Sanitorium in Ontario once housed the largest year-round Inuit community in all of Canada (Bennet, 2016b). What strikes me, is that many who were taken south to treat their TB never returned home. Taken from their homes with no word of where they were going and unable to speak the language once they arrived at the sanitorium; even if they beat the odds and survived their TB, many were unable to find home. With families left waiting and wondering, some were never seen again. At minimum, language, culture, traditional medicine, and familial relationships were lost. But in many cases, lives were lost. For Indigenous Peoples, this generational grief, fear, and stigma still exist.

Hamilton's Sanatorium on the Mountain (Bennet, 2016a)

Since finishing nursing school, T has made it her career to address TB in the Indigenous population in Canada. Although she no longer lives in Nunavut, T has found another place where TB affects Indigenous Peoples disproportionately in this country. She now resides in northern Saskatchewan and leads the TB program as the TB Nurse Advisor for the Indigenous communities there. Combining her knowledge, lived experience, and traditional and Cree cultural aspects to her work has created a profound impact on the TB community in Canada. Additionally, she is the nominated/appointed Co-Chair for STOP TB Canada; appointed member of the Board of Directors for Lung Sask; spoken for/worked with: the Saskatchewan Health Authority; delivered various podcasts, Lung Sask, Canadian Agency for Drugs and Technologies in Health, Communities, Alliances and Networks; written an op-ed and co-authored articles on TB and public policy; panelist at the Canadian Conference on Global Health; presenter at The Union: World Conference on Lung Health; Future 40 recipient with CBC Saskatchewan; Inuit Tapiriit Kanatami webinar presenter; keynote speaker for the Parliamentary Reception for World TB Day; and panelist at the United Nations Multistakeholder hearing on Tuberculosis. All because her TST came back positive 15 years ago.

A TB Survivor B.P.

Not unlike T's family stories, a Saskatchewan First Nations man, B.P., has told a similar story of his experiences at the Fort Qu'Appelle, Saskatchewan TB sanitorium, 'Fort San' (Bamford, 2022). B.P. has shared that in the 1960's, when he was four years old, he and twenty-one other children were taken from their homes on George Gordon First Nation without any notice. He echoes what T's family had told her and has stated that adults were separated from children and that he never saw his sister, who also was at the sanitorium, during his time there. He said that his parents tried to visit twice but that they were chased away. B.P. has stated that he and other First Nations kids were horribly abused by doctors and nurses at the sanitorium, though

never the "white kids." When detailing the abuse, B.P. also went on to say that he was in and out of jail numerous times, but that "jail was a hell of a lot nicer than being in a sanatorium" (Bamford, 2022, para. 56).

(Fort Qu'Appelle Sanitorium, SK, "Fort San;" National Trust for Canada, 2024)

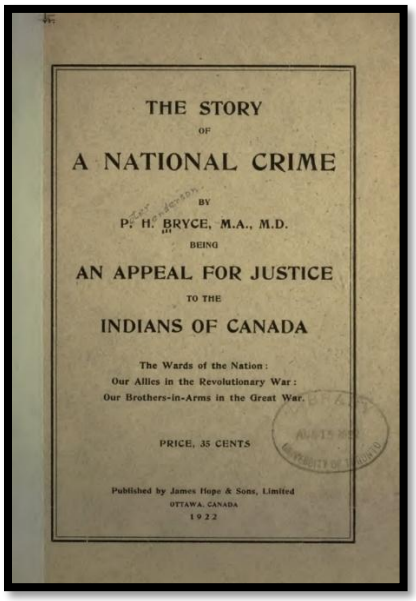
Dr. Peter Henderson Bryce

One of the most insightful pieces of my reflective journey has been reading the reports from Dr. P. H. Bryce, the Canadian government's public health whistleblower on residential schools (Bryce, 1922). Most of you have likely never heard this name, as I had not before I really started to dig deeper into the history of residential schools and TB.

Dr. Bryce was appointed Canada's first ever Chief Medical Officer of the Interior and Indian Affairs Department in 1904. He was signed on to collect health statistics for the hundreds of 'Indian Bands' throughout Canada and write an annual report on the health of the 'Indians.' For fifteen years he completed this, even being assigned to complete a special inspection of the thirty-five Indian (residential) schools in the three Prairie provinces. In this report, he wrote about the origin of the Indian schools, unsanitary conditions, and statistics of the health of the students, including how 24 percent of all students who had been in the schools were known to be dead, and how at one school on the File Hills reserve, 75 percent of the students were dead after the 16 years that the school had been open. These statistics and recommendations were not published for the public. In 1907, Bryce authored a report on the Indian schools of Manitoba and the Northwest Territories which he shared with his superiors. The report was eventually leaked to the press, commonly referred to as *The Bryce Report*, leading to the headline *Schools Aid White Plague – Startling Death Rolls Revealed Among Indians – Absolute Inattention to the Bare Necessities of Health* (Bryce, 1907). But again, nothing changed. In fact, Dr. Bryce continued to repeatedly warn his superiors about the horrible conditions at these schools, compile alarming statistics about the health and mortality of the students, and provide public health recommendations to improve conditions and decrease rates of TB, but nobody seemed to care.

In 1914, the head of the Department of Indian Affairs, Duncan C. Scott, relieved Dr. Bryce of his duty to report the annual health statistics and conditions of residential schools. But this did not stop Dr. Bryce from trying to expose the truth. In 1918, Dr. Bryce created a pamphlet highlighting how, based on his calculations, the Indigenous population between 1904 and 1917 should have increased by 20,000, not decreased by 1,600, which he largely attributed to preventable and treatable disease, such as TB. The government also refused to publish this. But Byce continued to compile data, even requesting statistics from the government to round out his information, of which the government declined to provide him. I have heard stories of Bryce referencing that milk infected with bovine TB was purposefully given to children at these schools, how the schools seemed more like jails than schools, and even that these conditions seemed deliberate and intentional on the part of the government, placing kids in these environments laden with TB as a form of genocide. In 1921, Bryce was essentially forced to retire from the federal government after they passed an act, known as the Calder Act, forcing "Retirement of Certain Members of the Civil Service" (Bryce, 1922, p. 16).

In 1922, no longer silenced by the government, Bryce self-published *The Story of a National Crime: An Appeal for Justice for the Indians of Canada; The Wards of the Nation, our Allies in the Revolutionary War, our Brothers-in-Arms in the Great War* (Bryce, 1922), detailing the conditions of the schools and the complacency and inaction of the government. Still, few listened. Dr. Bryce's bravery and unwavering morality in sharing his reports have only recently received some attention, 100 years after he published them. With the discovery of unmarked graves at former residential schools in 2021, there was suddenly a renewed interest in these concerns Bryce had reported long ago (Canadian Press, 2021; Davis, 2021). When we explore what has created these conditions and allowed TB to flourish in Indigenous communities, we can now look to Dr. Bryce's reports as an early attempt to work towards truth and reconciliation.



THE STORY
OF
A NATIONAL CRIME
BY
P. H. BRYCE, M.A., M.D.
BEING
AN APPEAL FOR JUSTICE
TO THE
INDIANS OF CANADA
The Wards of the Nation:
Our Allies in the Revolutionary War:
Our Brothers-in-Arms in the Great War.
PRICE, 35 CENTS
Published by James Hope & Sons, Limited
OTTAWA, CANADA
1922

The cover of The Story of a National Crime, published by Dr. Peter Henderson Bryce in 1922 (Bryce, 1922).

File Hills residential school, SK, noted in Dr. Bryce's report. Constructed in 1910, as it looked in the 1940s. (United Church of Canada, 1993), from The Children Remembered

My Reflections of TB

I recall very clearly the first time I heard about TB. I was twelve years old and had gone to 'Fort San' (then, a conference centre) for an outdoor education trip with my elementary school. We walked around the building and had a guided tour, heard stories about when the building was a sanitorium, and even took a "ghost tour." As a twelve-year-old girl, I was 'spooked out' that there were potential spirits there but had not considered the atrocities that had occurred inside those walls, where many people had died. If it were haunted, I now know it would have been for good reason.

I remember two things very clearly from the tour. The first is a feeling like these things had taken place so long ago in history, not as recently as 1971 when it closed its doors as a sanitorium. The second thing I remember most vividly is seeing the stairs going up from the morgue in the basement to the outside. The concrete steps were so worn away in a concave shape, purportedly from the undertaker having dragged so many bodies up to be buried in the hills. I do not know if this was true or not, but the image of the worn-away steps and knowing (now) how many lives were likely lost there, the image still haunts me.

After Becoming a TB RN

Only after I became the TB RN, did I remember my previous experiences at "Fort San." Once people began talking to me and sharing their stories, details came rushing back. In my time

as a TB RN, I heard devastating and disturbing accounts from survivors, though usually not actually related to their TB diagnosis. I am haunted by stories of the treatment of Indigenous Peoples at the hands of healthcare workers or the government at sanitoriums, Indian hospitals, and residential schools. Outlandish and almost unbelievable tales of physical abuse and medical experimentation, including detailing how TB-infected lungs were "popped" or filled with substances, even cement. Isolation, neglect, food deprivation and worse to prevent TB from spreading from an Indigenous person to the non-Indigenous people. Stories of patients being made to eat their own vomit as sustenance. And this is just what people have felt comfortable sharing with me.

Some of my most recent TB experiences are linked to TB outbreak responses and investigations. I have been afforded the opportunity to travel to remote and isolated First Nations communities in Saskatchewan with my job and have been able to see the effects of TB to Indigenous Canadians. I have said the word "TB" and had clients burst into tears, believing it was still a death sentence or it had drudged up associations of what TB used to mean to them. I have told a client that they are diagnosed with active TB and should self-isolate, finding out later they live in a house with 10 plus other people, sometimes sleeping in shifts due to lack of beds. I have seen the prohibitive cost of healthy, nutritious foods in the north, foods that are needed to provide proper nutrition for optimal medication absorption and healing. I have seen people hide a cough for fear of others around them believing they have TB. I have educated, smudged with, prayed with, danced with, beaded with, eaten traditional food with, held, and cried with my clients. I have seen firsthand how listening, building trust, and navigating the complexities of historical trauma are central to providing effective TB care. Compared to my first day when I stepped out of that government vehicle and none of my clients would see me, I have made strides in the relationships I have built and in my purpose of allyship and advocacy for my clients. I aspire to be a voice for those who could not have one.

Relevance to Nursing

The healthcare provider plays a key role in TB elimination efforts for Indigenous Peoples in Canada. Historical events, such as colonization, residential schools, TB sanatoria, and the determinants of health, have led to the disproportionate TB burden for Indigenous peoples in Canada and must be addressed (Jetty, 2021). In the *Canadian TB Standards*, Dunn et al. (2022), provide several more detailed recommendations for healthcare workers serving Indigenous peoples related to TB, including: education, reflection and acknowledgement of colonization, personal and systemic racism, practicing cultural safety, recognizing the determinants of health, and understanding that each Indigenous group is historically and culturally distinct and may, therefore, have unique TB needs.

Acknowledging Historical Events

The role of the nurse in TB elimination for Indigenous Peoples in Canada is wrought with responsibility to acknowledge the impact of historical events and wrongdoings, as outlined in the

TRC's *Calls to Action*, and work towards reconciliation (TRC: Government of Canada, 2015). Understanding the impact of these historical events will be pivotal to bridging the relationship between the nurse, as a representative of the colonial health care system, and the people they serve (Jetty, 2021).

Culturally Competent Care

The Canadian Nurses Association (CNA, 2018) posits that nurses have the professional and ethical responsibility to respect and be mindful of the culture of every person they encounter, in every domain of practice and to adhere to principles of cultural competency, safety and humility. *Cultural competency* is a shared responsibility between all and is to value diversity and maintain sensitivity to cultural needs in all aspects of interaction (CNA). *Cultural safety* is a process whose goal is to achieve equity by addressing power imbalances and inequitable social relationships (First Nations Health Authority, 2024). And, *Cultural humility* is the process and continued commitment by the caregiver to achieve self-awareness in practice, challenging their own values, beliefs, and behaviours (Foronda et al., 2016). The CNA (n.d.) has outlined several commitments to working toward reconciliation and healing with First Nations, Inuit, and Métis Peoples: upholding the *Calls to Action* outlined by the TRC; advocating for self-determined, culturally specific, safe solutions to anti-Indigenous racism within nursing and the healthcare system; respectful allyship with our partners in their endeavors to enhance the quality of life and health outcomes for all First Nations, Inuit, and Métis patients and families; and, fostering a holistic, organization-wide approach to developing and implementing a reconciliACTION plan, guided by the wisdom of First Nations, Inuit, and Métis governments, organizations, advisors, and partners (CNA, para. 6).

My provincial regulatory body, the College of Registered Nurses of Saskatchewan (CRNS, n.d.) also takes a stance on our responsibilities as registered nurses (RN) in Saskatchewan related to the TRC's *Calls to Action*, specifically calls eighteen through twenty-four for nursing (TRC: Government of Canada, 2015), affirming that every RN provides culturally safe care as a standard of practice (CNA, n.d.).

On the road to achieving culturally competent care in the context of TB, as recommended in the *Calls to Action* (TRC: Government of Canada, 2015), Jetty (2021) suggests that all staff working with Indigenous Peoples complete cultural competence training (TRC #23iii) and this be incorporated into medical curricula (TRC #24), consulting with Indigenous Peoples to minimize barriers to timely diagnosis and treatment for TB, incorporating Indigenous healing practices into the care plans of Indigenous Peoples (TRC #21–22), increasing the number of Indigenous Peoples working within organizations (TRC #23i), and encouraging health practitioners to develop sustainable models of Indigenous-focused care (TRC: Government of Canada, 2015).

Improving Determinants of Health

The healthcare provider may be successful at helping to eliminate TB in Indigenous Peoples by embracing the *TRC Calls to Action* and collaborating with First Nations, Inuit, and Métis Peoples to address the socioeconomic factors that influence TB in Indigenous Peoples (Jetty, 2021). Crowded housing, exposure to indoor molds and pollutants such as tobacco or cannabis, chronic food insecurity leading to malnutrition, barriers to accessing health services in Indigenous communities, and continued healthcare staff shortages and turnover delay TB diagnosis, isolation precautions and treatment (Jetty). Tuberculosis is a social disease. It will not be eliminated with new diagnostics or treatments. We must improve the conditions that have kept it here and allowed it to flourish.

The Path Forward

The way forward is by first looking back. The elimination of TB begins with understanding the history of TB in Canada and the reasons that it remains such a problem in this country. Often referred to as a "social disease with medical consequences" (National Collaborating Centre for Indigenous Health, 2021, para. 58), TB thrives where there is poverty and health inequity (Jetty, 2021). Addressing the determinants of health through "complex, long-term and multisectoral work" may be the only chance that we have at working toward TB elimination among First Nations, Inuit, and Métis Peoples (Jetty, 2021, para. 17). Part of this work is simply understanding what has happened and where we need to go from here. As a TB program manager in this province, I noted a gap in education and understanding of TB for our community health nurses (CHNs) who work in Indigenous communities. My first order of business in the position was to find a way to provide fulsome and meaningful information for these nurses as they are the frontline providers for the Indigenous population. From this need I developed an annual CHN TB workshop. The 2.5-day workshop, sponsored by the federal government for all nurses working in Indigenous communities in Saskatchewan, has truly become a sought-after event to attend for many. The content ranges from survivors sharing their lived experiences, elders sharing stories about residential schools or sanitoriums, to clinical TB experts and epidemiologists sharing the trends. Having created the agenda in previous years and having just hosted the 5th annual in January/February 2024, I see the CHN TB workshop as a means for nurses to fulfill those three implications for nursing and TB as recommended by the Canadian TB Standards (2022).

When considering culturally competent care, I am also cognizant that language matters. At a recent TB workshop, a TB survivor brought up how colonial, antiquated and negative our TB language is. Terms such as 'TB control,' 'contact investigation,' 'medication compliance,' 'tolerance,' and even 'TB prevention' (as it insinuates that the client could have prevented their TB), are traumatizing language and damaging to the healthcare provider and client relationships.

Our country must make TB elimination a priority and do the work to reach the federal and global goals of TB elimination by 2030 and 2035, respectively. To answer the global health crisis of TB, the World Health Organization developed a framework for TB elimination in 2014, highlighting eight priority actions to work towards the elimination of TB in TB low incidence

countries and the challenges to achieving global TB elimination (Craig et al., 2016). As noted by Craig et al., future projections suggest that none of the thirty-three low incidence countries will achieve TB elimination by 2035, and perhaps only one country would manage TB elimination by 2050.

Implications for My Nursing Clinical Practice

Understanding the truth and historical treatment of Indigenous Canadians is necessary to address not only the disparate rates of TB in Indigenous Peoples in this country but is the crux of all health inequities experienced by this population. We, as Canadians, are responsible for the health and well-being of all Canadians, especially the First peoples. Implications for nurses and other healthcare providers, as well as all Canadians was discussed in this paper so that we may begin to effectively address why the White Plague still reigns.

Conclusion

Tuberculosis, a major global health problem, is a complex socioeconomic issue, disproportionately affecting Indigenous Peoples in Canada (Boffa et al., 2011; Jetty, 2021; Kulmann & Richmond, 2011; Mayan et al., 2019; Mounchili et al., 2022; PHAC, 2014, 2018, 2021, 2024; Richmond & Cook, 2016). With vast implications for healthcare providers, TB elimination may one day be realized when TB is seen as more than an Indigenous-only health issue in Canada. The elimination of TB will require systemic changes and must start with us who are on the frontlines, who hear the stories and who see the impact of this country's treatment of Indigenous Peoples with TB. We must move from the business of healthcare to a better health*care*. As my friend, T, has said, governments and officials from around the world must stop neglecting their people, *her* people (our people in Canada), and must not leave anyone behind. Urgent action must be taken to capitalize on the innovations and systems that were put into place to respond to the COVID-19 pandemic, to prevent, diagnose, and treat something that affects us all, or *should* affect us all. Through on-going and active work by nurses and all healthcare providers, we may increase TB awareness, reduce stigma and discrimination, improve access to culturally competent TB care, and reach healing and self-determination (Jetty). No longer can we stay silent and ignore our history if we are to have any hope of eliminating TB in our lifetime. I hope to one day see TB end, but when we really listen and hear these stories, it is easy to understand how we have allowed the White Plague to reign.

Dedication

I wholly acknowledge that I live, learn, work, and play on Treaty 4 Territory, the traditional lands of the Cree, Saulteaux, Dakota, Nakota, Lakota, and on the homeland of the Métis Nation. I respect and honour the Treaties that were made on all territories, and acknowledge the harms and mistakes of the past, and am committed to moving forward in partnership with Indigenous Peoples in the spirit of reconciliation and collaboration.

I would first like to dedicate this project to all the amazing people who have supported me throughout my journey from novice nurse and learner until now. Without my husband, Tyler, I would never have been able to complete this project or any of the other projects in our life that I take on with little regard for how it will affect us. I am able to say 'yes' to everything because of you. To my kids, you have been all of my motivation for late nights of reading, writing, and homework as a tired working mom. My wish for you is that you will see the health and wellness equity gaps between you and your Indigenous friends close in your lifetimes. It is with great gratitude that I dedicate this project to my academic supervisor, Dr. Arlene Kent-Wilkinson. You have provided guidance, mentorship, encouragement, and support in organizing this project to be the best reflection of my experiences. You have shown me the importance of and worth in my experiences and once again enlivened my passion for TB in the Indigenous Peoples of Saskatchewan. And finally, to my friends, colleagues, clients/patients, and anyone who has ever felt safe enough to share their story with me, this is for you. Through sharing your stories, I have learned of loved ones who never made it home, lost culture and language, and of your strength and resilience as a people. Without you, I would have no project. And to my special friend, T. I am able to complete this project today because you have invited me into your story and let me stay. Your unwavering strength and continued advocacy for TB and Indigenous Peoples in our province is inspirational.

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