

Manitoba Policy Analysis Case Report

Canadian Harm Reduction Policy Project (CHARPP)

July 2017

This research was conducted as part of the Canadian Harm Reduction Policy Project (CHARPP), a mixed-method, multiple-case study drawing on four data sources (policy documents, key informant interviews, media portrayals, and a national public opinion survey) to describe how policies governing harm reduction services are positioned within and across the 13 Canadian provinces and territories.

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1.0 Overview

This document provides a descriptive and analytical account of Manitoba's provincial harm reduction policy documents produced between 2000 and 2015. This account is part of the Canadian Harm Reduction Policy Project (CHARPP), a multimethod multiple case study comparing provincial/territorial harm reduction policies across Canada. Manitoba results reported in this document will be summarized and integrated into a national-level report that outlines key features of each set of provincial/territorial policies, and compares the strength of each case's policy commitment to harm reduction services.

This document begins with an overview of Manitoba's harm reduction policy context including: governance, healthcare delivery structures, substance use trends and harm reduction programming. Next, a description of study methodology is provided, including information about the policy documents retrieved during a systematic search. Finally, we detail the results of our inductive and deductive policy analysis.

Four key findings are highlighted from the inductive analysis: 1) In Manitoba, the commitment to harm reduction is stronger at the regional level than provincial level. The two highest quality documents apply to subsets of the provincial population only; 2) Descriptions of harm reduction vary widely between current policy documents, and there is no overarching provincial definition; 3) In provincial-level STBBI policy, historical policy reflects an understanding of harm reduction more in line with internationally recognized standards than current policy; 4) Harm reduction, addiction, and substance use are not meaningfully addressed in "mental health and addiction" policies. In the deductive analysis, a set of criteria were applied to current policy documents. Deductive results are presented in a standardized policy report card.

2.2 Contextual Background¹

Manitoba is one of Canada's three prairie provinces, spanning 647,797 square kilometers (Statistics Canada, 2005). Bounded by Saskatchewan on the west and Ontario on the east, it is located at the longitudinal center of Canada. With a population of 1,318,128 (Statistics Canada, 2015) it has one major city, Winnipeg (population 759,600) (Statistics Canada, 2015), which is home to roughly 60% of the province's population (CCENDU, 2011).

In April 2016, the Progressive Conservative Party of Manitoba won the provincial election in the largest majority in the province's history, led by Brian Pallister (Lee, 2016). Prior to this, the

¹ Contextual information in sections 1.1 to 1.4 is current up to the end of 2016.

New Democratic Party (NDP) had been in power from 1999-2015 (Adams, 2006). It does not appear that Premier Pallister has publicly expressed a view on harm reduction, however, Health Minister Kelvin Goertzen commented on key interventions on behalf of the government. In December 2016, he expressed opposition to establishing safe injection sites in the province, stating he had not seen evidence supporting the intervention in the specific context of Winnipeg or Manitoba (Martin, 2016). He voiced support for existing needle-exchange programs, and remarked on the provinces plans to increase the availability of naloxone – particularly in rural Manitoba (Martin, 2016).

In January 2016, the Chief Provincial Public Health Officer for Manitoba updated a formal position statement on harm reduction, which also appears to be endorsed by Manitoba Health, Healthy Living and Seniors (Government of Manitoba, 2016). This document defines harm reduction; provides examples including needle distribution, opioid replacement, naloxone and outreach; and provides a list of affirmations. These include: there are many health, social and economic benefits when harm reduction principles are applied and that harm reduction approaches are evidence-informed and cost effective. This document outlines a position extensively, but does not provide any action items or endorse specific programs or funding. Notably, this update occurred while the NDP was still the governing provincial party.

1.2 Healthcare Governance

From 2012- 2013 there were two provincial departments responsible for health care in the province, *Manitoba Health* and *Manitoba Healthy Living, Seniors and Consumer Affairs* (IPAC, 2013). However, a change of leadership in 2013 led to a major shuffling of the provincial cabinet (CBC, 2013), resulting in the disestablishment of *Manitoba Healthy Living, Seniors and Consumer Affairs*, whose responsibilities were reallocated to the *Department of Health* and the *Department of Consumer Affairs* (Manitoba Order in Council, 2013). *Healthy Living and Seniors* was created as a new sub-department under the *Department of Health*. Since 2013, the two departments - referred to as *Manitoba Health, Healthy Living and Seniors* (MHLS) have coordinated efforts to administer health care in the province. *Manitoba Health* develops province wide goals, policies, legislation, and funding allocation as well as overseeing primary healthcare, mental health, public health, and home care. They also directly manage Cadham Provincial Laboratory, Selkirk Mental Health Center, provincial nursing stations, and insurance benefits related to Pharmacare, medical, personal, or hospital care (MHLS, 2015). *Manitoba Healthy Living and Seniors* manages the Addictions Foundation of Manitoba, the Manitoba Council on Aging, and directs policy related to tobacco regulations (MHLS, 2015).

Since 2012, health care has been delivered by five regional health authorities (RHAs) in the province (See Appendix A): Northern Health Regional Authority, Interlake-Eastern Regional Health Authority, Prairie Mountain Health, Southern Health–Santé Sud, and Winnipeg Regional Health Authority. In 2012, the previously eleven health authorities amalgamated into five authorities in an effort to better integrate services, streamline administration, and reduce expenditures (Institute of Public Administration of Canada, 2013). The *Regional Health Authorities of Manitoba Incorporated*, is a not-for-profit, established in 1998 to co-ordinate the efforts of the five regional authorities (RHAM, 2016).

CancerCare Manitoba is a provincially mandated organization that works to prevent cancer and to improve the outcomes and quality of life for people with cancer and blood disorders (CCMB, 2016). They operate the provincial screening program, patient navigation program and central referral office, manage the cancer registry, and conduct cancer-related research (IPAC, 2013). In 2002, *Diagnostic Services Manitoba* was created as a not-for profit, responsible for the province's laboratory services as well as rural diagnostic imaging services (Diagnostic Services Manitoba, 2015).

1.3 Substance Use Trends

According to data collected from the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS, 2012), 41.1% of Manitobans reported lifetime use of one or more illicit drugs. Over their lifetime, 6.3% of Manitobans reported using cocaine/crack, 12.4% reported using hallucinogens, and 3.4% reported using ecstasy. Manitobans also reported on drug use in the past 12 months; 14.7% reported using at least one illicit drug in the past year, while 13.4 % reported using one of the following illicit drugs: cannabis, cocaine/crack, speed, ecstasy, hallucinogens or heroin. In the same survey, 3.1% of Manitobans reported experiencing harm (from their own drug use over the past twelve months related to substance use over the past 12 months. These numbers are consistent with national trends; 43.2% of Canadians have used at least one illicit drug in the past 12 months and 2.0% of Canadians report experiencing harms related to drug use (CADUMS, 2012).

Since 2013, there has been a fairly steady increase in the number of overdose deaths related to the use of the drug fentanyl (Greenslade, 2015). The number of fentanyl-related overdoses in 2015 was almost double the rate of a five-year period between 2009-2013 (NDP, 2016). Fentanyl was a primary or contributing factor in 20 overdose deaths in 2015, compared to 13 in 2014 and 11 in 2013 (Cole, 2016).

1.4 Harm Reduction Services in Manitoba

Street Connections is part of the WRHA's Population and Public Health Program (Street Connections, 2014). It is a mobile outreach program which supplies safer drug use and sex supplies. The organization dispenses sterile injection supplies including alcohol swabs, syringes, and spoons and collects used syringes in order to safely dispose of them (Street Connections, 2014). In 2015, the organization dispensed 888,766 syringes throughout Winnipeg (Coubrough, 2016). In 2004, Street Connections became one of the first Public Health programs in Canada to distribute safer crack use kits (Backe et al., 2012), in an effort to prevent the transmission of HIV and other blood-borne diseases. The kits follow the standards laid out by the Canadian Aids Treatment Information Exchange (Strike, Gohil & Watson, 2014). There are considerable regional differences across the province in terms of access to syringe distribution and safer smoking kits, with large portions of Manitoba providing neither.

There are currently six methadone clinics in Manitoba, two of which are publicly funded by Manitoba Health and managed by the Addictions Foundation of Manitoba; one in the Southern town of Manitoba - Brandon, and one in Winnipeg. The other four clinics are all located in Winnipeg. Wait times may be between six months and one year (Luce & Strike, 2011) and once patients are accepted, they may still face several barriers. For example, in Manitoba, Methadone and Buprenorphine must be delivered daily on site and patients are subject to urine testing.

In December 2016, the provincial government announced plans to order 1,000 opioid overdose-reversal kits (with naloxone), to be distributed at several sites throughout the province, including Street Connections in Winnipeg (Glowacki, 2016).

2.0 Methods

We performed a comprehensive search of publicly-accessible Canadian harm reduction policy documents published from 2000 – 2015. Documents produced for Manitoba during this period were (a) analyzed and synthesized inductively to describe historical² and current³ policy developments guiding harm reduction services in the province over this time period, and (b) reviewed collectively and evaluated using a deductive coding framework comprised of 17

² A document was considered historical when (1) the years the policy applied to had passed, (2) the document was replaced by a newer document, or (3) the document was no longer available online.

³ A document was considered current when (1) the policy was in effect in 2015 (2) the document was the most recent version retrieved for the case and had not been replaced by a newer document of the same focus, and/or (3) the document had no stated end date.

indicators, assessing the quality of harm reduction policies in order to facilitate cross-case comparison.

2.1 Search Process

A separate paper provides complete methodological details regarding the National search process (Wild et al., 2017). Systematic and purposive search strategies identified and verified publicly-available policy documents produced from 2000 – 2015. We defined relevant documents as harm reduction policy texts that (1) were issued by and representing a provincial or territorial government or (2) issued by and representing a regional, provincial, or territorial delegated health authority; (3) that mandated future action; and (4) that addressed one of seven targeted harm reduction interventions⁴ or (5) were produced as either a stand-alone harm reduction policy or as part of a strategy document guiding services for substance use, addiction, mental health, and/or prevention of blood-borne or sexually transmitted infections. We excluded documents that described services at the municipal level, in prisons, and on First Nation reserves (where health services are the responsibility of the federal government). Additionally, given our focus on provincial and territorial policy frameworks, and not harm reduction practice, we excluded government or health authority authored documents exclusively focused on best practice guidelines for frontline service providers.

Seven current documents, and one historical documents were identified and analyzed using a two-step (inductive and deductive) process described below (Appendix B provides the Manitoba -specific search strategy).

2.2 Inductive Analysis

Each of the eight Manitoba documents was analyzed using a three-step process (Appendix C provides analytic details). First, relevant text⁵ was extracted from each policy document and analyzed, resulting in a set of analytic notes. The focus of the analytic notes was primarily descriptive and instrumental (i.e., generating a deeper understanding of the intent and purpose of the policy document and the relevant stakeholders and their roles). Next, each document's analytic notes and a set of accompanying quantitative data (see Appendix C) were synthesized and compiled into a narrative document description. Finally, all narrative document

⁴ The seven harm reduction interventions of interest to this research are 1) syringe distribution, 2) Naloxone, 3) supervised consumption, 4) low threshold opioid substitution, 5) outreach, 6) drug checking, 7) safer inhalation kits.

⁵ "Relevant text" refers to text that directly or indirectly relates to the provision of harm reduction services, including any mention of harm reduction or the seven interventions of interest.

descriptions for the case were synthesized and compiled into a single document. This resulted in a descriptive summary, describing the main themes and trends in Manitoba's set of harm reduction policy documents over the 15-year study period.

2.3 Deductive Analysis

We developed the CHARPP framework, a set of 17 indicators, to assess the quality of policy documents based on how well they described key *population characteristics* and *program features* of a harm reduction approach. To develop the CHARPP framework, a list of indicators was generated based on key harm reduction principles outlined by the International Harm Reduction Association (2010) and the World Health Organization (WHO, 2014). These indicators were refined through consultation with a working group of harm reduction experts from across Canada to ensure they reflected quality indicators of harm reduction policy in Canada.

Current Manitoba policy documents were content analyzed using this framework. Each document was reviewed for the presence (1 = yes, criteria met) or absence (0 = no, criteria not met) of each quality indicator. Dichotomous scores for each indicator were justified with an accompanying written rationale. Scores and rationales were then compiled into a standardized *policy report card* for each provincial or territorial case to facilitate comparisons of harm reduction policy across jurisdictions

3.0 Documents Retrieved

We retrieved eight unique policy documents in our provincial search and no corresponding update reports. Of the eight, seven were considered current policy documents – four at the provincial level and three at the regional level. See Table 1 below for further information on each document. Additional descriptive summaries of each policy document are included in Appendix D.

Table 1: Descriptive Details of Manitoba’s Policy Documents

Current Provincial	Document	Authors	Year Published	Years Active
	1 As long as the waters flow: An Aboriginal strategy on HIV/AIDS. A component of Manitoba's provincial AIDS strategy	Manitoba Health	2004	Not stated
	2 Manitoba sexually transmitted and blood-borne infections strategy 2015-2019	Manitoba Health, Healthy Living and Seniors	2015	2015-2019
	3 Breaking the chains of addiction: Manitoba's five-point strategic plan	Manitoba Health, Healthy Living and Seniors	2008	Not stated
	4 Rising to the challenge: A strategic plan for mental health and well begin of Manitobans	Manitoba Health	2011	5 years
<i>Historic Provincial</i>	5 <i>Provincial sexually transmitted diseases control strategy August 2001</i>	<i>Manitoba Health Public Health</i>	<i>2001</i>	<i>Not stated</i>
Current Regional	6 Position statement on harm reduction	Winnipeg Regional Health Authority	No date	Not stated
	7 Healthy sexuality and harm reduction strategic planning conceptual framework	Winnipeg Regional Health Authority Population and Public Health	2012, updated in 2015	2012-2017
	8 Position statement on mental health promotion and prevention March 2004	Winnipeg Regional Health Authority	2004	Not stated

4.0 Results: Inductive Analysis of Documents

4.1 In Manitoba, the commitment to harm reduction is stronger at the regional level than provincial level. The two highest quality documents apply to subsets of the provincial population only.

The harm reduction policy framework for Manitoba consists of eight documents, seven of which are current. Of these seven, the strongest commitment to harm reduction appears in two documents which apply to subsets of the provincial population only; the *Position Statement on Harm Reduction [6]* (year unknown), authored by and pertaining to the Winnipeg Regional Health Authority (WRHA); and *As Long as the Waters Flow: An Aboriginal Strategy on HIV/AIDS [1]* (2004), authored by Manitoba Health and pertaining to approximately 196,000 Aboriginal peoples living in the province⁶. In looking at what policy currently exists to govern harm reduction services for *all people* in the province – the *Manitoba STBBI Strategy 2015-2019* is the only document that meets this criterion. As such, the present “provincial commitment” to harm reduction can be understood as what is endorsed in this strategy.

4.1.1 Current harm reduction policy for sub-sets of the provincial population

The *Position Statement on Harm Reduction (no year)* includes a comprehensive explanation of harm reduction that aligns with internationally recognized principles. Risk and risk-taking are described as ubiquitous across time and society, and examples of “harm reduction” outside of substance use are noted, including seat belts, smoking bans and sunscreen (p. 4). Key principles noted include: that abstinence is not required (or expected) (p.8), the promotion of autonomy and human dignity (p.7), pragmatism (p.8), encouraging people to start “where they’re at”(p.8), supporting the rights and responsibilities of individuals and communities (p.8), and challenging discriminatory policies and their consequences (p.9). The *Position Statement [6]* notes interventions for various modes of use and substance types, including needle exchange, supervised injection and inhalation, safer crack use kits, heroin prescription and street drug testing (p.5). Despite presenting a comprehensive understanding of the approach, the stated aim of the document is to outline the WRHA’s *position* on harm reduction, rather than to guide specific action. As such, the document includes a limited number of vague action items. While it

⁶ Population as of 2011. Source: Statistics Canada. (2016). *Aboriginal Peoples: Fact Sheet for Manitoba*.

is a very useful visionary document that frames harm reduction as an effective, evidence-based approach, and clearly demonstrates the WRHA's support for harm reduction moving forward, it does not inform specific policy actions. Despite this, it presents the strongest endorsement of a harm reduction approach of all documents in the policy corpus for Manitoba.

As Long As the Waters Flow: An Aboriginal Strategy on HIV/AIDS [1] (2004) touches on several key principles of harm reduction, including: a focus on preventing drug-related harm; recognizing the limitations of abstinence; acknowledging that harm reduction can benefit individuals, communities and society; recognizing the need for evidence informed policy; endorsing human rights, recognizing the social determinants of health and how these impact risk; and special consideration of key populations in the context of harm reduction, including women, youth and quite obviously – Aboriginal peoples. The document has a comprehensive definition of harm reduction that considers Aboriginal cultural diversity, and endorses harm reduction as a key guiding principle. The major shortcoming of the document is that injection drug use is the only mode of drug use considered, and the document tends to focus on reducing risks associated with injection drug use, with a clear goal of preventing/reducing STBBI transmission. Despite this, the comprehensive discussion around harm reduction and related principles conveys a holistic understanding of the approach as a method of practice, rather than just the implementation of interventions.

Two additional policies apply to sub-sets of the provincial population. The *Healthy Sexuality and Harm Reduction Strategic Planning Conceptual Framework [7]* is one of two “named” harm reduction documents in the corpus, and was authored by and for the WRHA. As with the *WRHA Position Statement [6]*, this document endorses harm reduction in the WRHA, albeit to a much lesser extent. It does not define harm reduction or include clear action items. Very little context is provided in this document, making it difficult to interpret what role it may serve in directing policy. The *Position Statement on Mental Health Promotion and Prevention [8]* (2004) does not address harm reduction or any of the interventions of interest.

4.1.2 Current harm reduction policy for all Manitobans

Only one current document exists that endorses harm reduction and is applicable to the province as a whole- the *Manitoba STBBI Strategy 2015-2019*. The commitment to harm reduction in this document is considerably weaker than what is outlined in the *WRHA Position Statement [6]* or the *Aboriginal Strategy on Aboriginal HIV/AIDS [1]*. The *Manitoba STBBI Strategy 2015-2019* is a well-organized policy document that generally addressed many principles of a harm reduction approach, including stigma, human rights and social

determinants of health – however, these are not addressed in the context of harm reduction specifically. Harm reduction is referenced many times throughout the document, but is endorsed very generally with non-specific references rather than key interventions. Syringe distribution is mentioned one time, and injection drug use is the only mode of drug use considered. Furthermore, harm reduction is not defined explicitly, so it is difficult to understand just what approach is being promoted. Near the end of the document, an operational indicator supports the development of a “provincial harm reduction policy statement” and a “provincial harm reduction position statement” (p.24), implying that a provincial stance on the matter has not been defined.

Two more documents exist that are both current and apply to the province as a whole: *Breaking the Chains of Addiction: Manitoba's five-point strategic plan [3]* (2008) and *Rising to the Challenge: A strategic plan for mental health and well begin of Manitobans [4]* (2011). Notably, neither document includes any reference to harm reduction at all, or any of the seven interventions of interest. Neither contributes anything to policy in regards to harm reduction.

4.1.3 Summary

Only four current documents in the Manitoba policy set address harm reduction at all, and of these - only one applies to all adults in the province. This document endorses a non-specific approach to harm reduction and incorporates few principles of harm reduction that are internationally recognized. The strongest commitment to harm reduction in the policy set exists in two documents produced for sub-populations of the province, rather than the province as a whole. This means that a large proportion of Manitobans may be receiving harm reduction services ad hoc, outside of any formal policy direction, or that services are absent entirely.

4.2 Descriptions of harm reduction vary widely between current policy documents, and there is no overarching provincial definition.

Of the seven documents in the Manitoba policy set, only four actually mention harm reduction at all. Of these, two provide formal definitions, one describes the approach enough that an implicit understanding can be ascertained, and one includes no context or information.

4.2.1 Formal definitions of harm reduction

Two documents provide formal definitions of harm reduction. In *As Long as the Waters Flow:*

An Aboriginal Strategy on HIV/AIDS [1] (2004), a very comprehensive definition of harm reduction is described as follows:

“Harm reduction strategies engage people who are at risk of contracting HIV or hepatitis C, focusing on where they are in their lives. It is a pragmatic approach that recognizes the limitations of abstinence-based approaches for populations with well-entrenched high-risk behaviour patterns. Harm reduction approaches focus on decreasing the negative consequences of high-risk behaviours to individuals, communities and society. Rather than necessarily attempting to have people cease engaging in behaviours that are associated with the spread of HIV (such as sharing injection drug equipment and unprotected sexual contact), it seeks to reduce the potential harm of such activities. These strategies may result in some people abstaining from risk behaviours; however, abstinence is not the primary objective of harm reduction. The focus is on assisting people to change their risk behaviours through education, peer support and opportunity building. Harm reduction strategies can include confidential condom provision; needle distribution and exchange; safe disposal sites for used injection equipment; safe injection sites; a policing focus on drug dealers; and pharmacy, health centre, nursing station and community involvement in needle exchange and sales. They can also include media campaigns focusing on the continuing prevalence and risk of HIV, sexually transmitted disease and hepatitis C infection, prevention and harm reduction activities and the benefits of early testing and treatment in reducing transmission to others and improving quality of life for persons with HIV/AIDS. Harm reduction approaches must recognize and be sensitive to Aboriginal cultural diversity, the traumatic effects of attempted assimilation and the unique aspects of post-colonial cultural revitalization” (p.24).

In the WHRA Position Statement on Harm Reduction [6] (no year), the definition is as follows:

“There are a variety of definitions available for harm reduction, all of which include the reduction of harms. In sum, harm reduction can be defined as strategies, programs and policies, which aim to reduce the negative health, social and economic outcomes associated with the use of licit or illicit substances. It is an evidence-informed and cost-effective approach – bringing benefits to the individual, community and society (International Harm Reduction Association, 2006)” (p.3)

The above definitions share key similarities. Both recognize that harm reduction can be broadly applied through policies, programs, practices and interventions and that harm reduction can be applied to at-risk populations, as well as the general public. There are also key differences. The first definition limits the application to those “at risk of contracting HIV or hepatitis C” and has a clear focus on preventing STBBI transmission. It also explicitly recognizes the limitations of an abstinence-based approach, and considers the importance of being sensitive to Aboriginal cultural diversity. The second definition is much less in-depth, it does not recognize abstinence

at all, and it encompasses a broader approach to harms – including health, social and economic outcomes, rather than just disease transmission. Clearly, there is not a key shared understanding of harm reduction between these documents. They also apply to different sub-groups of the Manitoba population.

4.2.2 Informal descriptions of harm reduction

Two documents describe harm reduction to a degree that an implicit understanding can be ascertained. However, unlike the two definitions described above, they are not endorsed as formal definitions or descriptions.

In the *Manitoba sexually transmitted and blood-borne infections strategy 2015-2019 [2]*, the first time harm reduction is discussed in detail, it is described as the key guiding principle of “incorporating a harm reduction approach”. This is further explained as “recognize and focus on reducing the harms associated with practices through which STBBIs may be transmitted such as drug use and/or unprotected sex. Accept that these practices are a part of human behaviour and acknowledge the need for harm reduction programs to reduce adverse health consequences” (p.12). This is the closest example of a formal definition in the document, and endorses the view that harm reduction should focus on reducing risk, while accepting that drug use is inevitable. Elsewhere in the document, harm reduction is discussed in quite different contexts, making it difficult to pin down a specific understanding. For example, harm reduction is listed as an example of a “prevention activity” (p.15), alongside screening, early detection and diagnosis. It is also described as being part of an integrated continuum of services for persons who use licit or illicit substances – alongside health promotion, illness prevention, early identification and management (p.16).

In the *Healthy sexuality and harm reduction strategic planning conceptual framework [7]*, harm reduction is mentioned several times but there is absolutely no context included or any sort of definition. In terms of informal descriptions of harm reduction, there is clearly no consistency between these two cases. The first description above aligns somewhat with the first formal definition, in that they focus on harms associated with STBBI transmission. Other than this, there is little commonality in each documents’ framing of harm reduction.

4.2.3 Consistency in defining harm reduction across the case

It is evident that across the province there is not a shared understanding of the approach, nor is there agreement on what the primary purpose of harm reduction should be. Understandings vary from formal definitions with several key principles to use of the term alone, with no

context provided. Conceptions of harm reduction appear to align with the stated goals of each document, rather than reflecting an overarching provincial understanding of the approach. Notably, the remaining three documents in the case did not mention harm reduction at all, further supporting the conclusion that a shared understanding of harm reduction is not in place throughout the province.

4.3 In provincial-level STBBI policy, historical policy reflects an understanding of harm reduction more in line with internationally recognized standards than current policy

There were two documents found in our search for the province of Manitoba with a stated focus on STBBIs and disease transmission prevention. One was published in 2001 (*Provincial sexually transmitted diseases control strategy August 2001 [5]*) and is considered to be historical as it was replaced by a newer document of the same focus in 2015 (*Manitoba sexually transmitted and blood-borne infections strategy 2015-2019 [2]*).

The historical policy document mentions three interventions of interest (syringe distribution, supervised consumption and outreach) and includes a comprehensive description of - and rationale for – a harm reduction approach:

Traditionally, prevention of sexually transmitted diseases has been equated with abstinence from engaging in risky behaviours. There is a growing realization however that for many individuals and communities, abstinence is not an attainable goal. In contrast, a harm reduction model accepts the reality that many behaviours are too strongly motivated and habituated to be readily changed. Harm reduction sets as its primary goal a decreased risk of infection. This model includes abstinence not as an end, but rather as one of several means to lowering one's risk (p.20).

Several key principles of harm reduction are identified in this description including abstinence not being required and the primary goal of reducing harm (rather than the behavior itself). Later in the document, harm reduction is described as an approach that can be applied at the population level, in addition to targeting high-risk groups.

As was discussed in the previous point – in the current policy document (*Manitoba sexually transmitted and blood-borne infections strategy 2015-2019 [2]*), "incorporating a harm reduction approach" is explained as, "recognize and focus on reducing the harms associated with practices through which STBBIs may be transmitted such as drug use ... accept that these

practices are part of human behaviour and acknowledge the need for harm reduction programs to reduce adverse health consequences" (p.12). There is no further explanation of the approach. Notably, this is significantly less thorough than the approach described in the (now historic) policy document the present document replaced. Additionally, only one intervention of interest is noted in this document one single time (syringe distribution), compared to three in the earlier version, perhaps indicating a less comprehensive endorsement of the approach.

4.3.1 Summary

Although both definitions narrowly frame harm reduction as a method for reducing or preventing disease transmission, the first definition encompasses more internationally recognized principles of harm reduction and acknowledges more interventions of interest. Considering that these documents were published over ten years apart, it is notable that the description of harm reduction did not become more straightforward or encompassing of more internationally recognized principles. In contrast, the description in the present document can be considered poorer quality and a weaker endorsement of operationalizing harm reduction in practice.

4.4 Harm reduction, addiction, and substance use are not meaningfully addressed in “mental health and addiction” policies.

There are two current documents in the policy set that explicitly focus on mental health. At the provincial level, *Rising to the Challenge: A strategic plan for mental health and well-being of Manitobans* [4] (2011), and at the regional level, *Position statement on mental health promotion and prevention* (2004). Both documents acknowledge substance use to some degree – broadly indicating that it is a topic relevant to discussions around mental health. However, in both cases, this discussion is incredibly limited and provides no policy direction specific to harm reduction, addiction or substance use more broadly.

Harm reduction is never actually mentioned in either document, nor are any of the seven interventions of interest. In *Rising to the Challenge* [4], addiction is rarely addressed, and is always noted alongside mental illness rather than an independent issue. There are no action items or recommendations that pertain to this area. “Substance abuse” and “problematic substance use” are noted throughout the document, with no context or action items provided. In the *Position statement on mental health promotion and prevention* [8], a single statistic is shared regarding the number of Canadians reporting “alcohol or illicit drug dependence” (p.3).

This is the only mention of substance use in the document. Addiction is never considered at all.

A third document, *Breaking the chains of addiction: Manitoba's five-point strategic plan* [3] (no year) has a stated focus on addictions, but also mentions mental health. Despite the more direct focus on addictions in this document, again, no action items around addictions, substance use or harm reduction are ever endorsed. Objectives are broad, for example, “establishing a provincial navigation and support intake line for adult addiction services” (n.p.) and “developing community-based treatment services in under-served areas of the province” (n.p.).

4.4.1 Summary

The provincial response to “addictions and mental health” is informed by two current provincial-level documents, *Breaking the chains of addiction* [3] and *Rising to the Challenge* [4]. Neither includes specific action regarding substance use or addictions. As such, there is essentially no policy within the province to guide services in these areas. At the regional level, the situation remains the same, as reflected by the lack of action endorsed in the WRHA’s *Position statement on mental health promotion and prevention* [8]. Given the minimal consideration of substance use or addictions, it is not surprising that none of the three documents incorporates harm reduction to any degree.

5.0 Results: Deductive Analysis of Current Documents (Manitoba Policy Report Card)

All current documents were content analyzed using a deductive coding framework comprised of 17 indicators. These assessed the quality of policies relative to how well they described key *population* aspects (nine indicators) and *program* aspects (eight indicators) of a harm reduction approach. Each document was reviewed for the presence (1 = yes, criteria met) or absence (0 = no, criteria not met) of each quality indicator. Results are displayed in the following three tables.

Table 1: Presence of key population indicators in current policy documents

	As long as the waters flow: An Aboriginal strategy on HIV/AIDS: A component of Manitoba's provincial AIDS strategy	Manitoba sexually transmitted and blood-borne infections strategy 2015-2019	Breaking the chains of addiction: Manitoba's five-point strategic plan	Rising to the challenge: A strategic plan for mental health and well being of Manitobans	Position statement on mental health promotion and prevention March 2004	Position statement on harm reduction	Healthy sexuality and harm reduction strategic planning conceptual framework	Total (out of 7)
[1] Does the document recognize that stigma and/or discrimination are issues faced by people who use drugs or have drug problems?	0	0	0	0	0	1	0	1
[2] Does the document affirm that people who use substances need to be involved in policy development or implementation?	1	0	0	0	0	0	0	1
[3] Does the document acknowledge that not all substance use is problematic?								

[4] Does the document recognize that harm reduction has benefits for both people who use drugs and the broader community?	1	1	0	0	0	1	0	3
[5] Does the document acknowledge that harm reduction can be applied to the general population?	0	1	0	0	0	1	0	2
[6] Does the document target women in the context of harm reduction?	1	0	0	0	0	0	0	1
[7] Does the document target youth in the context of harm reduction?	1	0	0	0	0	0	0	1
[8] Does the document target indigenous populations in the context of harm reduction?	1	0	0	0	0	0	0	1
[9] Does the document target LGBTQI populations in the context of harm reduction?	0	0	0	0	0	0	0	0
TOTAL (out of 9)	5	2	0	0	0	3	0	10/63

Table 2: Presence of key program indicators in current policy documents

	As long as the waters flow: An Aboriginal strategy on HIV/AIDS. A component of Manitoba's provincial AIDS strategy	Manitoba sexually transmitted and blood-borne infections strategy 2015-2019	Breaking the chains of addiction: Manitoba's five-point strategic plan	Rising to the challenge: A strategic plan for mental health and well being of Manitobans	Position statement on mental health promotion and prevention March 2004	Position statement on harm reduction	Healthy sexuality and harm reduction strategic planning conceptual framework	Total (out of 7)
[10] Does the document acknowledge the need for evidence-informed policies and/or programming?	1	1	0	1	0	1	1	5
[11] Does the document acknowledge the importance of preventing drug related harm, rather than just preventing drug use or blood borne or sexually transmitted infections?	1	1	0	0	0	1	0	3
[12] Does the document discuss low threshold approaches to service provision?	0	0	0	0	0	1	0	1
[13] Does the document specifically address overdose?	0	0	0	0	0	1	0	1
[14] Does the document recognize that reducing or abstaining from substance use is not required under a harm reduction approach?	1	1	0	0	0	1	0	3
[15] Does the document consider harm reduction approaches for a variety of drugs and modes of use?	0	0	0	0	0	1	0	1

[16] Does the document address human rights (e.g. dignity, autonomy) concerns of harm reduction?	1	0	0	0	0	1	0	1
[17] Does the document consider social determinants (i.e. income, housing, education) that influence drug-related harm?	1	1	0	0	0	1	0	3
TOTAL (out of 8)	5	4	0	1	0	8	1	19/56

Table 3: Proportion of policy quality indicators endorsed for all documents within cases

Case	Target population quality (out of 9 indicators)	Service quality (out of 8 indicators)
British Columbia (10)	38/90 (42%)	52/80 (65%)
Alberta (4)	7/36 (19%)	14/32 (44%)
Saskatchewan (3)	9/27 (33%)	13/24 (54%)
Manitoba (7)	10/63 (16%)	19/56 (34%)
Ontario (7)	3/63 (5%)	9/56 (16%)
Quebec (11)	24/99 (24%)	26/88 (30%)
New Brunswick (1)	0/9 (0%)	1/8 (13%)
Nova Scotia (4)	12/36 (33%)	11/32 (34%)
Prince Edward Island (1)	0/9 (0%)	1/8 (13%)
Newfoundland (2)	1/18 (6%)	1/16 (6%)
Yukon (0)	n/a	n/a
North West Territories (2)	2/18 (11%)	1/16 (6%)
Nunavut (2)	3/18 (17%)	5/16 (31%)
Canada (54)	109/486 (22%)	153/432 (35%)

6.0 Conclusion

In Manitoba, the commitment to harm reduction in current, provincial-level policy, can be described as conceptually weak overall. Although the policy framework includes examples of high-quality harm reduction policy documents - these apply to subsets of the provincial population, leaving most Manitobans outside of the Winnipeg area in a context where harm reduction services and interventions are implemented without the guidance of formal policy. In this sense, a patchwork of policies exists, with many gaps across the region.

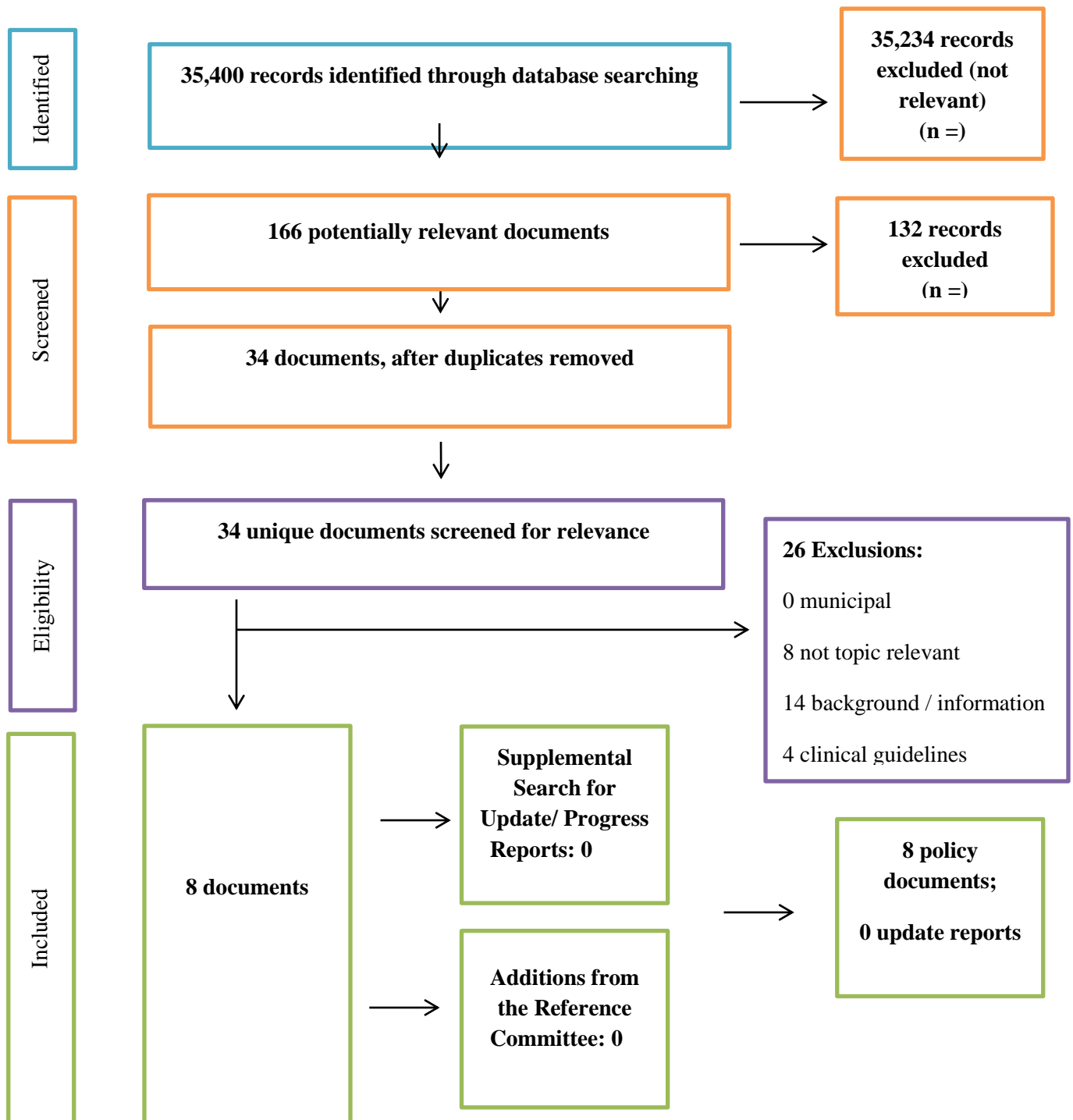
In looking at policies that address harm reduction, at both the provincial and regional levels, understandings of the approach differ widely – both in terms of written descriptions and in how it is “operationalized” in policy. Although the most commonly endorsed interventions pertain to injection drug use (needle exchange, supervised injection), with a clear emphasis in current policy on preventing the transmission of STBBIs, this is not the case for all documents. Overall, a consistent understanding or approach to harm reduction is not endorsed across the province.

In looking at key provincial policies over time, evidence suggests that historical policy endorsed a broader range of interventions and reflected an understanding of harm reduction more in line with internationally recognized standards than current policy does. This shows that little improvement has been made in the past decade to increase policy commitments to harm reduction at the provincial level. In the case of Manitoba, regional-level policies can serve as useful policy templates, and can provide key direction for the implementation of provincial-level policy that is suited to the unique context of the province.

Appendix A: Regional Health Authorities

Regional Health Authority	Population
Northern Health Regional Authority	75,947
Interlake-Eastern Regional Health Authority	127,273
Prairie Mountain Health	168,477
Southern Health–Santé Sud	194,257
Winnipeg Regional Health Authority	754,389

Appendix B: Systematic search strategy flow diagram⁷



⁷ Adapted from PRISMA 2009 Flow Chart (Moher, Liberati, Tetzlaff, Altman, The PRISMA Group, 2009).

Appendix C: Standard methodology for generating provincial/territorial case report

Overview

A separate paper (Wild et al., 2017) describes the search and verification strategies used to assemble a corpus of harm reduction policy texts for each case. All policy documents meeting inclusion criteria were coded into one of three categories: (1) primary documents (i.e., policy texts that direct harm reduction services or resources as their main named purpose), (2) secondary documents (i.e., policy texts that direct services and resources that relate to harm reduction, and for which harm reduction is embedded throughout the document [e.g., as part of an addiction strategy or as part of an HIV/AIDS policy framework]), and (3) tertiary documents (i.e., policy texts that direct services and resources that relate to harm reduction but do not mention harm reduction explicitly).

Documents were analyzed in a two-step process, involving inductive and deductive methods. The inductive analysis was designed to provide a synthesis of *current and historical* developments in harm reduction policy for the case. The deductive analysis was designed to facilitate cross-case comparisons, and involved evaluating *current* policy documents for each case in relation to the CHARPP framework – a set of 17 indicators assessing the quality of harm reduction policies.

Inductive analysis

The qualitative analysis proceeded in three phases for each relevant policy document. First, each document was reviewed for relevant text (i.e. text directly or indirectly relating to the provision of harm reduction services in the given provincial/territorial jurisdiction). Relevant sections were then excerpted into word processing software. Each excerpt was then analyzed using a modified version of Mayan's (2009) latent content analysis procedure and analytic notes were generated. The focus of the analytic notes was primarily descriptive and instrumental (i.e., generating a deeper understanding of the intent and purpose of the policy document and the relevant stakeholders and their roles).

Next, each document's analytic notes and accompanying quantitative data (see next page) were synthesized and compiled into a narrative document description. Combining the quantitative and qualitative data at this stage was useful for two reasons; (1) quantitative data presented at the start of each document description provided a quick means to compare across documents in each case; and 2) presenting the quantitative data at the start of the synthesis facilitated review of the analytic notes to ensure that they contained adequate qualitative information to contextualize each quantitative data point. For example, if the quantitative data indicated that there is mention of funding mechanisms in the report, than the analyst reviewed their analytic notes and ensured this funding commitment is adequately described in the narrative synthesis. This narrative description provided an overview of current and historical developments in provincial/territorial harm reduction policymaking. The length of the narrative descriptions vary considerably depending on whether a given document is primary, secondary or tertiary, as well as whether it is shorter or longer and simple or complex.

Finally, the narrative document descriptions were synthesized and compiled. Descriptive comments summarized the overall scale and scope of the documents contained in each case, and described the main features of the set of policy documents. Particular attention

was paid to identifying points of convergence and divergence within and between policy documents.

Deductive analysis

To facilitate cross-case comparison between the policy documents of each province and territory, we developed the CHARPP framework – a set of 17 indicators that assessed the quality of policies based on how well they described key *population characteristics* and *program features* of a harm reduction approach. The indicators were guided by principles outlined by the International Harm Reduction Association (2010) and the World Health Organization (2014), and developed in consultation with a working group of harm reduction experts from across Canada.

Nine *population* indicators were specified, based on the premise that high-quality harm reduction policies characterize service populations accurately when they: (1) recognize that stigma and discrimination are issues faced by people who use illegal drugs; (2) affirm that people who use drugs need to be involved in policy development or implementation; (3) acknowledge that not all substance use is problematic; (4) recognize that harm reduction has benefits for both people who use drugs and the broader community; (5) acknowledge that a harm reduction approach can be applied to the general population; and affirm that (6) women; (7) youth; (8) indigenous peoples; and (9) LGBTQI (lesbian, gay, bisexual, trans, queer and questioning, and intersex) people are key populations for harm reduction.

Eight *program* indicators were specified based on the premise that high-quality harm reduction policies should (10) acknowledge the need for evidence-informed policies and/or programs; (11) recognize the importance of preventing drug-related harm (rather than just preventing drug use, or blood-borne or sexually-transmitted infections); (12) discuss low-threshold [49] approaches to service provision; (13) specifically address overdose; (14) recognize that reducing or abstaining from substance use is not required; (15) consider harm reduction approaches for a variety of drugs and modes of use; (16) discuss harm reduction's human rights (e.g. dignity, autonomy) dimensions; and (17) consider social determinants (including income, housing, education) that influence drug-related harm.

Each document was reviewed for the presence (1 = yes, criteria met) or absence (0 = no, criteria not met) of each quality indicator. Dichotomous scores for each indicator were justified with an accompanying written rationale. Scores and rationales were then compiled into a standardized *policy report card* for each provincial or territorial case to facilitate comparisons of harm reduction policy across jurisdictions. Formal policies that score highly on CHARPP indicators are high-quality because they conceptualize and describe a harm reduction approach in close accordance with its internationally-recognized attributes and principles. Conversely, poor-quality harm reduction policies score low on CHARPP indicators because they refer to the approach only sparingly, and/or do not elucidate its key attribute and principles.

Accompanying Quantitative Data

- Author(s);
- Year published;
- Number of years the policy covers;
- Page length of the document;
- Triage level (primary, secondary, tertiary);
- Number of distinct mentions of the term 'harm reduction' as well as each of the 7 specific harm reduction services described earlier;
- Language used (i.e. 'harm reduction', 'reducing harm', 'risk reduction');
- Policy level (provincial or regional health authority);
- Scope/target population (entire population, specific target population);
 - Specify target population: (i.e. Aboriginal communities, rural communities, health region);
- Population size of target population;
- Timeline for the policy provided? (yes/no);
 - Specify timeline: (i.e. 3-year plan, 5-year plan)
- Evidence of endorsement from Premier or other member of Cabinet? (yes/no);
- Any reference to legislation enacted to support policy implementation? (yes, no);
 - Specify name of Act or Statute
- Does the document assign specific roles and responsibilities to relevant actors? (yes/no);
- Does the document mention funding mechanisms and/or commitments? (yes/no)
- Does the document have regular progress reporting or updates? (yes/no)
 - Names and date of progress reports or updates
- Does the document have any progress reporting or updates?
- Reference to consultations with target population during policy development?

Appendix D: Descriptive summary of current policy documents

As long as the waters flow: An Aboriginal strategy on HIV/AIDS. A component of Manitoba's provincial AIDS strategy

The Aboriginal Strategy on HIV/AIDS was developed in 2004. It was created in response to a need identified in the Manitoba HIV/AIDS Strategy (1996) - to develop a complementary strategy that addressed issues affecting Aboriginal peoples more specifically. The Aboriginal Strategy – as a component of Manitoba's provincial AIDS strategy, is intended to provide leadership and direction to key stakeholders, and includes a series of guides for action that complement the strategic goal in the original Manitoba AIDS strategy (1996). The strategy is intended to guide work by all organizations and communities affected by HIV/AIDS, and to act as a benchmark to assess the actions of Manitoba Health in working to address the HIV/AIDS crisis. Harm reduction is mentioned 12 times throughout the 54 page document. It is listed as one of three “principles” of the strategy, having been identified as important during the consultation process. Needle exchange and supervised consumption are noted.

Manitoba sexually transmitted and blood-borne infections strategy 2015-2019

The Manitoba Sexually Transmitted and Blood-Borne Infections Strategy for 2015-2019 was published in 2015 by Manitoba Health, Healthy Living and Seniors (MHHS). It builds on the foundation provided by the first Manitoba HIV/AIDS Strategy (1996), the Sexually Transmitted Infection Strategy (2001) and the First Nations, Metis and Inuit HIV/AIDS Strategy (2004). The strategy was developed with the ultimate goal of preventing and minimizing the impact of STBBIs on Manitobans, and comes in response to changing STBBI trends in Manitoba, contributing to an increased burden on health and the healthcare system. The stated purpose of the strategy is to provide strategic leadership for an integrated and collaborative approach to addressing STBBIs. Harm reduction is noted throughout the document, and one of six guiding principles is “incorporating a harm reduction approach”. However, no interventions of interest are noted anywhere in the document.

Breaking the chains of addiction: Manitoba's five-point strategic plan

Breaking the Chains of Addictions: Manitoba's Five-Point Strategic Plan was first released in 2008, and is still available as current on the Government of Manitoba website. It is described as a “five-point vision to guide planning and investments in addictions services to ensure residential and community-based treatment options are accessible to Manitobans across the province” (n.p.). The document is only about one page long, and briefly outlines five goals. The focus of this document is entirely on “addictions” – and there is no recognition of substance use outside of this, or any interventions that apply to substance use or reducing harms. Harm reduction is never mentioned, nor are any of the interventions of interest.

Rising to the challenge: A strategic plan for mental health and well begin of

Manitobans

Rising to the Challenge: A strategic plan for mental health and well-being of Manitobans, was developed to provide high-level direction to planning in the area of mental health and well-being in Manitoba over a five year period. Released in 2011 by Manitoba Health, the plan is the result of consultation and discussion with many stakeholders including people with lived experience of mental health problems, clinicians and policy makers. The document acknowledges addiction and substance use disorders, but is primarily focused on mental health more broadly, and does not recognize substance use outside of a “problematic” context. Furthermore, harm reduction is never mentioned, nor are any of the interventions of interest.

Position statement on harm reduction

The Winnipeg Regional Health Authority released the “*Position Statement on Harm Reduction*” sometime around 2008 or 2009. The document does not include a date, but references in other places - including on the WRHA website - indicate it was developed around this time. The purpose of the document is to outline the WHRA’s position on harm reduction, including how harm reduction is defined, understood and promoted in practice within the region. It emphasizes the evidence-based nature of harm reduction throughout. Despite presenting a comprehensive understanding of the approach, there is little indication how harm reduction will be applied in practice. The document includes only a few vague action items. The stated aim of the document is to outline the WHRA’s position on harm reduction, rather than guide specific action. Harm reduction is discussed in great detail (mentioned 46 times), and five interventions of interest are noted.

Healthy sexuality and harm reduction strategic planning conceptual framework

The Healthy Sexuality and Harm Reduction (HSHR) Strategic Planning Conceptual Framework was authored by the Winnipeg Regional Health Authority department of Population and Public Health. Updated in 2015, it is a diagram outlining the HSHR “strategic planning conceptual framework” - followed by an outline of four key “strategic priorities”. It is not stated what the purpose of the document is, but it appears to outline a strategic framework for the WRHA Population and Public Health branch to follow in terms of providing services that promote “healthy sexuality and harm reduction”. A tagline on the diagram reads, “the HSHR Team works at multiple levels to promote healthy sexuality and harm reduction; to reduce the burden of STBBIs; to diminish other harms associated with sexuality, drug use, and society’s response to these practices; and to redress social and health inequalities” (p.1). Harm reduction is mentioned five times in the document, but is never defined or described. Although some interventions of interest are noted (outreach, Narcan), they are never actually linked to harm reduction or given as an example.

Position statement on mental health promotion and prevention March 2004

The *Position Statement on Mental Health Promotion and Prevention* was released in March 2004 by the Winnipeg Regional Health Authority. It outlines the position of the WRHA, which is to “encourage, support and facilitate the efforts of individuals, families, communities, volunteers, schools, and workplaces to promote positive mental health” (p.2). This position is elaborated on, including a series of

specific commitments and background information on mental health. The document is only 4 pages long, and does not address harm reduction or any of the interventions of interest. "Alcohol or illicit drug dependence" is mentioned once in a statistic on prevalence (p.3). Other than this, there is no discussion of substance use or addictions within the statement.

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