BC Centre for Disease Control
PROVINCIAL HEALTH SERVICES AUTHORITY

# TB

## Annual Report 2025

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2025

# List of Abbreviations

3HP – Once-weekly Isoniazid-Rifapentine for 3 months
4R – Daily Rifampin for 4 months
BC – British Columbia
BCCDC – British Columbia Centre for Disease Control
FNHA – First Nations Health Authority
HIV – Human Immunodeficiency Virus
IGRA – Interferon-gamma release assay
INHR – Isoniazid resistant
iPHIS – Integrated Public Health Information System
MDR – Multi-drug resistant
RR – Rifampin resistant
TB – Tuberculosis
TBI – Tuberculosis infection
TPT – Tuberculosis preventive treatment
TST – Tuberculin skin test

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# Introduction and Land Acknowledgement

The presented data includes people in British Columbia (BC) who have been diagnosed with Tuberculosis (TB) disease and TB Infection. The pathogen that causes these conditions is transmitted among populations as a result of a complex mix of social, cultural, economic and structural factors. We recognize that the presentation of public health data, including TB data, has historically focused on disparities without an acknowledgement of the colonial and systemic structures that underlie them. This report represents our ongoing commitment toward more respectful, inclusive, and responsible approaches to public health reporting. **All data are preliminary and subject to change.**

We acknowledge the Title and Rights of First Nations in BC who have cared for and nurtured the lands, air and waters for all time, including the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh Úxwumixw (Squamish Nation), and səl̓ílwətaʔ (Tsleil-Waututh Nation) on whose unceded, occupied, and ancestral territory BCCDC is located. As a provincial organization, we also recognize and acknowledge the inherent Title and Rights of First Nations in BC whose territories stretch to every inch of the lands colonially known as "British Columbia".

BC is also home to many First Nations, Métis, and Inuit people from homelands elsewhere in Canada. We recognize the distinct rights of First Nations, Inuit, and Métis people and BCCDC is beginning its work to uphold a distinctions-based approach to Indigenous data sovereignty and self-determination. All Indigenous Peoples who live in BC have rights to self-determination, health and wellness, and respectful use of their data in alignment with Indigenous data governance principles, including but not limited to OCAP®.

In 2014, stewardship of First Nations health data transitioned to First Nations Health Authority (FNHA), which coordinates all TB-related activities within First Nations communities in BC. Year-round, BCCDC works in partnership with FNHA to provision provincial TB disease and TB infection treatment data to support TB services including routine surveillance, program planning, advocacy, and reporting. FNHA TB Services provides a range of services tailored to First Nations communities and enhanced TB reduction strategies in areas with the highest incidence. This includes, but is not limited to, expanding TB screening and treatment access, and increasing outreach to decrease barriers to TB screening. For additional information on TB among First Nations people, see the FNHA TB Infographic and FNHA Tuberculosis Services.

BCCDC is working to address the consequences of colonial policies which have had lasting effects on all Indigenous Peoples living in the province. Consistent with the Coast Salish teaching of thee-eat (truth) gifted to PHSA by Coast Salish Knowledge Keeper Siem Te Ta-in', we recognize that ongoing settler colonialism in BC undermines the inherent rights of Indigenous Peoples who live in BC and significantly contributes to health inequities and data gaps. While the data shown in this report represent BC residents, there is no stratification by Indigeneity and as such, the results are not reflective of the situation for First Nations, Métis and Inuit Peoples and communities. For public health surveillance indicators pertaining to First Nations/Métis/Inuit Peoples in BC, please see:

- In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care
- Taanishi kiiya? Miiyayow Métis saantii pi miyooayaan didaan BC. Métis public health surveillance program-Baseline report, 2021.

# Foreword

Tuberculosis (TB) services have a long and complex history in British Columbia (BC). While the province has been home to some of Canada's earliest sanatoria and longstanding TB control programs, these services have not always served all communities equitably. In particular, TB programs which often operated under or alongside federal jurisdiction have caused deep and lasting harm to Indigenous Peoples, including through coercive screening, forced removal from home communities, and institutionalization. This legacy continues to reverberate today, contributing to stigma and mistrust of health systems. At the BC Centre for Disease Control (BCCDC), we acknowledge this history and are committed to working in partnership to build TB services that are respectful, culturally safe, and grounded in the self-determined priorities of communities most affected by TB.

This is our second year of producing a more concise and timely TB annual report that covers key data from both 2024 and 2025. In support of improved accessibility and responsiveness, we have moved detailed tables and figures to our interactive TB surveillance dashboard, allowing this report to focus on high-level findings, key indicators, and areas of emerging concern. This transition supports our goal of delivering more relevant and timely insights for public health action.

Several findings from this year's report highlight the ongoing need for coordinated and sustained efforts. The provincial rate of TB disease has remained stable over the last nine years and the burden continues to be unequally distributed. Specifically, TB remains concentrated in regions and communities experiencing higher levels of structural vulnerability, including residential instability and social exclusion. These patterns reinforce the importance of embedding equity into all aspects of TB care and prevention and aligning our work with broader social and health system reforms.

This report aligns with the goals of BC's Provincial TB Elimination Plan and the World Health Organization's End TB Strategy, both of which emphasize integrated, people-centred care and address the social determinants that drive TB risk. As part of this commitment, we are committed to including indicators that are key structural determinants of health.

We are also working toward a more responsive reporting cycle. We have aligned the release of this report with World TB Day (March 24), reinforcing the importance of global and local accountability in TB elimination. Finally, we are transitioning to a two-tiered approach: an annual summary report, such as this one, for routine monitoring, complemented by focused reports that take a deeper dive into specific topics of concern including TB among young people or individuals experiencing homelessness.

Thank you for your continued partnership as we work toward the elimination of TB in British Columbia.

Sincerely,

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Provincial Health Services

# Summary of Trends

## TB Disease

- In 2025, 358 people were diagnosed with tuberculosis (TB) disease in BC, a rate of 6.3 per 100,000 population and essentially unchanged over the past decade despite large increases in the province's population.
- Regional rates of TB disease in 2025 were greatest in Fraser Health (8.4/100,000 population) and Vancouver Coastal Health (7.1/100,000 population) regions.
- Over one third of people with TB disease (n=123 of 358) resided in neighbourhoods with the highest levels of residential instability.
- TB disease in BC shows a bimodal age distribution, with the highest rates among young adults (20-39 years) and seniors (60 years and above). This is similar to the national picture.
- In BC, TB disease counts and rates are higher among people born outside of Canada (18.3 per 100,000 population). This is consistent with historical trends and the national picture.
- In 2025, 67% (n=241) people with TB disease had known HIV status (either through laboratory report or self-report of HIV diagnosis). Of those with known HIV status, only 2% of people with TB disease were co-infected with HIV.
- The majority of people with TB disease (87%) had at least one respiratory site as part of their diagnosis in 2025.
- 72% (n=246) of people with TB disease diagnosed in 2024 completed their treatment within 12 months.
- Overall, the rates of isoniazid-resistant TB had been increasing in BC since 2017; however, rates of rifampin and multi-drug resistance remain low. In 2025, 6.4% (n=23) of all people diagnosed with TB had isoniazid resistance, down from 8.7% (n=28) in 2021. Eight people (2.2%) with multi-drug resistant TB were seen in 2025.

## Contact Tracing

- In 2025, 1,526 contacts were reported to BCCDC with a corresponding mean of 5.4 contacts per person with respiratory TB, similar to the 5.8 contacts per person with respiratory TB in 2024.
- In 2024, among all contacts of people with respiratory TB aged 5 years and older (1,526 total contacts) reported to BCCDC, 88% (1,343 contacts) completed an initial assessment, 1% (14 contacts) were diagnosed with TB disease (i.e. secondary diagnoses), 22% (334 contacts) screened positive, and 9% (141 contacts) successfully completed TB infection (TBI) treatment.

## TB Preventive Therapy (TPT)

- A total of 1,160 individuals were started on TPT (previously described as TB infection (TBI) treatment) in 2024, an increase of 16% from the prior year.
- 71% (n=825) successfully completed treatment within 6 months and 1% (n=10) were treated for longer than 12 months.
- Of those that started TPT, 16% (n=187) were documented with incomplete treatment in 2024.

# TB Disease

## Background

Tuberculosis (TB) disease is a preventable and curable disease that is caused by Mycobacterium tuberculosis. It is spread through the air following prolonged contact with an infectious person, typically via coughing, sneezing, or speaking.

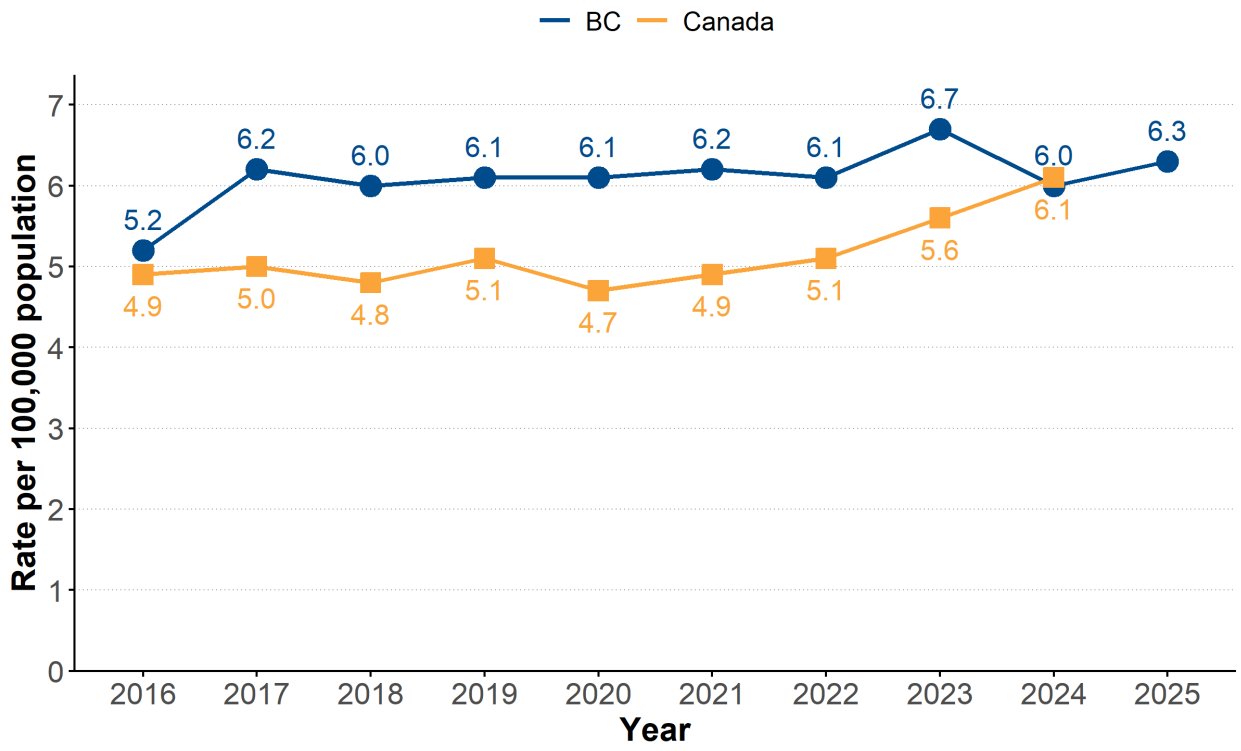
Despite decades of global public health efforts, TB remains a global health challenge. After being replaced by coronavirus disease (COVID-19) for three consecutive years, TB reclaimed its position as the world's leading cause of death from as single infectious pathogen in 2023 (1). This highlights the need for continuous surveillance, strengthened TB management, and research to advance efforts toward TB elimination.

This report includes all people diagnosed or treated for TB in BC, Indigenous Peoples in Canada, non-Indigenous Canadians, permanent residents, and temporary residents.

# TB Disease Historical Trends

In 2025, the rate of TB disease in BC was 6.3 per 100,000 population (n=358), which is similar to historical rates (since 2017) (Figure 1; Supplementary Appendix (S)1). In 2024, the rate of TB disease in BC (6.0 per 100,000 population) was slightly lower than the national rate (6.1 per 100,000 population) for the first time. Although the rate of TB disease in BC has remained relatively stable over the past decade, crude counts have continued to increase as the BC population continues to grow, with the highest number recorded in 2023 (n=369) (2). Nationally, the rate of TB disease has been climbing steadily since 2020. This underscores the need for sustained and enhanced surveillance to support public health action delineated in the provincial TB elimination plan.

**Figure 1. TB Disease Rates*⁺ in BC and Canada**, 2016 to 2025**




*All rates are per 100,000 population. ⁺Population denominators from 2025 BC Statistics' Population Estimates. **Canadian rates from the Public Health Agency of Canada (3). Data for 2025 is not publicly available at the time of this report.

# TB Disease by Region

The highest TB disease rates were in the two most populous health regions: Fraser Health (8.4 per 100,000 population) and Vancouver Coastal Health (7.1 per 100,000 population) in 2025 (2). These regions also receive the greatest number of newcomers to Canada in BC including those from high TB burden countries (4).

In 2025, TB disease rates varied between and within health authorities. Within the Fraser Health region, Fraser South (10.8 per 100,000 population) recorded the highest rate of TB disease in 2025. This was followed by Richmond (9.1 per 100,000 population) and Vancouver (8.8 per 100,000 population), both within the Vancouver Coastal Health region (Figure 2). Overall, TB disease rates were stable in Vancouver Coastal Health and Fraser Health Authorities, recording no change in rates between 2024 and 2025; whereas a general increase was observed in other regions (2, S3-B).

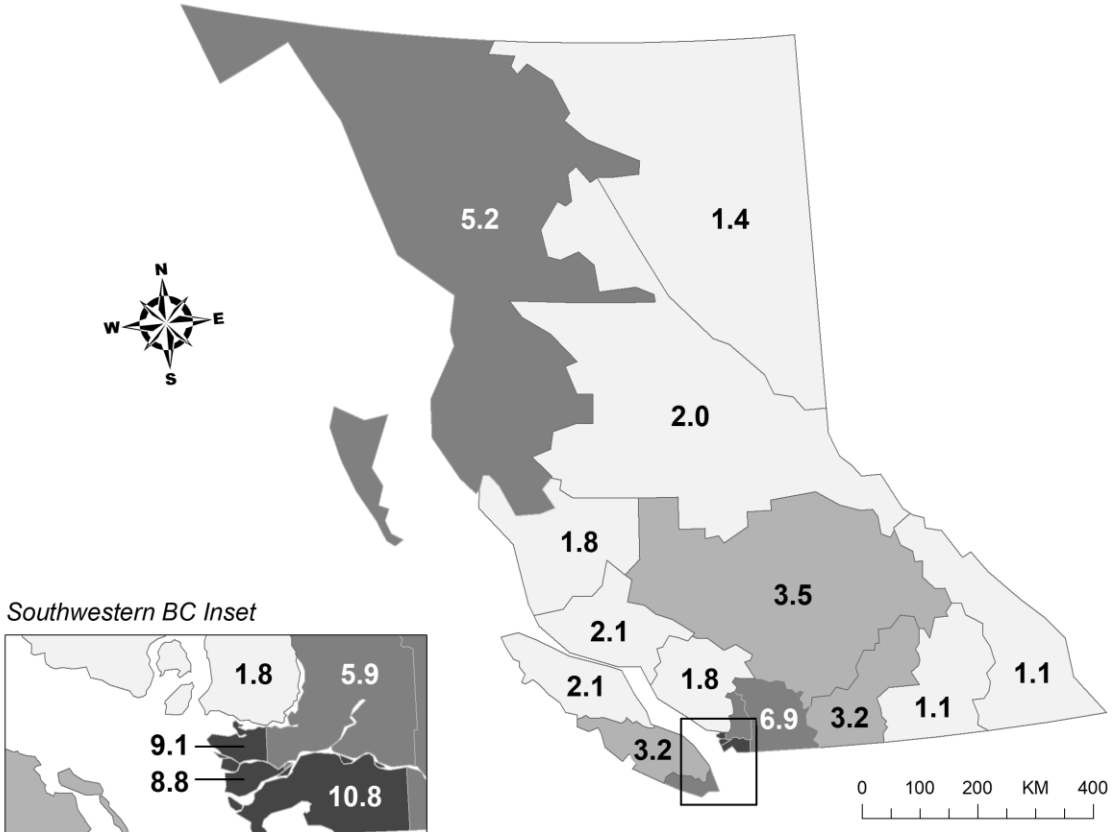
Many people with TB disease (36%; n=123) resided in neighbourhoods with the highest levels of residential instability (Table 1). Each individual with TB disease was assigned a level of residential instability (Quintiles 1-5) based on British Columbia's Index of Multiple Deprivation for Community Health Service Areas (see data sources for details). Residential instability is notably observed in neighbourhoods with increased urbanization (5).

**Table 1. People With TB Disease* by Neighborhood-Level Residential Instability** in BC, 2025**

| Residential Instability | Born Outside of Canada | Canadian Born | Total |
|---|---|---|---|
| Q1 (Least deprived) | 47 (15%) | 5 (17%) | 52 (15%) |
| Q2 | 24 (8%) | 2 (7%) | 26 (8%) |
| Q3 | 78 (25%) | 4 (14%) | 82 (24%) |
| Q4 | 53 (17%) | 7 (24%) | 60 (17%) |
| Q5 (Most deprived) | 112 (36%) | 11 (38%) | 123 (36%) |

*9 people excluded due to unknown postal code. For further details, see data sources in appendix.
**Residential Instability is defined as the tendency of neighborhood inhabitants to fluctuate over time, considering both housing and familial characteristics British Columbia's Index of Multiple Deprivation for Community Health Service Areas data) (5).

**Figure 2. TB Disease Rates by Health Service Delivery Area*+ in BC, 2025**




**Rate per 100,000 population by HSDA**

- 1.1 - 2.1
- 3.2 - 3.5
- 5.1 - 6.9
- 8.8 - 10.8

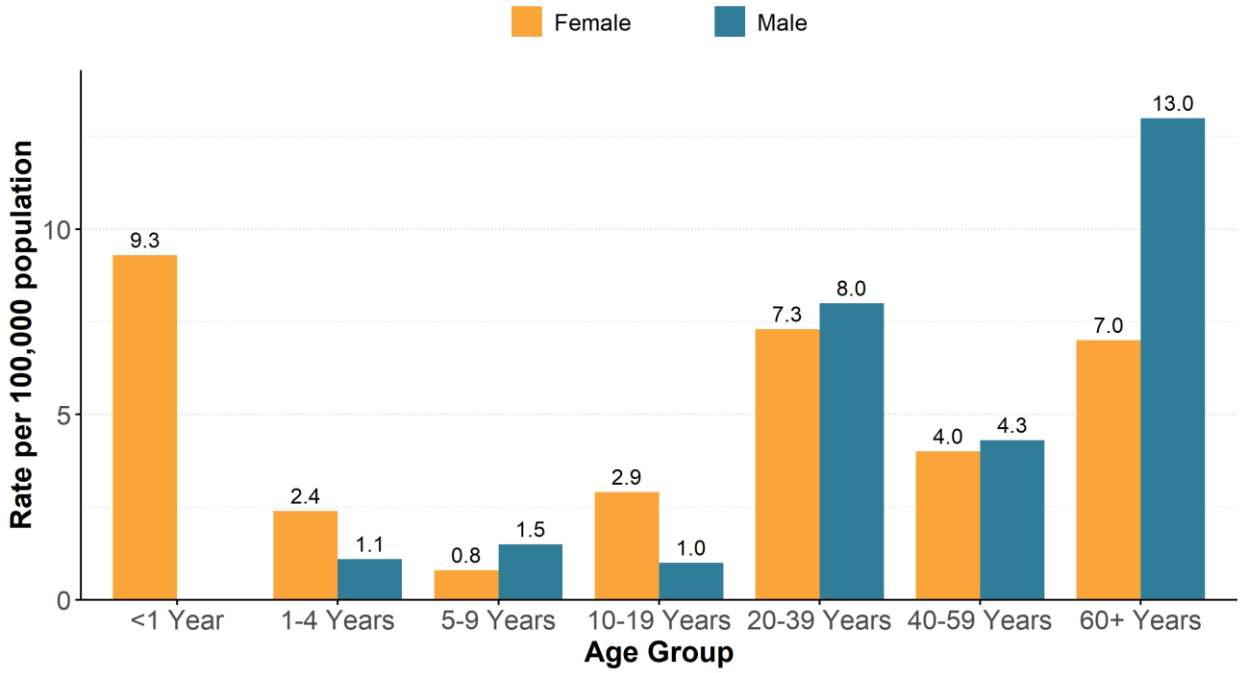
| ID | Health Service Delivery Area | Cases | Rate |
|---|---|---|---|
| 11 | East Kootenay | 1 | 1.1 |
| 12 | Kootenay Boundary | 1 | 1.1 |
| 13 | Okanagan | 14 | 3.2 |
| 14 | Thompson Cariboo Shuswap | 9 | 3.5 |
| 21 | Fraser East | 25 | 6.9 |
| 22 | Fraser North | 48 | 5.9 |
| 23 | Fraser South | 117 | 10.8 |
| 31 | Richmond | 22 | 9.1 |
| 32 | Vancouver | 68 | 8.8 |
| 33 | North Shore/Coast Garibaldi | 6 | 1.8 |
| 41 | South Vancouver Island | 23 | 5.1 |
| 42 | Central Vancouver Island | 10 | 3.2 |
| 43 | North Vancouver Island | 3 | 2.1 |
| 51 | Northwest | 4 | 5.2 |
| 52 | Northern Interior | 3 | 2.0 |
| 53 | Northeast | 1 | 1.4 |

*Health Service Delivery Area determined at time of diagnosis; diagnoses with a client address outside of BC are excluded (n=3). +Population denominators from 2025 BC Statistics' Population Estimates (6).

# TB Disease by Sex and Age Group

Consistent with historical trends, the 2025 rate of TB disease was greater in older age groups, and generally, higher in males than in females (2). Accordingly, the rate of TB disease was highest among males aged over 60 years at 13.0 per 100,000 population (n=94) (Figure 3; S2-A; S2-B). There were 2 females under 1 year of age with TB disease in 2025, the first among this age group since 2019. The relatively high rate (9.3 per 100,000 population) observed for this group is due to its very small population size. The rate of TB disease among children between 1 and 4 years of age remains very low. The overall Canadian rates show a similar bimodal age distribution among younger adults and seniors (3).

**Figure 3. TB Disease Rates by Sex and Age Group* in BC, 2025**

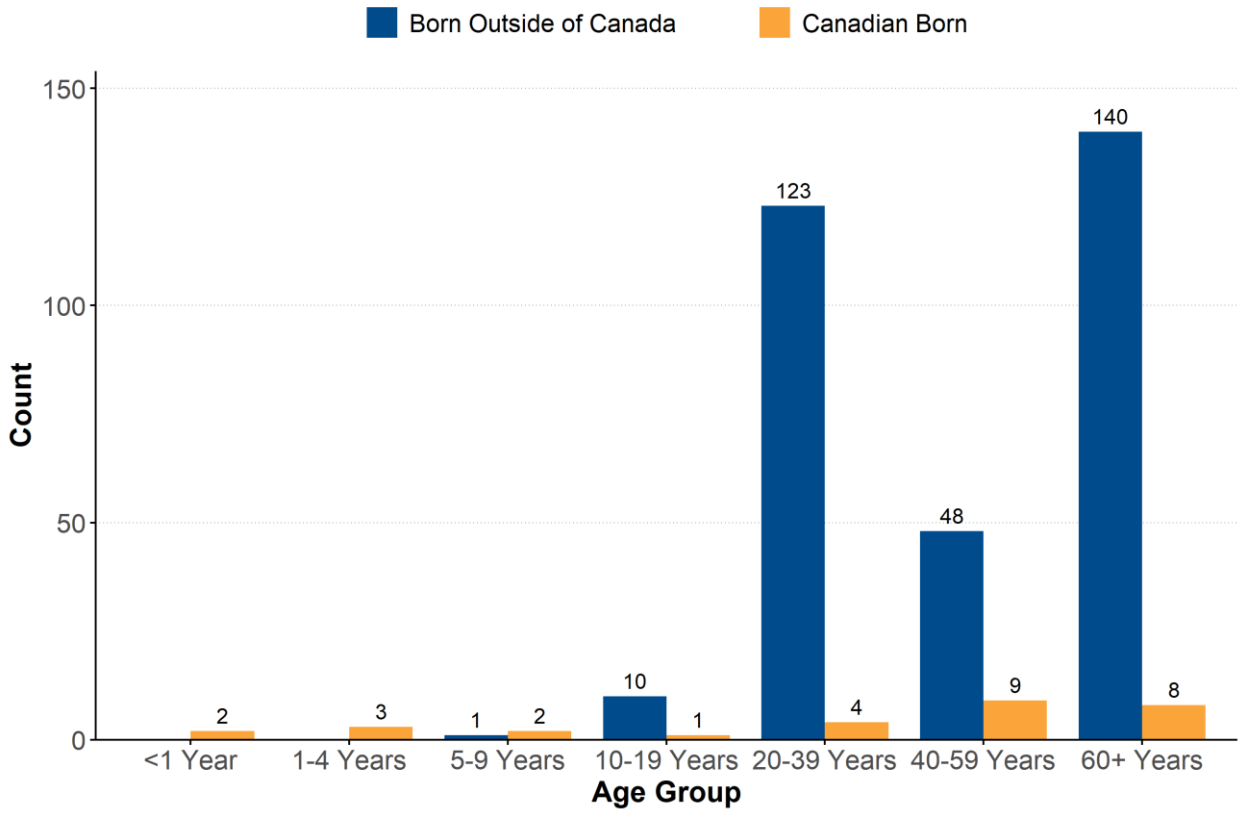



*Age at time of diagnosis. See supplementary data for full 10-year trend by age group and sex.

# TB Disease by Country of Birth and Age Group

Most TB disease observed in 2025 occurred in people born outside of Canada aged 20-39 years (n=123) and over 60 years (n=140) (Figure 4). Among people with TB disease born in Canada n=29), those aged 40-59 years accounted for 31% of diagnoses (n=9), followed by those aged 60 and above (28%; n=8) (S3-A – S3-B).

**Figure 4. People With TB Disease Among Populations Born in Canada and Outside of Canada by Age Group*, 2025**




*Age at time of diagnosis.

# TB Disease by Country of Birth and Health Authority

Similar to historical trend, the 2025 rate of TB disease in people born outside of Canada was greater than among people born in Canada (18.3 per 100,000 population compared to 0.8 per 100,000 population, respectively) (Table 2). The rate of TB disease was higher among people born outside of Canada across all health authorities. Within this group, Fraser Health recorded the highest rate of TB disease (20.8 per 100,000 population). Though TB disease counts among people born outside of Canada remain relatively low in Northern Health, the region saw its greatest increase in incidence over the past decade in 2023, reaching 44.9 per 100,000 population (n=14), which has since lowered to 12.5 per 100,000 population (n=4) in 2025 (Table 2; S3-C). Wide fluctuations in rates observed in Northern Health are due to its relatively small population size.

**Table 2. TB Disease Rates per 100,000 Population by Country of Birth and Health Authority in BC, 2016 to 2025**

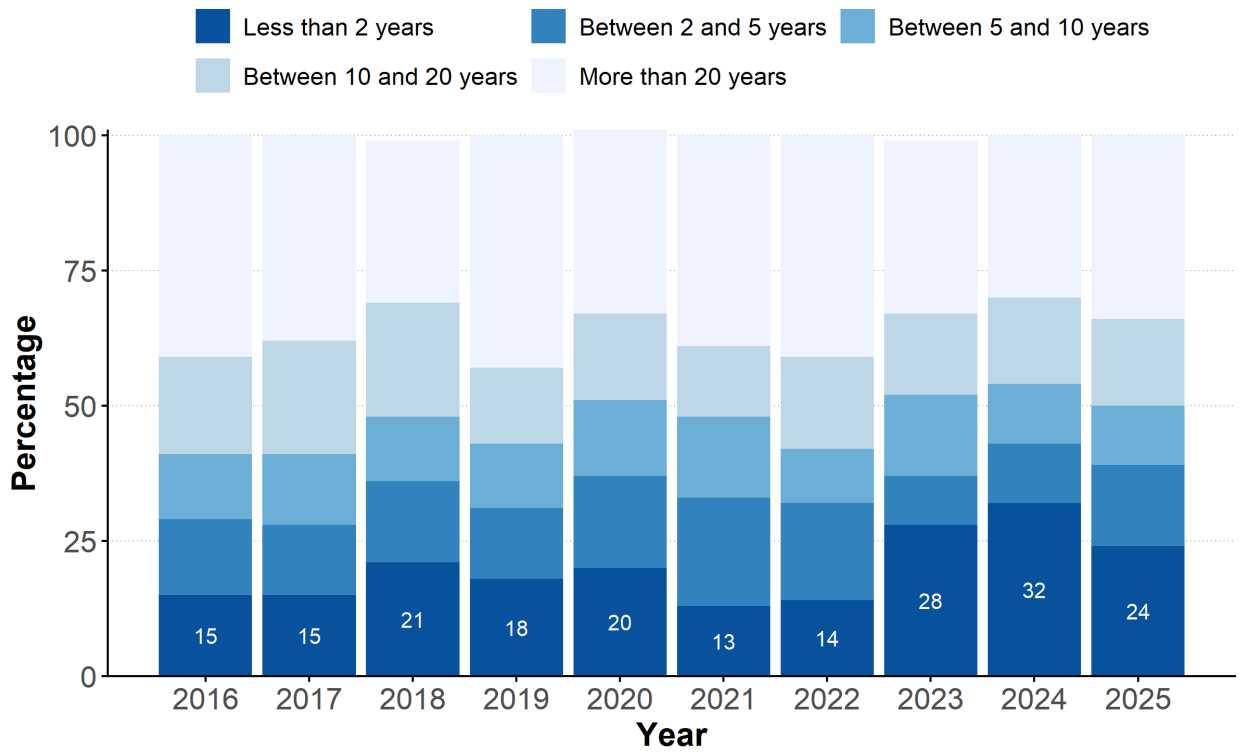
| Health Authority* | Country of Birth | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Interior Health | Born Outside of Canada | 11.2 | 13.0 | 13.6 | 10.2 | 10.9 | 11.5 | 13.1 | 15.5 | 12.4 | 17.3 |
| | Canadian Born | 0.3 | 0.2 | 0.8 | 0.2 | 0.6 | 0.7 | 0.1 | 0.4 | 0.1 | 0.4 |
| Fraser Health | Born Outside of Canada | 18.3 | 20.3 | 21.5 | 20.7 | 20.3 | 21.5 | 21.8 | 21.0 | 22.1 | 20.8 |
| | Canadian Born | 0.8 | 1.7 | 1.7 | 1.8 | 2.1 | 1.1 | 0.8 | 1.0 | 0.9 | 1.0 |
| Vancouver Coastal Health | Born Outside of Canada | 15.1 | 20.1 | 17.4 | 16.0 | 17.0 | 14.7 | 13.1 | 18.9 | 15.4 | 14.8 |
| | Canadian Born | 2.2 | 2.2 | 0.7 | 1.8 | 1.8 | 1.5 | 2.7 | 2.1 | 1.8 | 1.1 |
| Island Health | Born Outside of Canada | 4.6 | 6.0 | 10.3 | 9.4 | 6.4 | 7.6 | 10.9 | 14.0 | 9.8 | 17.9 |
| | Canadian Born | 0.5 | 1.1 | 0.3 | 1.5 | 0.6 | 1.6 | 1.7 | 1.3 | 1.3 | 0.6 |
| Northern Health | Born Outside of Canada | 7.1 | 0.0 | 10.3 | 27.2 | 3.3 | 26.4 | 16.3 | 44.9 | 6.3 | 12.5 |
| | Canadian Born | 2.8 | 2.0 | 1.2 | 2.4 | 2.8 | 4.1 | 3.3 | 0.8 | 1.6 | 1.6 |
| BC Total | Born Outside of Canada | 15.1 | 18.1 | 18.2 | 17.4 | 16.9 | 17.3 | 17.1 | 19.7 | 17.7 | 18.1 |
| | Canadian Born | 1.0 | 1.4 | 1.0 | 1.4 | 1.5 | 1.4 | 1.4 | 1.1 | 1.0 | 0.8 |

*Residence at time of diagnosis. Diagnoses with a client address outside of BC are excluded.

# Time to TB Diagnosis for People Born Outside of Canada

TB disease among people born outside of Canada largely occurs from progression of tuberculosis infection (TBI) acquired within their countries of origin (7). Understanding time to diagnosis among individuals born outside of Canada is important to limit spread of TB disease and maximize health outcomes. In 2023, among people with TB born outside of Canada, the proportion who were diagnosed within 2 years post-arrival in Canada increased noticeably (28%) compared to the year before (14% in 2022). This rate has remained high since; in 2025, 25% of people with TB born outside of Canada were diagnosed within 2 years of arrival (Figure 5; S4-A; S4-B).

**Figure 5. Time to TB Disease Diagnosis Since Arrival in Canada for Population Born Outside of Canada, 2016 to 2025**




# TB Disease and HIV Status

In 2025, 67.3% (n=241) of people with TB had known HIV status (through laboratory report or self-report of HIV diagnosis) (Table 3). Consistent with historical trends, only 2.1% of people with TB with known HIV status were co-infected with TB/HIV.

**Table 3. People With TB Disease by HIV Status, 2016 to 2025**

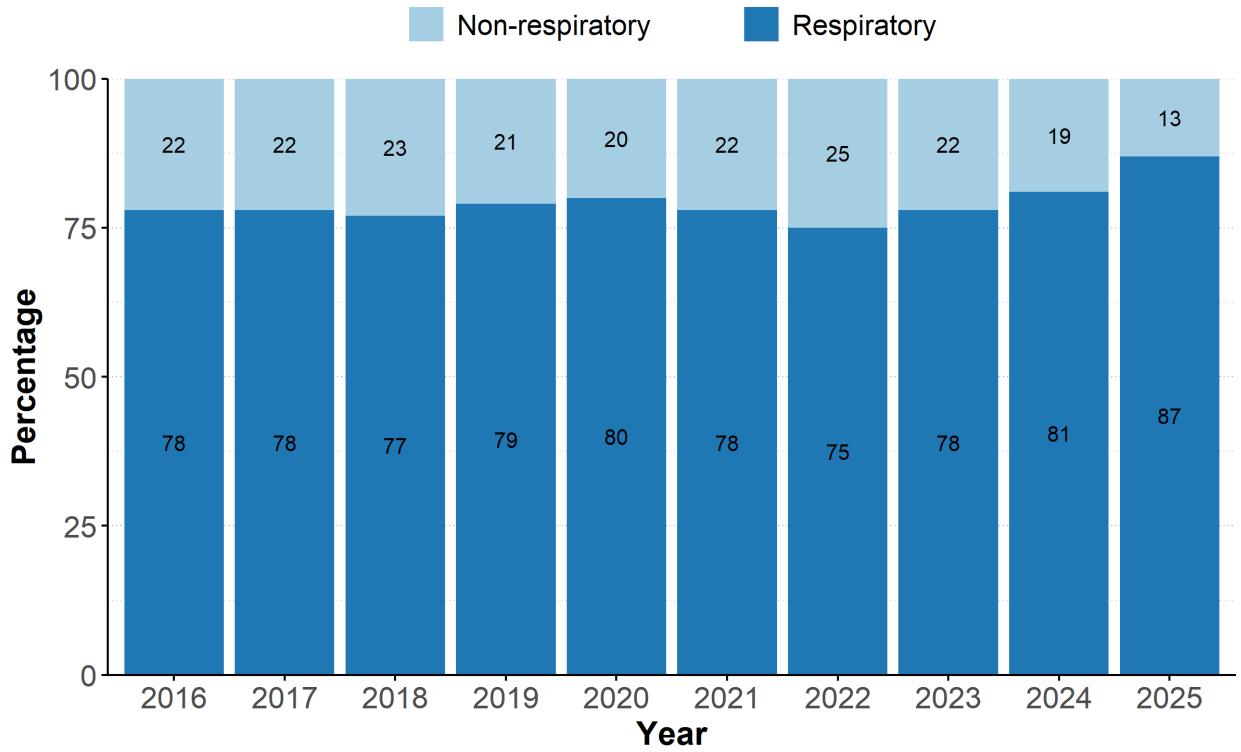
| HIV Status | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|---|---|---|---|---|
| Living with HIV | 5 | 2 | 4 | 4 | 3 | 4 | 0 | 6 | 6 | 5 |
| Known HIV Status* | 220 | 253 | 214 | 227 | 238 | 243 | 209 | 275 | 281 | 241 |
| Missing HIV Status** | 35 | 55 | 89 | 87 | 77 | 81 | 119 | 94 | 61 | 117 |

*People with TB with known HIV status (either through lab report or self-report of HIV diagnosis reported in Panorama). **People with TB where HIV status was unknown at the time of TB diagnosis. For further details, see HIV screening and co-infection under case definitions in the Appendix.

## TB Disease by Site of Disease

Respiratory TB disease is the most prevalent and transmissible form of TB, posing a greater public health risk compared to non-respiratory TB. In 2025, 87.% of people with TB were diagnosed with respiratory TB disease, consistent with trends over the past decade (Figure 6; S4-C).

**Figure 6. Percentage of People With TB Disease by Site of Disease*, 2016 to 2025**




*Respiratory includes all people with at least one respiratory site present (i.e. defined as pulmonary, primary, miliary, and other pulmonary) (see case definitions in appendix). Non-respiratory only includes people with no documented respiratory site present but at least one non-respiratory site present (see case definitions in Appendix).

# Treatment Outcomes of TB Disease

Treatment outcomes are reported for people diagnosed in 2024 to account for the duration of treatment and reporting delays. Post-mortem diagnoses are excluded (0 reported in 2024).

Of people diagnosed with TB disease in 2024, 98% (n=335/342) are documented to have initiated treatment. 269 people (79%) successfully completed TB treatment; most within 12 months since diagnosis (Table 4; S4-B). A total of 18 people (5%) did not complete treatment due to various factors including drug reaction/intolerance (n=2), loss to follow up (n=5), and other or unknown reasons (n=9) (Table 4; S5-C). Of individuals with TB disease who died during treatment (S6-A and S6-B) most were male (62%) and died within three months of initiating treatment (71%). All were older than 60 years of age.

People with TB disease in the least deprived quintile for residential instability had the lowest rate of treatment completion at 71% (Table 5). While the rate of treatment completion among people who have recently immigrated to Canada has decreased annually since 2019, among those who completed treatment, the proportion doing so within 12 months remains very high (95%) (Table 6).

The annual proportion of people with TB disease who had previously been treated for TB remains low, at 6% in 2025. Consistent with historical trends, the majority (87% of TB people with disease with prior treatment) obtained their treatment outside of Canada (Figure 7). TB disease contributed to death in 76% of people who died during treatment (n=16) and was the underlying cause of death of 2 people (10%) (Table 7).

**Table 4. Treatment Outcome by Year, 2016 to 2024**

| Treatment Outcome* | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|
| **Treatment Completed** | **198 (79%)** | **250 (82%)** | **241 (80%)** | **250 (80%)** | **264 (85%)** | **269 (83%)** | **271 (83%)** | **305 (83%)** | **269 (79%)** |
| - Within 12 Months | 162 (64%) | 214 (70%) | 215 (71%) | 204 (65%) | 210 (68%) | 244 (76%) | 242 (74%) | 275 (75%) | 246 (72%) |
| - Greater Than 12 Months | 36 (14%) | 36 (12%) | 26 (9%) | 46 (15%) | 54 (17%) | 25 (8%) | 29 (9%) | 30 (8%) | 23 (7%) |
| **Incomplete Treatment** | **8 (3%)** | **17 (6%)** | **9 (3%)** | **21 (7%)** | **16 (5%)** | **9 (3%)** | **10 (3%)** | **13 (4%)** | **18 (5%)** |
| **Left Province During Treatment** | **18 (7%)** | **5 (2%)** | **15 (5%)** | **17 (5%)** | **6 (2%)** | **10 (3%)** | **13 (4%)** | **16 (4%)** | **27 (8%)** |
| **Died During Treatment** | **26 (10%)** | **19 (6%)** | **24 (8%)** | **20 (6%)** | **20 (6%)** | **27 (8%)** | **28 (9%)** | **19 (5%)** | **21 (6%)** |
| **No Treatment Documented**** | **2 (1%)** | **13 (4%)** | **12 (4%)** | **4 (1%)** | **4 (1%)** | **8 (2%)** | **6 (2%)** | **15 (4%)** | **7 (2%)** |

*Excluding those diagnosed post-mortem. See case definitions in the appendix. **People without documented treatment may include individuals for whom follow-up is ongoing, individuals who were not treated, and/or instances where treatment information was not adequately captured within Panorama; data remediation is routinely ongoing.

**Table 5. Treatment Outcome by Residential Instability*, 2024**

| Treatment Outcome** | Q1 (Least deprived) | Q2 | Q3 | Q4 | Q5 (Most deprived) |
|---|---|---|---|---|---|
| **Treatment Completed** | **37 (71%)** | **18 (90%)** | **53 (73%)** | **54 (81%)** | **103 (84%)** |
| - Within 12 Months | 34 (65%) | 15 (75%) | 48 (66%) | 50 (75%) | 97 (80%) |
| - Greater Than 12 Months | 3 (6%) | 3 (15%) | 5 (7%) | 4 (6%) | 6 (5%) |
| **Incomplete Treatment** | **3 (6%)** | **1 (5%)** | **3 (4%)** | **3 (4%)** | **7 (6%)** |
| **Left Province During Treatment** | **6 (12%)** | **1 (5%)** | **13 (18%)** | **2 (3%)** | **4 (3%)** |
| **Died During Treatment** | **6 (12%)** | **0 (0%)** | **2 (3%)** | **6 (9%)** | **6 (5%)** |
| **No Treatment Documented***** | **0 (0%)** | **0 (0%)** | **2 (3%)** | **2 (3%)** | **2 (2%)** |

*Residential Instability is defined as the tendency of neighborhood inhabitants to fluctuate over time, considering both housing and familial characteristics (5). **Excluding those diagnosed post-mortem. See case definitions in the appendix. ***People without documented treatment may include individuals for whom follow-up is ongoing, individuals who were not treated, and/or instances where treatment information was not adequately captured within Panorama; data remediation is routinely ongoing.

**Table 6. Treatment Outcome for People Who Have Recently Immigrated*, 2019 to 2024**

| Treatment Outcome** | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|
| **Treatment Completed** | **19 (100%)** | **17 (94%)** | **16 (94%)** | **20 (91%)** | **27 (87%)** | **20 (74%)** |
| - Within 12 Months | 15 (79%) | 13 (72%) | 16 (94%) | 18 (82%) | 25 (81%) | 19 (70%) |
| - Greater Than 12 Months | 4 (21%) | 4 (22%) | 0 (0%) | 2 (9%) | 2 (6%) | 1 (4%) |
| **Incomplete Treatment** | **0 (0%)** | **0 (0%)** | **0 (0%)** | **0 (0%)** | **1 (3%)** | **1 (4%)** |
| **Left Province During Treatment** | **0 (0%)** | **0 (0%)** | **0 (0%)** | **1 (5%)** | **2 (6%)** | **5 (19%)** |
| **Died During Treatment** | **0 (0%)** | **1 (6%)** | **0 (0%)** | **1 (5%)** | **1 (3%)** | **0 (0%)** |
| **No Treatment Documented***** | **0 (0%)** | **0 (0%)** | **1 (6%)** | **0 (0%)** | **0 (0%)** | **1 (4%)** |

*A person who recently immigrated is someone who arrived in Canada up to five years prior to TB disease diagnosis and had landed immigrant or permanent resident status at the time of diagnosis (8). **Excluding those diagnosed post-mortem. See case definitions in the appendix. ***People without documented treatment may include individuals for whom follow-up is ongoing, individuals who were not treated, and/or instances where treatment information was not adequately captured within Panorama; data remediation is routinely ongoing.

**Figure 7. People With TB Disease Previously Treated for TB, 2016 to 2025**

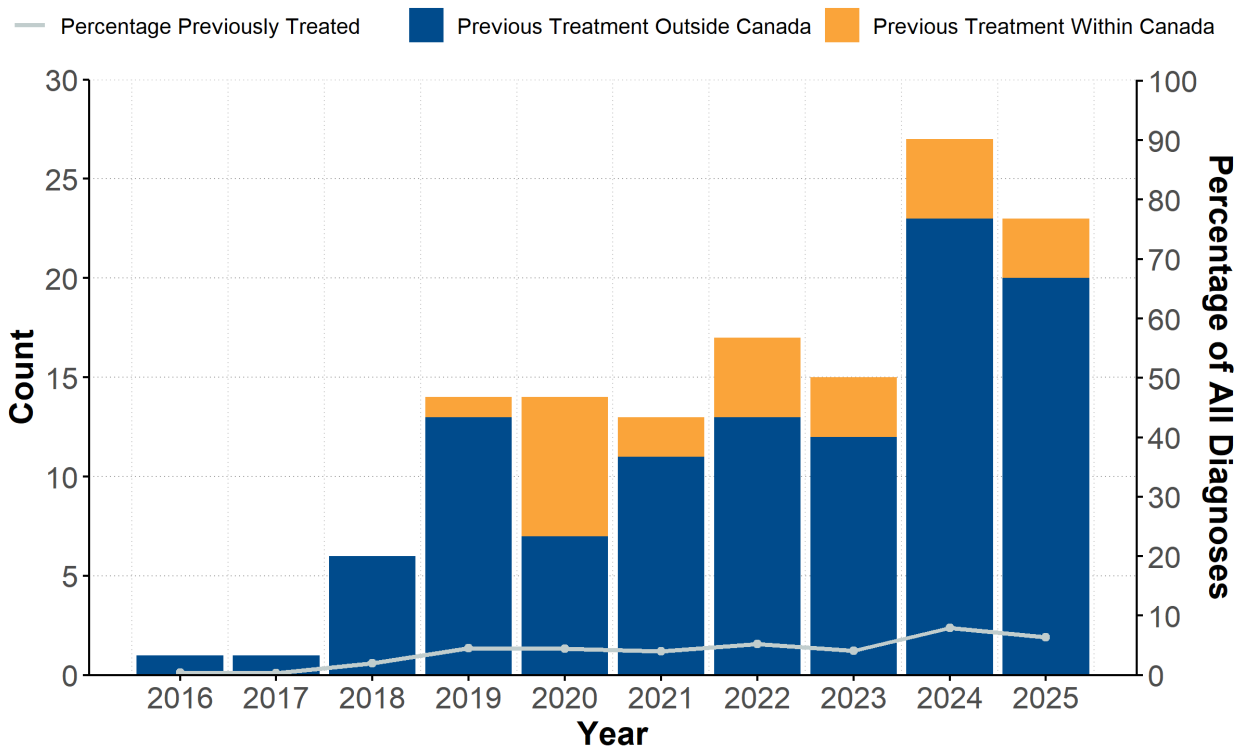



**Table 7. Causes of Death during TB Disease Treatment, 2016 to 2024**

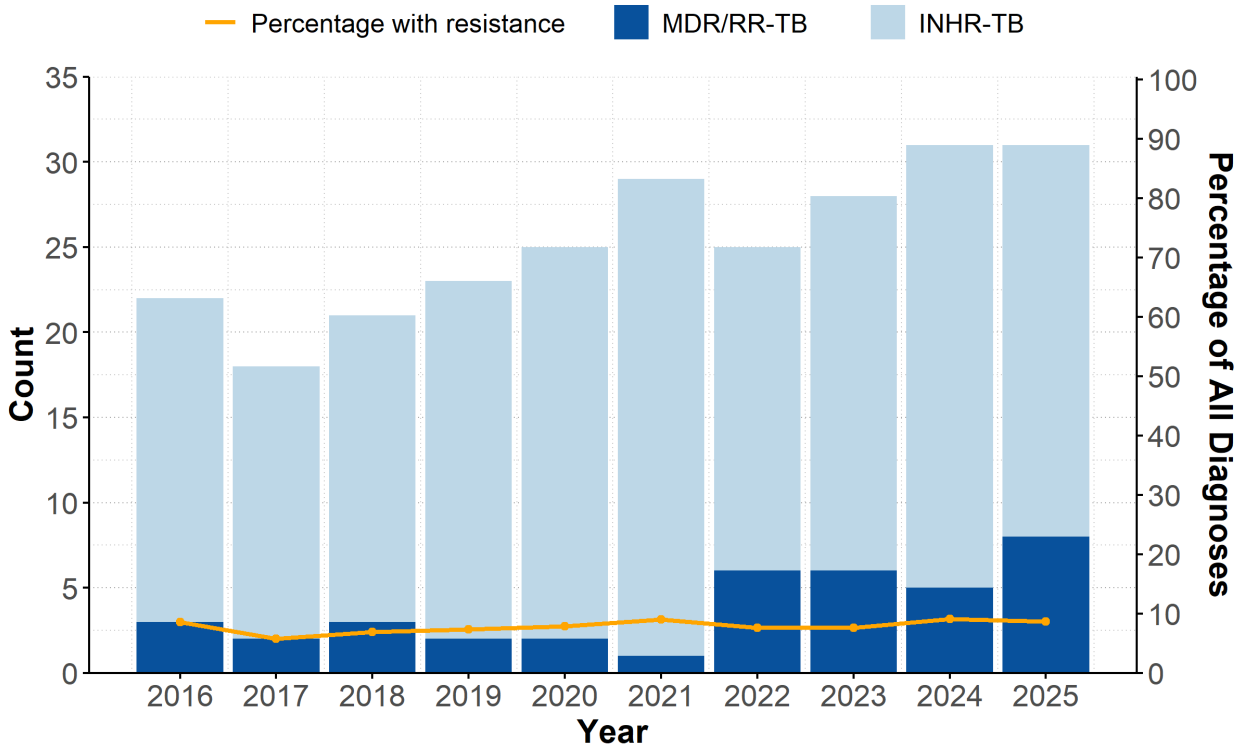
| Died During Treatment* | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|
| TB Underlying Cause | 5 | 3 | 1 | 1 | 1 | 0 | 2 | 1 | 2 |
| TB Contributed, Not Underlying Cause | 9 | 13 | 12 | 9 | 9 | 24 | 17 | 14 | 14 |
| TB Unrelated to Death | 9 | 3 | 5 | 9 | 9 | 2 | 9 | 3 | 5 |
| Unknown | 1 | 0 | 3 | 1 | 1 | 1 | 0 | 1 | 0 |

# Drug Resistant TB Disease

Globally, drug resistant TB continues to pose a substantial burden on healthcare systems. Incidence rates of drug-resistant TB gradually declined between 2015 and 2020, they have since remained relatively stable (1).

In BC, most TB isolates are tested for susceptibility/resistance to TB treatment (S7-A; S7-B) and, since 2016, fewer than 10% of those tested were found to be resistant. In 2025, 6.4% of people (n=23) were resistant to the most common drug, isoniazid, compared with 7.6% in 2023 (n=26) (Figure 8). TB that was rifampin resistant (RR) or multi-drug resistant (MDR), defined as resistance to both isoniazid and rifampin, was identified for 8 people (2.2%) in 2025; this is lower than the 4 to 5% rate of MDR-TB seen globally (1).

**Figure 8. People With TB Disease with Drug Resistance*, 2016 to 2025**




*INHR-TB refers to isoniazid-resistant tuberculosis. MDR/RR-TB refers to multi-drug-resistant tuberculosis (MDR-TB) or rifampin-resistant tuberculosis (RR-TB), consistent with World Health Organization (WHO) definitions.

# TB Contact Tracing

TB contact tracing is a key public health tool used to prevent further transmission of disease. It involves the identification and evaluation of individuals who may be at risk of developing TB infection (TBI) or TB disease following exposure to a person who has infectious TB disease (i.e. index person).

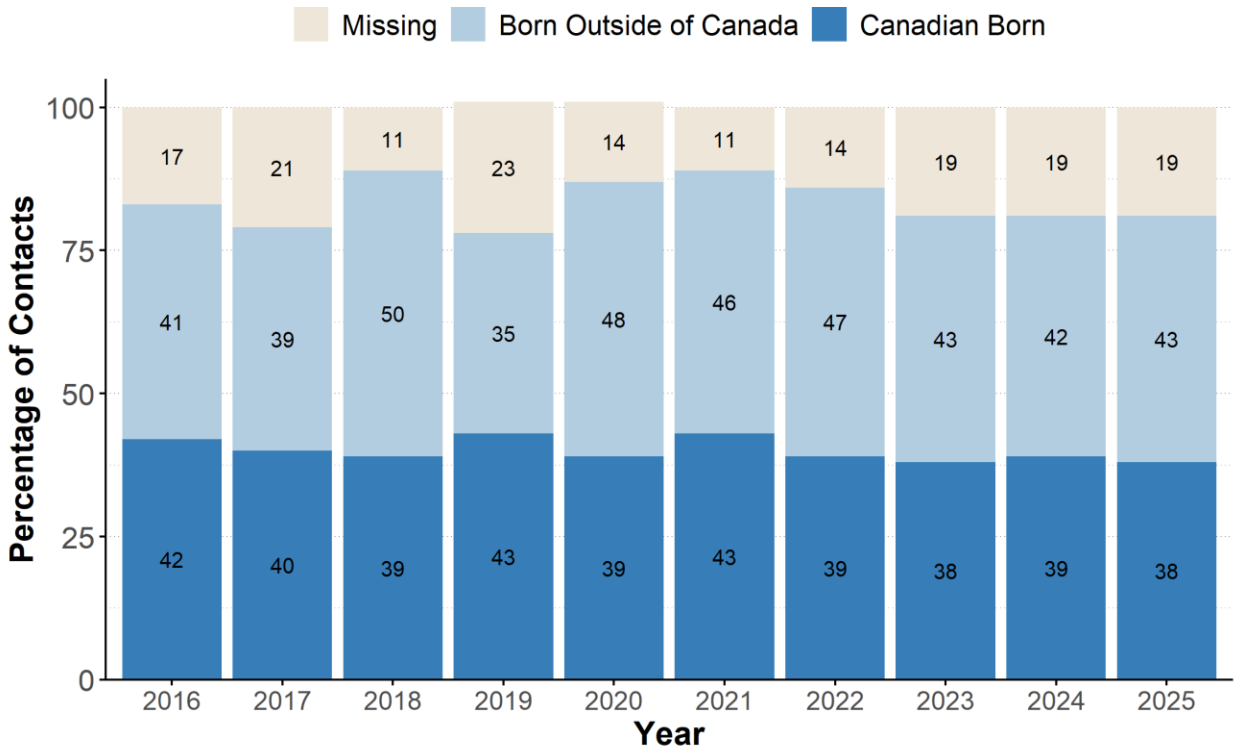
This section presents only contacts of people with TB diagnosed in BC, who were residing in BC at time of investigation, and linked to an index person in Panorama. Regions have separate databases for contact investigations that may not be reported in Panorama. As a result, contact information available in Panorama does not reflect the full scope of contact tracing efforts in the province due to varying data collection, data entry, and reporting practices across regional health authorities. The presented data may not fully reflect the true underlying patterns and should be interpreted with caution (see Technical Appendix for more information).

In 2025, a total of 1,526 unique contacts were reported for 282 people with respiratory TB disease, averaging 5.4 contacts per person. The maximum number of contacts identified for a single person with TB was 160 (S9-A). Between 2016 and 2023, Fraser Health reported the highest number of contacts per year. However, in 2025, Island Health reported the most (n=406), followed by Fraser Health (n=315) (S8-A). The region with the most contacts per person with TB was Island Health (11.3), followed by Interior Health (9.9) (S8-B). The majority of contacts were aged 20-39 years (34.5%), followed by those aged 40-59 years (28.3%), and 60 years and older (23.7%) (Figure 9; S9; S10-B).

# Contacts by Country of Birth

Over the past decade, the proportion of identified contacts by country of birth has remained relatively stable. In 2025, 43% (n=502) of contacts were born outside of Canada, while 38% (n=439) were Canadian born. 216 contacts (19%) had missing information on country of birth (Figure 10; S11-A; S11-B).

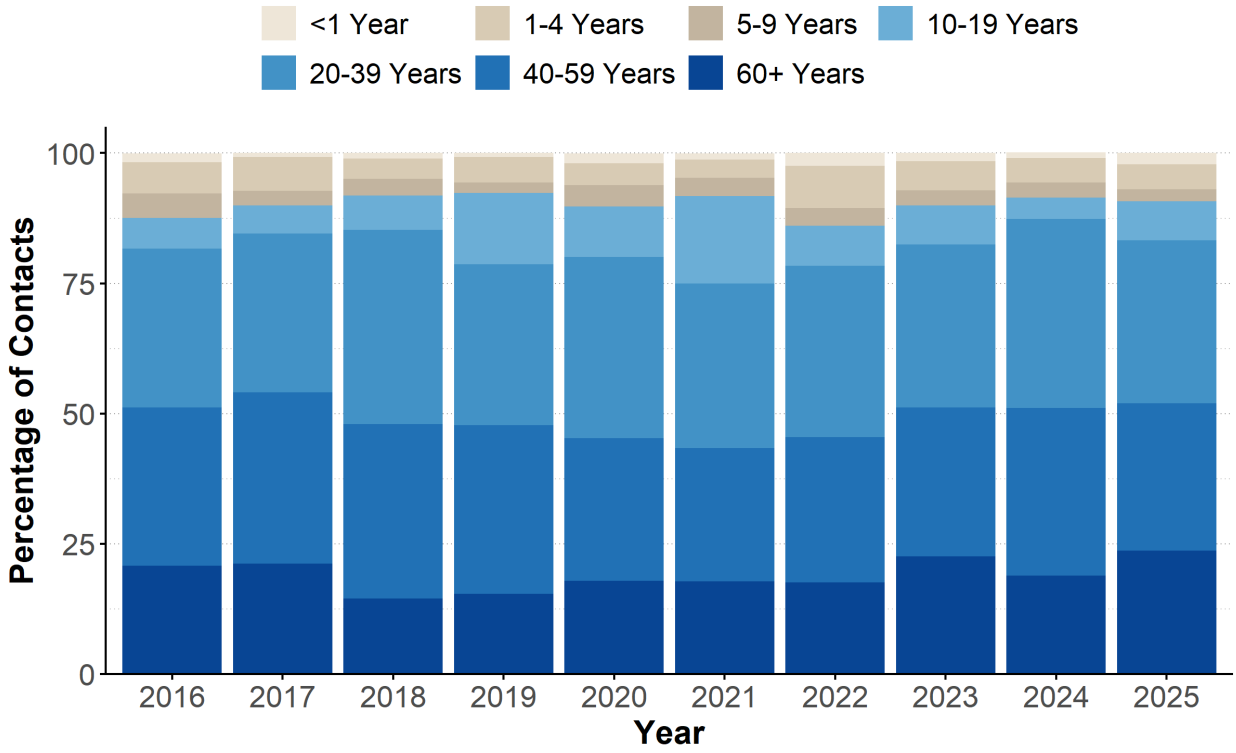
**Figure 9. Percentage of Contacts of People With Respiratory TB Disease in BC by Country of Birth*, 2016 to 2025**




*Missing represents unknown or missing country of birth.

## Contacts by Age Group

**Figure 10. Percentage of Contacts of People With Respiratory TB Disease in BC by Age Group*, 2016 to 2025**




*Age of contact at time of source TB diagnosis.

## Contact Tracing Cascade of Care

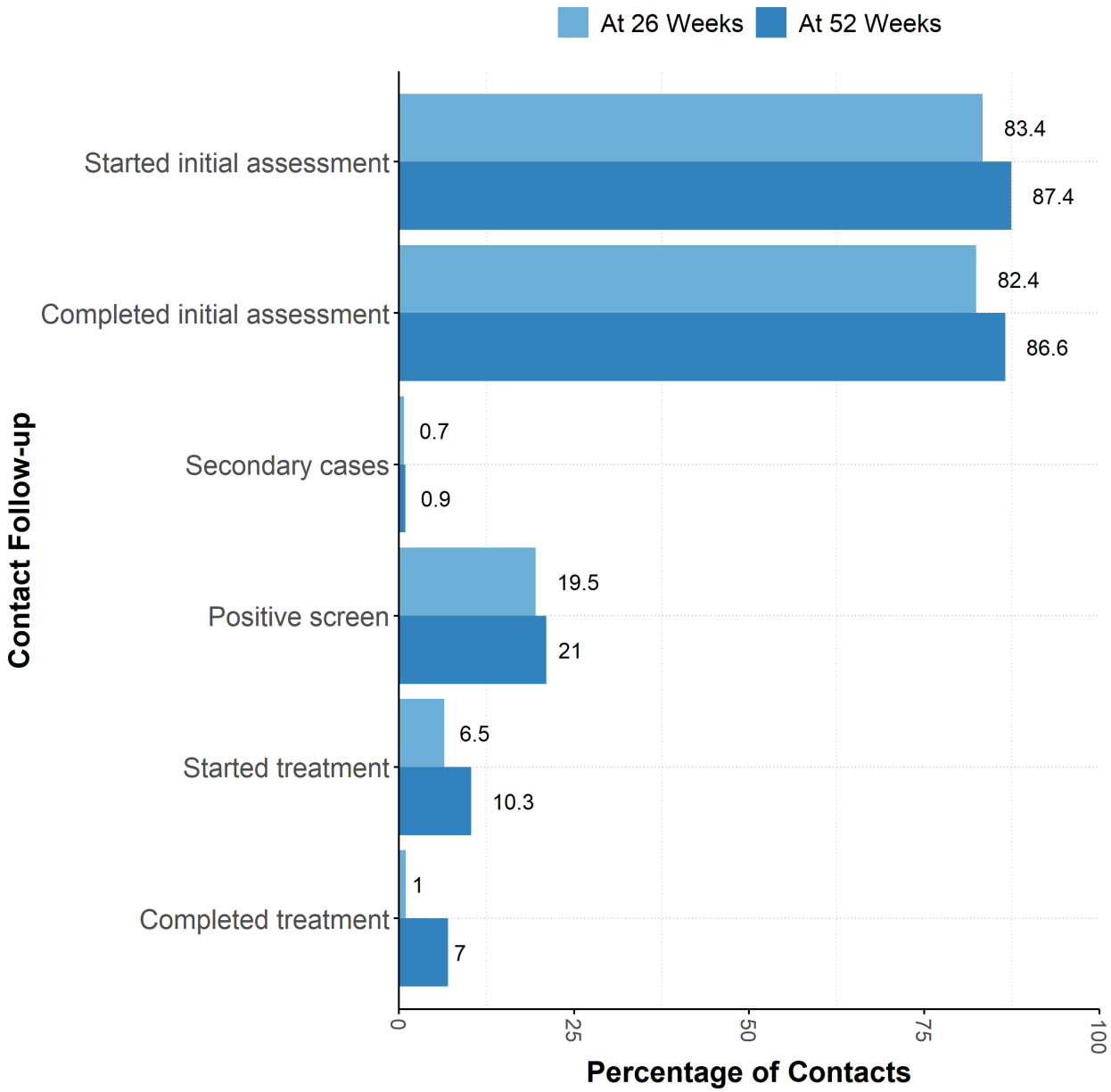
The contact tracing cascade of care outlines steps along the continuum of care provided to persons potentially exposed to TB. Its structure allows public health programs to identify points along the pathway where losses occur during follow-up activities and to target interventions accordingly to improve outcomes. See case definitions for indicator definitions.

This section presents the cascade of care for reported contacts of people with respiratory TB in BC aged 5 years and older. People with respiratory TB under 5 years of age and their associated contacts were excluded as they typically represent primary infection from recent transmission and are followed up through reverse contact investigation (i.e. identifying the index person for the child's infection). The contact cascade of care is presented for people diagnosed in 2022, 2023 and 2024 at a follow-up time of 52 weeks from index person diagnosis to account for duration of treatment regimens and reporting delays. See S12 for data at 12 weeks, 26 weeks, and 2 years post index person diagnosis.

In 2024, a total of 1,526 reported contacts were associated with people with respiratory TB disease aged over 5 years. At 52 weeks post index person diagnosis, 1,321 contacts (87%) had

completed an initial assessment, 321 contacts (21%) had a positive IGRA or TST screen (indicative of TBI; see case definitions in Appendix), and 14 contacts (1%) were diagnosed with TB disease (i.e. secondary diagnoses) (Figure 11; Table 8). Among contacts with a positive screen, 107 (33%) initiated and completed tuberculosis preventive treatment (TPT) within 52 weeks since source diagnosis. In BC, TPT is administered to people with TBI, with a particular focus on people at elevated risk of progressing to TB disease (9).

**Figure 11. Contact Tracing Indicators Among Contacts of People With Respiratory TB Disease* in BC Aged 5 Years and Older at 26 Weeks and 52 Weeks After Source Diagnosis, 2024**




*Percentage of total contacts reported.

**Table 8. Contact Tracing Indicators Among Contacts of People With Respiratory TB Disease in BC Aged 5 Years and Older by Completion at 52 Weeks Post Source Diagnosis, 2021 to 2024**

| 52 Weeks Post Source Diagnosis | Count | | | |
|---|---|---|---|---|
| **Indicator** | **2021** | **2022** | **2023** | **2024** |
| **Number of contacts** | **1,528** | **992** | **1,659** | **1,526** |
| **Started initial assessment** | **1,283** | **884** | **1,464** | **1,334** |
| **Completed initial assessment*** | **1,277** | **880** | **1,454** | **1,321** |
| - IGRA | 387 | 43 | 42 | 112 |
| - TST | 541 | 551 | 1,093 | 873 |
| - XRay | 349 | 286 | 319 | 336 |
| **Secondary diagnoses** | **13** | **10** | **14** | **14** |
| **Positive screen**** | **195** | **221** | **328** | **321** |
| - IGRA | 106 | 45 | 46 | 36 |
| - TST | 89 | 176 | 282 | 285 |
| **Started treatment** | **107** | **125** | **165** | **157** |
| **Completed treatment** | **58** | **77** | **106** | **107** |

*Using earliest screening date. **For contacts with both IGRA and TST positive results, the IGRA date and result were used.

# TB Preventive Therapy (TPT)

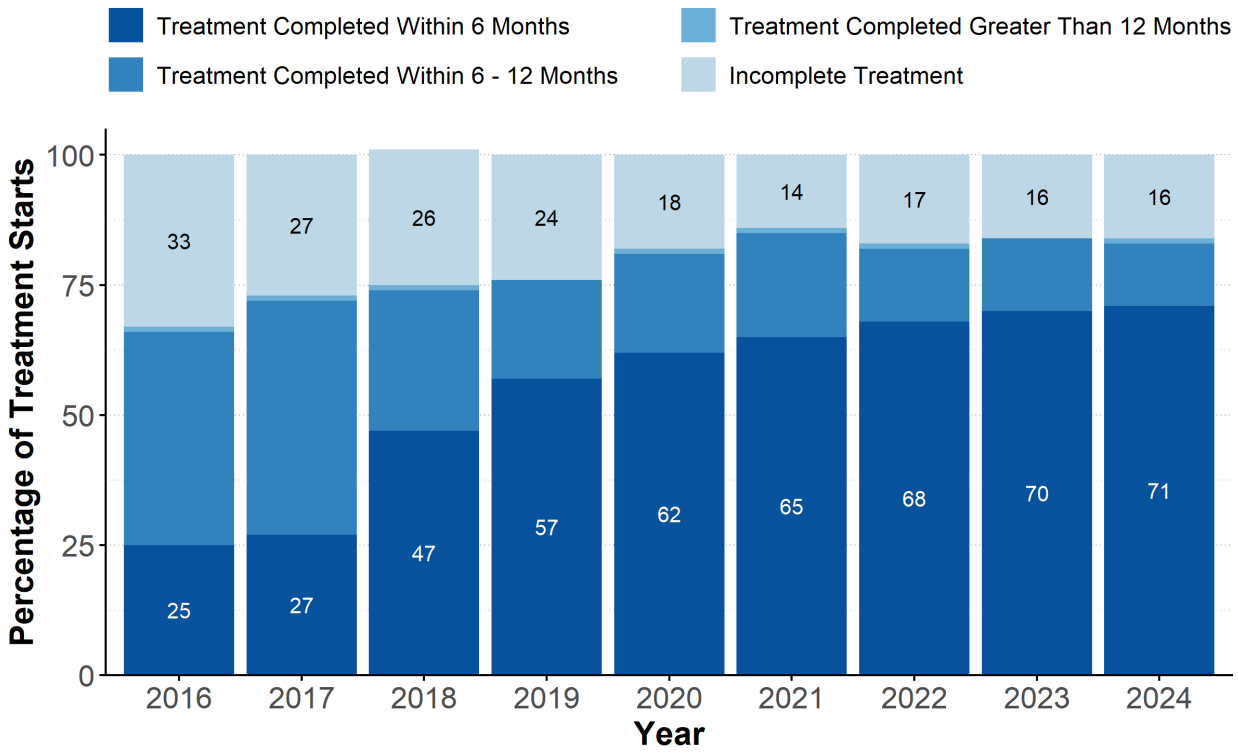
In this section, reporting on TBI outcomes is limited to treatment started in 2024, to allow sufficient time for follow-up, treatment completion, and reporting delays. This report does not include TPT initiations that are not recorded in Panorama (e.g. treatment given in federal or provincial correctional facilities) or among those receiving primary prophylaxis. This section highlights people who initiated TPT in 2023 following a positive screen in 2023 or earlier.

## TPT

There were 1,160 documented TPT initiations in 2024, an increase of 16% from the previous year (2). Since 2020, the volume of TPT initiations has increased every year. In 2024, people aged 20-39 years accounted for most treatment initiations (37.0%), followed by 34.7% among those 40-59 years, and 22.9% in those aged over 60 years (2).

Most people successfully completed treatment; the majority (71.1%) within 6 months of treatment initiation (Figure 12). Since 2016, the proportion of treatment completed within 6 months has increased every year, which is likely attributed to the introduction of newer regimens (e.g. 3HP, 4R) that provide effective treatment with a shorter duration (9). Between 2016 and 2021, a reduction in incomplete treatments was observed (from 32.7% to 14.5%); this proportion has remained stable since (16.1% of TPT initiations in 2024 were not completed).

**Figure 12. Percentage of TPT Initiations by Treatment Outcome, 2016 to 2024**




## TPT by Country of Birth

Overall, TPT initiations has predominantly occurred among people born outside of Canada. Of those starting treatment in 2024 (n=1,160), 76.2% (n=762) were born outside of Canada, 11.7% (n=136) were Canadian born, and 12.1% (n=140) had an unknown country of birth (Table 9).

**Table 9. TPT Initiation by Country of Birth, 2016 to 2024**

| Country of Birth | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|---|---|---|---|
| Born Outside of Canada | 506 | 487 | 637 | 524 | 427 | 453 | 535 | 719 | 884 |
| Canadian Born | 149 | 154 | 148 | 160 | 104 | 102 | 125 | 153 | 136 |
| Unknown country of birth | 20 | 45 | 45 | 81 | 111 | 109 | 103 | 128 | 140 |

# Contributors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- The BC Centre for Disease Control (BCCDC) TB Services staff for time spent entering provincial data and assisting with reporting.
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- The BCCDC Public Health Laboratory staff for collecting and compiling TB and HIV requisition data.
- Designated public health nurses in the Health Service Delivery Areas for data collection as part of follow-up to persons testing positive for TB.
- The BCCDC TB Services Health Registry Clerk and the Island TB Program staff for their help with TB disease data entry and remediation.
- Fraser Health, Interior Health, Island Health, Northern Health, Vancouver Coastal Health, and First Nations Health Authority partners involved in data collection, access, management, analysis and TB reporting.
- Sunny Mak from the BCCDC for creating the map of TB disease rates by Health Service Delivery Areas.
- The BCCDC Data & Informatics team for modelling TB data to the Communicable Disease Data Mart and making it accessible for reporting.
- Tuberculosis Section, Centre for Communicable Disease and Infection Control, Public Health Agency of Canada (PHAC) for providing the annual rates of TB disease in Canada.

# Appendix

## Technical Appendix

- All TB surveillance data comes from Panorama Public Health Solution for Disease Surveillance and Management, unless otherwise noted. The BCCDC TB Services commenced using Panorama on March 12, 2016, with data conversion from the previous Integrated Public Health Information System (iPHIS). Minor differences in the aggregate counts may be seen if comparing annual report data to that found in iPHIS due to data conversion from iPHIS to Panorama. Numbers in this report are subject to change due to data clean up and delay in reporting.
- All geographic breakdowns reflect place of residence in BC at time of diagnosis or time of treatment (including temporary residence). If residence is unknown, the diagnosis is assigned to the health region where the individual was diagnosed or screened. Subsequent movement is not reflected in this report.
- Sex values are reported as they appear on a person's Government ID or health card and does not reflect gender. We recognize that gender identity is a complex social construct with real health impacts. We are actively working to improve our systems to better reflect gender identity.
- All TB disease, TB infection, contact tracing, and laboratory data were extracted from Panorama on February 18, 2026.
- TB disease is rare in BC. Rates or percentages over time for some indicators may reflect minor differences in small numbers and not meaningful changes in the underlying disease process.
- TB disease diagnosis totals may differ from those reported by PHAC. Among temporary residents (visitors, students, and people granted work permits) and undocumented foreign nationals who are in Canada, PHAC includes only those who started treatment in BC in the provincial totals. However, BCCDC reports on people who have been diagnosed or received treatment in BC in provincial totals – regardless of where the treatment initially began.
- This report includes HIV status and co-infection reliant on testing or self-reporting done at time of TB disease diagnosis. Accordingly, People with TB living with HIV that were not tested for HIV or did not self-report their HIV diagnosis at the time of TB diagnosis would not be represented in this data. For that reason, the percentage of people with TB living with HIV is believed to be an underestimate due to incomplete ascertainment of screening tests and HIV/AIDS diagnosis reports.
- The contact information presented in this report includes only contacts of People with TB (i.e. source infections) identified in BC, who were residing in BC at time of

investigation, and who were linked to a source TB diagnosis in Panorama. The data does not include contacts identified as part of federal airplane screening, contacts of source infections not identified in BC, or anonymous contacts. Regions have separate databases for contact investigations that may not be reported in Panorama. As a result, the data presented does not reflect the full workload of contact tracing teams within the health authorities. For instance, contacts and negative screening results are underreported in Panorama due to varying data entry practices. Trends in the number of contacts are affected by the circumstances of each diagnosis and differences in the collection, entry and reporting of contact data. Provincial workflows for contact tracing and contact data entry changed in 2016 with the implementation of Panorama and should be considered when interpreting the provincial surveillance TB contact data presented here.

- The contact tracing cascade of care indicators are based on screening, diagnosis, and treatment completed after the index person was diagnosed, and does not capture contact tracing activities initiated before the index person was diagnosed. Total completion is reported at 2 years post index person diagnosis for all indicators except for secondary diagnosis identification (Indicator 3), which may be reported up to the date of data extraction (i.e. any time after index person diagnosis). Each indicator (i.e. step along the cascade of care) is a subset of the previous step, except for secondary diagnoses (Indicator 3) which is derived from all contacts (i.e. denominator).

- TPT data presented in this report is from Panorama only. Any TPT data not documented in Panorama (e.g. treatment given in federal and provincial correctional facilities) would not be represented here.

## Supplementary Appendix

Additional tables and figures are available in the supplementary file published alongside this report.

# Case Definitions

## A. TB Disease

Detection and confirmation of *Mycobacterium tuberculosis* complex or clinical presentation compatible with active tuberculosis disease, excluding tuberculosis re-treatment within 6 months.

**Laboratory confirmed diagnoses**

- **Infections** with *Mycobacterium tuberculosis* complex (excluding *M. bovis* BCG strain), isolated by culture from a clinical specimen; OR
- **Infections** with laboratory detection of *Mycobacterium tuberculosis* complex by nucleic acid amplification (NAAT) and with clinical findings with current active tuberculosis disease.

**Clinically confirmed diagnoses**

In the absence of culture or NAAT proof, infections clinically compatible with active tuberculosis. For example:

- chest x-ray changes compatible with active tuberculosis;
- clinical symptoms and/or signs of non-respiratory tuberculosis (e.g. meningeal, bone, kidney, peripheral lymph nodes, etc.);
- pathologic evidence of active tuberculosis (e.g. compatible histopathology, positive AFB staining);
- post-mortem evidence of active tuberculosis;
- favorable response to therapeutic trial of anti-tuberculosis drugs.

***Re-treatment exclusion:***

A re-treatment diagnosis of tuberculosis is a diagnosis that has both current active tuberculosis disease and historic documentation of previous active disease. Where re-treatment commences within 6 months after the end of treatment for previously active tuberculosis, the re-treatment is not counted as a new diagnosis of active tuberculosis. This is consistent with the Public Health Agency of Canada's case definition of re-treatment.

**HIV Screening and Co-infection**

*HIV co-infection*

- People with TB with a positive HIV test result at the time of TB disease diagnosis;
- People with TB with self-reported HIV diagnosis at the time of TB disease diagnosis.

*Known HIV status*

- People with TB with a positive or negative HIV test result at the time of TB disease diagnosis;
- People with TB with self-reported HIV diagnosis at the time of TB disease diagnosis.

**Drug Resistance**

People with TB are classified as resistant to isoniazid, rifampin, or both (i.e. multi-drug resistant). Resistance to other TB medications is not reported here.

## B. Site of Disease

Since the implementation of Panorama, tuberculosis sites of disease were rationalized into a list of body sites used and recognized by tuberculosis clinicians. The new tuberculosis sites are similar to many sites in ICD-9 tuberculosis disease coding.

This report divides tuberculosis into respiratory and non-respiratory based on site of disease. Tuberculosis is classified as respiratory if at least one respiratory site is present. Tuberculosis is considered non-respiratory if no respiratory site is present but at least one non-respiratory site is present.

**Respiratory sites**

- bronchiectasis tuberculosis
- bronchus tuberculosis (excluding isolated tracheal or bronchial tuberculosis)
- cavitation of lung tuberculosis
- fibrosis of lung tuberculosis
- infiltrative of lung TB
- intrathoracic lymph node tuberculosis
- isolated tracheal or bronchial tuberculosis
- laryngitis tuberculosis (excluding esophageal tuberculosis)
- miliary tuberculosis
- nodular of lung tuberculosis
- nose or sinus tuberculosis
- pleurisy tuberculosis
- pneumonia tuberculosis
- pneumothorax tuberculosis
- primary tuberculosis
- primary progressive tuberculosis
- pulmonary tuberculosis

**Non-respiratory sites**

- adrenal gland tuberculosis

- bone tuberculosis (including mastoid, dactyl tuberculosis)
- bone and joint tuberculosis
- central nervous system tuberculosis
- ear tuberculosis
- erythema nodosum tuberculosis
- epididymis tuberculosis
- eye tuberculosis
- gastrointestinal tuberculosis (including lymph nodes)
- genital tuberculosis
- genitourinary tuberculosis
- hip tuberculosis
- joint tuberculosis
- kidney tuberculosis
- knee tuberculosis
- lymph node tuberculosis (peripheral)
- meningitis of brain and/or spine tuberculosis
- meningeal or central nervous system tuberculosis
- meningeal tuberculoma
- other organ tuberculosis (excluding respiratory)
- peripheral lymph node tuberculosis
- peritoneal tuberculosis
- skin and subcutaneous tuberculosis
- spinal column tuberculosis
- spleen tuberculosis
- thyroid gland tuberculosis
- urinary tuberculosis

## C. Tuberculosis Infection (TBI)

The clinical definition for TBI is based on a complex mix of demographic characteristics and the presence of co-morbidities. As a surrogate, we report on people who have documentation of TPT initiation in Panorama, which is likely an underestimate of the actual number of persons with TBI.

## D. Treatment Completion

For the purposes of this report, treatment completion for TB disease and TBI documented in Panorama excludes People with TB diagnosed post-mortem and is defined as the following:

**Treatment Completed:** A treatment start date, treatment end date, and treatment status reported as “Completed-satisfactory”. The length of treatment is calculated based on the treatment start date and treatment end date.

**Incomplete Treatment:** A treatment start date, treatment end date, and treatment status other than "Completed-satisfactory" (i.e. "Completed-unsatisfactory", "Incomplete", "Other", "Unknown"), or no treatment end date is documented.

**Left Province During Treatment:** Includes transfers within Canada and outside of Canada.

**No Treatment Documented:** No treatment start date is documented.

## E. TB Contact Tracing Cascade of Care Indicators

**Each indicator (i.e. step) in the cascade is a subset of the previous, except for secondary diagnoses (Indicator 3) which is derived from all contacts (i.e. denominator). Indicators are reported based on the year the index person was diagnosed.**

**Denominator - Number of contacts:** Number of unique contacts linked to people with respiratory TB aged 5 years and older in BC, excluding contacts residing outside of BC at time of investigation. For contacts who were exposed to more than one index person in the reporting year, the earliest exposure for the contact (i.e. based on index person diagnosis date) was used.

**Indicator 1 - Started initial assessment:** Number of contacts who started any of the following after the index person diagnosis date: Tuberculin Skin Test (TST) planted, Interferon-Gamma Release Assay (IGRA) test, or X-ray. For contacts who received more than one type of screen, the earliest screening date was used.

**Indicator 2 - Completed initial assessment:** Number of contacts who completed any of the following after the index person diagnosis date: TST read with valid result, IGRA test with valid result, or X-ray. For contacts who received more than one type of screen, the earliest screening date was used.

**Indicator 3 - Secondary diagnoses:** Number of total contacts (i.e. denominator) diagnosed with confirmed or clinical TB disease after the index person diagnosis date.

**Indicator 4 - Positive screen:** Number of contacts – who are not secondary diagnoses – with any of the following after the index person diagnosis date: a reactive IGRA, or a positive TST (without a subsequent non-reactive IGRA). For contacts with multiple TST or IGRA results, the earliest screening date was used. For contacts with both IGRA and TST positive results, the IGRA date and result was used. This is a measure for people with TBI.

**Indicator 5 - Started treatment:** Number of contacts with a positive screen and a treatment start date after the index person diagnosis date.

**Indicator 6 - Completed treatment:** Number of contacts with a treatment start date, treatment end date, and treatment status reported as "Completed-satisfactory" after the index person diagnosis date.

# Data Sources

## Panorama

Data presented in this report was extracted from Panorama on February 18, 2026. The BCCDC TB Services commenced using Panorama on March 12, 2016, with data conversion from the previous Integrated Public Health Information System (iPHIS). Some iPHIS-converted data could not be readily extracted for reporting in Panorama (e.g. drug resistance, HIV status and co-infection, contact follow-up), and these data were obtained from iPHIS using the 2015 TB Annual Report (10) to produce trend lines for this reporting period (this is indicated throughout the report in footnotes). Historic counts may have changed since the data was reported in 2015 (due to data cleanup and late reporting); therefore, these trends should be interpreted with caution.

## Population Data

Population data and associated rates for the general BC population, age, gender, regional health authority, and health service delivery area were based on the Population Estimates released by BC Stats on January 13, 2026.

Population data and associated rates for people born outside of Canada and people born in Canada were estimated from the 2011, 2016, and 2021 Census Program, conducted by Statistics Canada. Estimates for people born outside of Canada were calculated as the sum of "immigrant" and "non-permanent resident" counts, while Canadian born estimates were obtained from the "non-immigrant" counts. For population estimates for the years between the census, this method assumes proportional annual changes in the population until the following census.

## British Columbia's Index of Multiple Deprivation (BCIMD) for Community Health Service Areas

The BCIMD replicates the Canadian Index of Multiple Deprivation (CIMD) method used by Statistics Canada to derive ecological indicators of deprivation at the Community Health Service Area. The index comprises of four dimensions of deprivation: residential instability, economic dependency, ethno-cultural composition, and situational vulnerability.

This report focuses on residential instability which speaks to the tendency of neighborhood inhabitants to fluctuate over time, taking into consideration both housing and familial characteristics. The component scores are ordered from smallest to largest and then divided into five equally sized groups, or quintiles, and categorized from 1 through 5. Quintile 1 represents the most privileged/least deprived and 5 represents the most deprived.

People with TB disease were assigned to a quintile of residential instability based on their residential postal code to assess neighborhood-level of deprivation.

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