

Nunavut Policy Analysis Case Report

Canadian Harm Reduction Policy Project (CHARPP)

August 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.

CHARPP is supported by an operating grant from the Canadian Institutes of Health Research.

Report Authored by:

*Jalene Anderson-Baron, School of Public Health, University of Alberta
Kamagaju Karekezi, School of Public Health, University of Alberta
Jakob Koziel, School of Public Health, University of Alberta
Ashley McCurdy, School of Public Health, University of Alberta*

CHARPP Project Leads

*T. Cameron Wild, Professor, School of Public Health, University of Alberta (Co-Principal Investigator)
Elaine Hyshka, Assistant Professor, School of Public Health, University of Alberta (Co-Principal Investigator)
Donald MacPherson, Executive Director, Canadian Drug Policy Coalition (Principal Knowledge User)*

CHARPP Co-Investigators

*Mark Asbridge, Associate Professor, Faculty of Medicine, Dalhousie University
Lynne Bell-Isle, National Programs Consultant, Canadian AIDS Society
Walter Cavalieri, Director, Canadian Harm Reduction Network
Carol Strike, Associate Professor, Dalla Lana School of Public Health, University of Toronto
Colleen Dell, Professor, School of Public Health, University of Saskatchewan
Richard Elliott, Executive Director, Canadian HIV/AIDS Legal Network
Andrew Hathaway, Professor, Department of Sociology and Anthropology, University of Guelph
Keely McBride, Project Lead, Public Health and Wellness Branch, Alberta Health
Bernie Pauly, Scientist, Centre for Addiction Research of BC
Kenneth Tupper, Director, Implementation & Partnerships, British Columbia Centre on Substance Use*

Related citations:

*Wild, T. C., Pauly, B., Belle-Isle, L., Cavalieri, W., Elliott, R., Strike, C., ... & Hyshka, E. (2017). Canadian harm reduction policies: A comparative content analysis of provincial and territorial documents, 2000–2015. *International Journal of Drug Policy*, 45, 9–17.*

Table of Contents

1.0 Overview	4
1.1 Contextual Background	4
1.2 Healthcare Governance	5
1.3 Substance Use Trends	6
1.4 Harm Reduction Services in Nunavut	6
2.0 Methods	7
2.1 Search Process	7
2.2 Inductive Analysis	8
2.3 Deductive Analysis	8
3.0 Documents Retrieved	10
Table 1: Descriptive details of Nunavut’s policy documents	10
4.0 Results: Inductive Analysis of Documents	11
4.1 Nunavut’s formal policy documents reflect a weak commitment to harm reduction in practice....	11
4.1.1 Summary.....	12
4.2 Nunavut policy documents do not demonstrate a strong commitment to accountability, follow-through, or implementation of policy	12
4.2.1 Summary.....	13
4.3 Policy documents are aligned with select harm reduction principles and demonstrate a potentially open environment for implementing a harm reduction approach	13
4.3.1 Summary.....	15
5.0 Results: Deductive Analysis of Current Documents (Policy Report Card)	16
Table 1: Presence of key population indicators in current policy documents.....	16
Table 2: Presence of key program indicators in current policy documents	17
Table 3: Proportion of policy quality indicators endorsed for all documents within cases	18
6.0 Conclusion.....	19
Appendix A: Systematic search strategy flow diagram.....	20
Appendix B: Standard methodology for generating provincial/territorial case report.....	21
Appendix C: Descriptive summary of current policy documents	24
References	25

1.0 Overview

This document provides a descriptive and analytical account of Nunavut'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. Nunavut's 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 Nunavut'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.

Three key findings are highlighted from our inductive analysis: 1) Nunavut's formal policy documents reflect a weak commitment to harm reduction in practice; 2) Nunavut policy documents do not demonstrate a strong commitment to accountability, follow-through, or implementation of policy; 3) Policy documents are aligned with select harm reduction principles and demonstrate a potentially open environment for implementing a harm reduction approach. In the deductive analysis, a set of criteria were applied to current policy documents. Results are presented in a standardized Policy Report Card.

1.1 Contextual Background¹

Formerly a part of the Northwest Territories, Nunavut separated to form its own territory in 1999, making it Canada's youngest subnational entity. It is larger than any territory or province in the country, spanning 1,877,788 square kilometers (Statistics Canada, 2011); approximately one fifth of Canada's land mass (Government of Nunavut, 2016). Despite its large land mass, it is the least populated of Canada's territories and provinces, with a population of 36,500 (Statistics Canada, 2015). The most populated municipality is the capital city, Iqaluit, with a population of 6,700 (Nunavut Bureau of Statistics, 2012). There are 24 other municipalities in the territory, all of which have a population under 2,500 (Nunavut Bureau of Statistics, 2012). Most of Nunavut's population (84%) is Inuit (Government of Nunavut, 2016). It is a linguistically diverse region with four official languages: Inuktitut, Inuinnaqtun, English, and French. Unlike the majority of jurisdictions in Canada, the government of Nunavut does not have a system of governance based on partisan party politics, but rather a consensus style of

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

government (Government of Nunavut, 2016). Peter Taptuna has been the premier of Nunavut since 2013. He was preceded by Eva Aariak (2008 -2013) and Paul Okalik (1999-2008). None of these individuals has expressed a public stance on harm reduction to date. However, in his later role of Minister of Health and Justice, Okalik expressed opposition to the opening of a government liquor store in Iqauluit, citing concerns over lack of access to addictions treatment (Varga, 2014).

1.2 Healthcare Governance

The Department of Health is responsible for the provision of health care services in Nunavut. When Nunavut separated from the Northwest in 1999, the regional health divisions that made up the former territory were abandoned and replaced by Nunavut's Department of Health and Social Services (DHHS) (Marchildon, 2013). In 2013 the DHHS was renamed the Department of Health, and a new department, the Department of Family Services, was formed. This new branch was intended to separate health and social services, and it assumed responsibility for issues including income support, homelessness, child protection and social advocacy (CBC, 2012).

The Department of Health in Nunavut is unique in that it is responsible for not only setting policy, guidelines and legislation related to health care, but it is also directly responsible for delivering virtually all health care services in the territory (Marchildon, 2013). The Department manages the territory's only hospital, its two regional health centers, and its community health centers.

Community health centers are dispersed throughout Nunavut's twenty-five communities and these provide the majority of available health care services. Community health nurses, employed directly by the Nunavut government, act as the primary health care service providers, delivering basic health and wellness services to residents (Marchildon, 2013). Given that physicians are only stationed in a few communities, nurses often take on responsibilities that are typically assumed by physicians in the rest of Canada (Chase, 2014). Because of the geographical spread of Nunavut's population, three health regions were implemented, each with its own hospital or regional health facility, providing a wider range of acute health care services than are available at community health centers. The Qikiqtaaluk region (population of roughly 17, 000) serves residents in Baffin Island and the far North; the Kivalliq region (population of about 9, 000) serves communities of the northern Hudson Bay area; and the Kitikmeot region (population of approximately 6, 000) serves the westernmost region of the territory (Statistics Canada, 2011; Marchildon, 2013). The two regional health centers are located in the communities of Rankin Inlet (Kivalliq region) and Cambridge Bay (Kitikmeot region). The territory's only hospital, the Qikiqtani General Hospital, is located in Iqaluit

(Qikiqtaaluk region), and provides the greatest range of acute care services in the territory. Patients with doctor referrals for more specialized services are flown out of territory, typically to Edmonton, Yellowknife, Churchill, Winnipeg, or Windsor (Marchildon, 2013).

1.3 Substance Use Trends

Although there is relatively little data available regarding substance use trends in Nunavut, the 2007-2008 Inuit Health Survey provides some insight (Galloway, 2012). According to the survey, 62% of respondents reported “experimenting with substances in order to get high” (p.8). A further 5% of Nunavummiut reported having tried or used hard drugs (ex. cocaine, crack, heroine, etc.) in the past twelve months. Over this same period, 4% of Nunavummiut reported using over the counter or prescription drugs “to get high” (p.39). Because national surveys, such as the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS), tend to exclude the territories, it is difficult to compare substance use in Nunavut with national trends. Comparing across different surveys can be misleading, as there may be important methodological differences. For instance, the Inuit Health Survey reported lifetime drug use as the percentage of Nunavummiut having used any substance to get high, while the CADUMS data reported lifetime drug use as the percentage of Canadians having used an illicit substance (including Cannabis, cocaine/crack, meth/crystal meth, ecstasy, hallucinogens, salvia, inhalants, heroin; abuse of pain relievers, stimulants; sedatives to get high). Given this difference, clear comparisons examining lifetime drug use in Nunavut and national averages cannot be made based on current data.

According to CADUMS data from 2008 (CADUMS, 2012), 3.9% of Canadians reported using at least one illicit drug including cocaine/crack, speed, ecstasy, hallucinogens, or heroin during that year. This may be comparable to the 5% of Nunavummiut reporting that they had tried or used a hard drug (examples included cocaine, crack, or heroin) between 2007 and 2008. However, subjectivity surrounding the term “hard drug” leaves room for uncertainty with respect to this comparison as well.

1.4 Harm Reduction Services in Nunavut

Given Nunavut’s prohibitive approach towards alcohol, it is perhaps not surprising that there are virtually no harm reduction measures in place with respect to other drugs. The use of alcohol has been banned in some communities and restricted in others. For example, some communities require residents to acquire a permit from a local education committee. Most of the discussion regarding harm reduction has focused on alcohol use, and there has been a recent push within the last decade or so to lift restrictions placed on the sale and consumption of alcohol (CBC, 2014; Nunatsiaq News, 2013).

Additionally, much like the other territories, there are significant challenges in implementing harm reduction policies in Nunavut including limited funding, a lack of anonymity, and a wide geographical distribution of a relatively small population (Cavaliere, 2012). Nunavut's health care system is costlier than any other in Canada (in large part due to the transport costs associated with medevac use) and supplying basic health care needs has been a challenge (Marchildon, 2013).

Nunavut is one of two jurisdictions in Canada in which methadone maintenance treatment is not available (Luce & Strike, 2011). Nunavut is the only subnational entity without any sort of needle exchange program in Canada (Sheldon et al., 2011).

2.0 Methods

We performed a comprehensive search of publicly-accessible Canadian harm reduction policy documents published from 2000 – 2015. Documents produced for Nunavut 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 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.

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.

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.

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.

Two current (and no historical) documents were identified and analyzed using a two-step (inductive and deductive) process described below. Appendix A provides the Nunavut-specific search strategy.

2.2 Inductive Analysis

Both documents were analyzed using a three-step process (Appendix B 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 B) were synthesized and compiled into a narrative document description. Finally, all narrative document 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 Nunavut'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 (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 Nunavut 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

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.

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 two unique policy documents in our territorial search and no corresponding update reports. Both were considered current policy documents. See Table 1 below for further information on each document. Additional descriptive summaries of each policy document are included in Appendix C.

Table 1: Descriptive Details of Nunavut Policy Documents

		DOCUMENT TITLE	AUTHORS	YEAR PUBLISHED	YEARS ACTIVE
CURRENT POLICY DOCUMENTS					
Territorial Level	1	Nunavut Addictions and Mental Health Strategy	Department of Health and Social Services	2002	Not specified
	2	Nunavut Sexual Health Framework for Action	Department of Health and Social Services	2012	2012-2017

4.0 Results:

4.1 Nunavut's formal policy documents reflect a weak commitment to harm reduction in practice

In Nunavut, there are no stand-alone harm reduction policy documents, or any documents with an explicit focus on harm reduction. Only two relevant documents were published between 2010 and 2015: the *Nunavut Addictions and Mental Health Strategy*[1], published in 2002, and the *Nunavut Sexual Health Framework for Action*[2], published in 2012.

The *Addictions and Mental Health Strategy*[1] refers to harm reduction nine times, however, outreach is the only intervention of interest mentioned, and it is not discussed in the specific context of harm reduction. A comprehensive discussion of the key principles of harm reduction is outlined in an appendix. Here they describe pragmatism, humanistic values, a focus on harms, balancing costs and benefits, and prioritizing immediate goals (p.59). This definition frames abstinence as optional, declaring “harm reduction neither excludes nor presumes the long-term treatment goal of abstinence” (p.59). Furthermore, other references are made to key harm reduction principles such as respecting the dignity and rights of a person using drugs.

Despite demonstrating a high level understanding of what harm reduction is, the document is less clear in communicating how harm reduction fits into Nunavut's approach to addiction and mental health. Harm reduction is never explicitly endorsed on its own, but rather presented as one option of many, sometimes in cooperation with contradictory approaches to addressing substance use that promote abstinence. For example, the document summarizes various best-practices models for treating addiction, including “the disease model, harm reduction model, medical inpatient treatments, etc” (p.13). They appear to settle on an “integrated” model of service as the option of choice for the present *Strategy*[1], which promotes assertive outreach, a focus on increasing motivation for treatment, and the use of behavioral strategies (p.13). In addition, an approach termed “community enforcement” is noted as “one of the best...to help clients with alcohol problems”, which is specifically geared towards abstinence.

Later in the document, harm reduction is noted again as one approach that should be used to meet client's needs: “Workers need multiple tools to “match” individual clients' views of addictions problems, and their motivation and comfort levels - i.e., different skills based on the disease model, or harm reduction model, using group, one-on-one counseling, or outreach approaches need to be developed over time” (p.31). This demonstrates that authors support the incorporation of a harm reduction philosophy into counselling practices; however, it is not prioritized over other approaches.

In the more recent *Sexual Health Framework for Action*[2], harm reduction is never mentioned, nor are any interventions of interest to this research. The document addresses the prevention and spread of sexually transmitted infections as one issue in a broad array of sexual health issues including, but not limited to: sexual abuse, teen pregnancy, intimate relationships, sexuality, access to contraceptives and safer sex supplies, and sex education. Unlike several of the other policy documents included in our analysis, which are focused STBBI strategies, this document only briefly mentions STI transmission as a subset of sexual health issues. This document represents the first territorial policy effort in Nunavut to address the issue of STI transmission (albeit tangentially).

Despite the fact the policy document lists “STI prevention initiatives” and “respond effectively to STI outbreaks” as two priority areas, neither mentions harm reduction services (such as syringe distribution or safer smoking kits) as a possible strategy to curb rising rates of STBBI’s in the territory. The document implies the concept of harm reduction with respect to safer sex practices, not promoting sexual abstinence, but rather aiming to reduce the harms associated with unprotected sexual activity. Improving sex education in schools and health centers and increasing access to safer sex supplies are promoted as key initiatives to prevent the transmission of STBBI’s. However, there are no references made to harm reduction in relation to illicit drug use or any of the seven relevant interventions. Given the relationship between intravenous drug use, STBBI’s and sexual health, this absence is noteworthy.

4.1.1 Summary

Neither of the documents that make up the Nunavut policy framework promote, or even mention, any specific interventions or services for harm reduction for illicit drug use. Despite a comprehensive definition, the *Addictions and Mental Health Strategy*[1] only vaguely endorses harm reduction as one of multiple options for dealing with addiction, while the *Sexual Health Framework*[2] does not address harm reduction for substance use at all. Clearly, there is no shared understanding of harm reduction in the region. Furthermore, it is notable that the only reference to harm reduction in formal policy is over ten years old, and that more recent policy omits this approach entirely. Overall, the commitment to harm reduction in formal policy can be classified as weak at best, and clearly not improving over time.

4.2 Nunavut policy documents do not demonstrate a strong commitment to accountability, follow-through, or implementation of policy

The Nunavut *Addictions and Mental Health Strategy*[1] lays out a set of priority recommendations and fairly specific goals, timelines, and relevant actors. It also includes

specific sections that outline the general importance of funding commitments, accountability and governance, policy and standard development, and evaluation (p. 35-36). For example, the Minister of Health and Social Services is named responsible for the development and implementation of the framework (p.35), and the document recommends ensuring monitoring and evaluation mechanisms are in place and developing benchmark protocols and standards for services (p.36). Given the clear recognition of the importance of these principles, the absence of any follow-up reports or implementation plans is especially notable. There is no way to track the progress of any goals or timelines outlined in the document. Furthermore, there is no official endorsement from the Premier or member of cabinet, or reference to legislation to support policy implementation. Considering that this document was published over ten years ago – ample time to develop supplementary policy documents, there is no evidence to indicate whether aspects of the *Strategy[1]* were actually implemented in this time frame.

The *Nunavut Sexual Health Framework[2]* does provide a useful framework and starting point for addressing sexual health issues, however, it does not provide a clear plan for implementation. The document includes a list of areas for action, along with specific priority actions to be addressed, although there are no clear timelines for implementing each item and key players are not listed for all actionable items. There is no endorsement from government officials, no funding commitments, and no evidence of progress reporting or updates. The document provides no measure by which to track progress or outcomes. Ultimately, this is a visionary document which outlines a series of important recommendations, but does little to demonstrate accountability or commitment to policy implementation.

4.2.1 Summary

The two documents that make up the harm reduction policy framework for Nunavut are well developed and include many important recommendations for the region. In terms of following-through on these measures, however, there is little evidence of accountability or implementation. The documents lack key mechanisms for ensuring that policy recommendations are translated into action. Underlying this is the fact that neither document articulates goals or recommendations which explicitly endorse harm reduction or any of the seven interventions of interest. In terms of promoting policy action around harm reduction, there are no directives in formal Nunavut policy in this regard.

4.3 Policy documents are aligned with select harm reduction principles and demonstrate a potentially open environment for implementing a harm reduction approach

Despite major shortcomings in specifically endorsing a harm reduction approach, both Nunavut documents incorporate principles that align with broader principles of harm reduction. In

developing the *Addictions and Mental Health Strategy*[1], extensive consultation was carried out with community members, Inuit organizations, front-line workers, experts from addictions and mental health, and Nunavut Health and Social Services. In a key principle, there is also a suggestion to “actively involve the often neglected “outsider” groups such as youth, elders, and children, etc. in service and program planning and delivery” (p.16). In the *Sexual Health Framework*[2], various youth groups were consulted, as well as social and government groups, Elders, and other Nunavut community members. The broad range of stakeholders included in policy development is promising to see, and aligns with Harm Reduction International’s (2010) promotion of open dialogue and consultation, and meaningful involvement of a range of stakeholders in policy development and program implementation. Importantly, both documents are explicit in considering the perspectives of Indigenous populations in the region, and emphasize the important of traditional knowledge. Missing from both, however, is any specific acknowledgement of the perspective of people who use drugs.

Each of the policy documents specifically recognizes the important of evidence-informed decision making, and promotes various recommendations on the basis of existing best practices and evidence sources. In the *Sexual Health Framework*[2], one of four key themes is “knowledge and evaluation”, explained as “sexual health knowledge and evaluation is important for evidence-informed decision-making for policy and program improvement” (p.9). There is further recognition of the importance of evidence gathering and research for action. In the *Addiction and Mental Health Strategy*[1], “best practices”, based on evidence, is commonly referenced as a rationale for the promotion of key initiatives in the document. In this regard, the document contends, “it is critical that we place scarce resources in the areas where they can be most effective” (p.44). This appreciation of evidence is aligned with Harm Reduction International’s (2010) assertion that harm reduction has a commitment to basing policy and practice on the strongest evidence available, and the prioritization of low-cost/high-impact interventions. Although harm reduction is not strongly promoted in the policy framework, the apparent endorsement of “evidence-based” programs and decision-making provides a strong foundation for future endeavors in this area. As harm reduction interventions do come with a strong evidence-base for successful outcomes, incorporating these into future policy documents is quite feasible given the current policy context.

Finally, both documents consider various target populations, albeit not in the specific context of harm reduction. The *Addiction and Mental Health Strategy*[1] identifies various “special populations” including people involved in corrections, people with concurrent disorders, people with disabilities, women, older adults (elders), young people and families (p.54). People who have addictions are also named as a target population for mental health (p.60) and people who have experienced trauma (p.63). Although there are not specific recommendations tied to all of

these groups, unique characteristics of each population and service considerations are outlined. In the *Sexual Health Framework*[2], target populations are not as well identified or considered. Youth are the only special population considered in detail. Tailoring interventions to address the specific risks and harms that people may experience is an important consideration promoted by Harm Reduction International (2010). Although neither document does this in terms of harm reduction, it is promising to see, especially in the *Addiction and Mental Health Strategy*[1], that the unique situation of different population groups is an important consideration in developing policy responses.

4.3.1 Summary

The Nunavut policy framework does not currently exemplify quality harm reduction policy, and does not promote specific principles in the context of harm reduction. However, many facets of policy are generally in line with these principles, and reflect a situation that could easily adapt to incorporate a more specific harm reduction approach. Principles such as transparency and consultation, promoting evidence-based decision making and policy making, and considering the unique risk factors affecting key populations, are all foundational elements of a harm reduction approach. As such, implementing formal harm reduction measures would be a feasible transition in this policy context.

5.0 Results: Deductive Analysis of Current Documents (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

	Nunavut Addiction and Mental Health Framework	Nunavut Sexual Health Framework for Action	Total (out of)
[1] Does the document recognize that stigma and/or discrimination are issues faced by people who use drugs or have drug problems?	1	0	1
[2] Does the document affirm that people who use substances need to be involved in policy development or implementation?	0	0	0
[3] Does the document acknowledge that not all substance use is problematic?	1	0	1
[4] Does the document recognize that harm reduction has benefits for both people who use drugs and the broader community?	1	0	1
[5] Does the document acknowledge that harm reduction can be applied to the general population?	0	0	0
[6] Does the document target women in the context of harm reduction?	0	0	0
[7] Does the document target youth in the context of harm reduction?	0	0	0
[8] Does the document target indigenous populations in the context of harm reduction?	0	0	0
[9] Does the document target LGBTQI populations in the context of harm reduction?	0	0	0
TOTAL (out of 9)	3	0	3 of 18

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

	Nunavut Addiction and Mental Health Framework	Nunavut Sexual Health Framework for Action	Total (out of)
[10] Does the document acknowledge the need for evidence-informed policies and/or programming?	1	1	2
[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	0	1
[12] Does the document discuss low threshold approaches to service provision?	0	0	0
[13] Does the document specifically address overdose?	0	0	0
[14] Does the document recognize that reducing or abstaining from substance use is not required under a harm reduction approach?	1	0	1
[15] Does the document consider harm reduction approaches for a variety of drugs and modes of use?	0	0	0
[16] Does the document address human rights (e.g. dignity, autonomy) concerns of harm reduction?	1	0	1
[17] Does the document consider social determinants (i.e. income, housing, education) that influence drug-related harm?	0	0	0
TOTAL (out of 8)	4	1	5 of 16

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%)

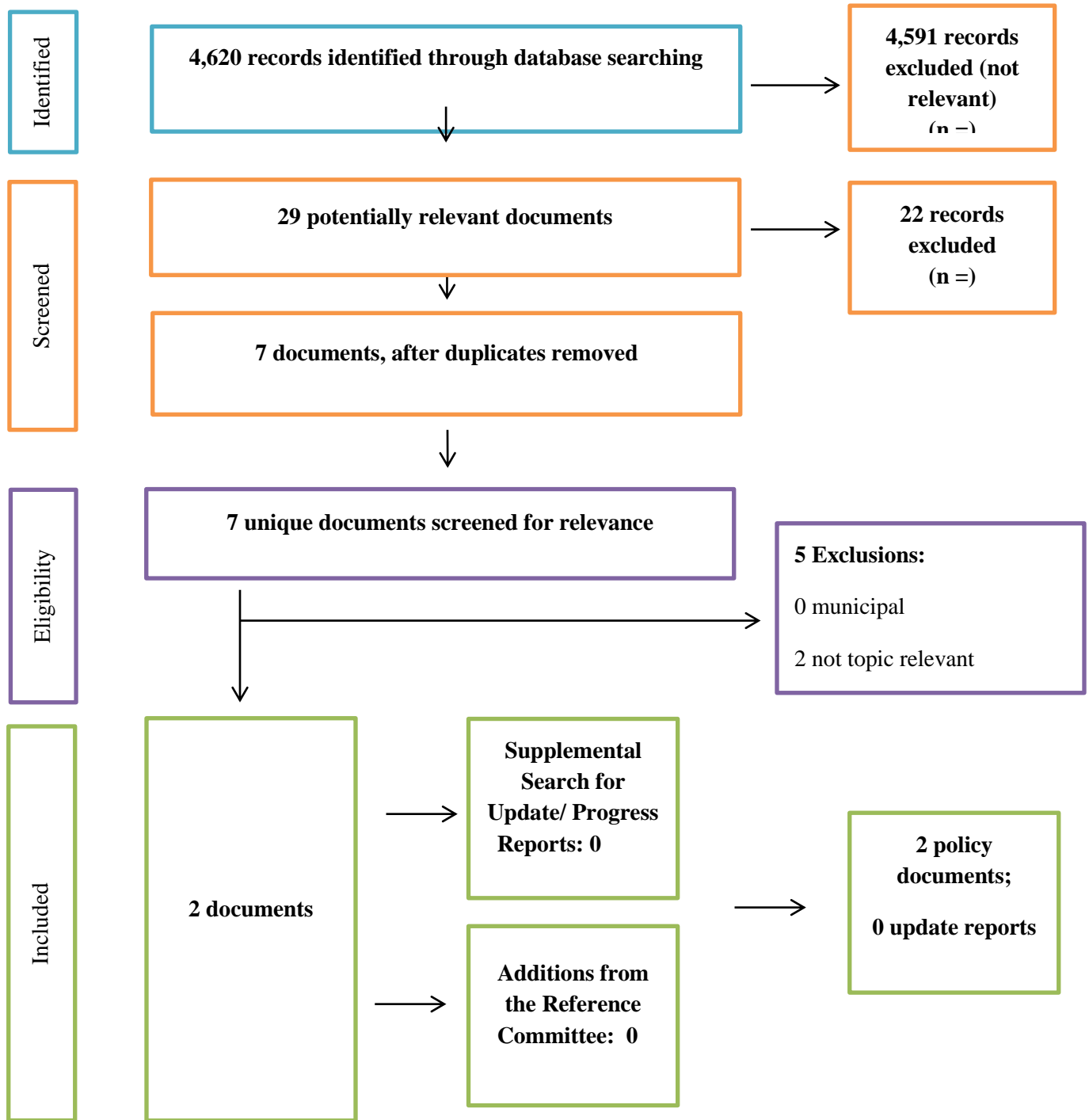
6.0 Conclusion

The formal harm reduction policy base for Nunavut is limited at best, and is comprised of only two policy documents. Of these, only one explicitly addresses harm reduction, and was published over ten years ago. Street outreach is referenced in this document, however, not in the specific context of harm reduction. Further to this, none of the remaining six interventions of interest are addressed anywhere in policy, and no formal recommendations in either document endorses a harm reduction approach. The focus of current policy is on addictions and mental health and sexual health, and no named harm reduction policy exists for the region. Although the two policy documents have differing areas of focus, and cannot be directly compared, it is notable that a document produced over ten years ago (2002) acknowledges harm reduction, while the recently published document (2012) includes zero references to this approach. Harm reduction is clearly not a new concept to the Yukon Department of Health and Social Services, making its absence in recent policy more notable.

Although each of the policy documents includes a number of important recommendations, there is limited evidence of follow through or implementation. Absent from policy are key mechanisms for translating policy into action. Furthermore, as no follow-up documents or benchmarking exist, there is no way to measure accountability to policy recommendations. Underlying this is the fact that neither document articulates goals or recommendations which explicitly endorse harm reduction or any of the seven interventions of interest. In terms of promoting policy action around harm reduction, there are no directives in formal Nunavut policy in this regard.

Finally, despite major shortcomings in harm reduction-specific policy, some facets of the policy framework are generally aligned with a harm reduction approach. This means that implementing formal harm reduction measures in the future is feasible in the current policy environment.

Appendix A: Systematic search strategy flow diagram⁶



⁶ Adapted from PRISMA 2009 Flow Chart (Moher, Liberati, Tetzlaff, Altman, The PRISMA Group, 2009).

Appendix B: 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 C: Descriptive Summary of Current Policy Documents

Nunavut Addictions and Mental Health Strategy was published in 2002 by the Government of Nunavut's Department of Health and Social Services. The document is the first in the territory to outline a single, comprehensive framework for mental health and addiction services. Its goal is to "provide a basis for setting priorities and goals, development of specific services and programming protocols, future planning, and informing funding proposals." It aims to foster an evidence based approach to addiction and mental health services that aligns with Nunavummiut values. The document is considered current, as there is no clear timeframe the document is intended to cover, and no update reports have been published. The document mentions harm reduction nine times, but does not explicitly promote a harm reduction approach. Street outreach is discussed, but not in the context of harm reduction, and none of the remaining six interventions of interest are noted.

Nunavut Sexual Health Framework for Action was published in 2012 by the Department of Health and Social Services. The purpose of the document is to provide a framework and action plan for improving the sexual health of Nunavummiut. The document addresses the prevention and spread of sexually transmitted infections as one issue in a broad array of sexual health issues including, but not limited to: sexual abuse, teen pregnancy, intimate relationships, sexuality, access to contraceptives and safer sex supplies, and sex education. Unlike several of the other included policy documents included in our analysis, which are focused STBBI strategies, this document only briefly mentions STI transmission as a subset of sexual health issues. This document represents the first territorial policy effort in Nunavut to address the issue of STI transmission (albeit tangentially). It is not considered a historical document, as it covers the years 2012-2017. Harm reduction is never mentioned in this document, nor are any of the seven interventions of interest.

References

- Canadian Alcohol and Drug Use Monitoring Survey. (2012). Summary of results for 2012. Retrieved from: <https://www.canada.ca/en/health-canada/services/health-concerns/drug-prevention-treatment/drug-alcohol-use-statistics/canadian-alcohol-drug-use-monitoring-survey-summary-results-2012.html>
- CBC News. (2012). *Nunavut government to restructure*. Retrieved from: <http://www.cbc.ca/news/canada/north/nunavut-government-to-restructure-1.1258683>
- CBC News. (2014, October 9). Anti-drunk driving group supports Iqaluit beer wine store. *CBC News*. Retrieved from: <http://www.cbc.ca/news/canada/north/anti-drunk-driving-group-supports-iqaluit-beer-wine-store-1.2793498>
- Chase, S. (2014). In Nunavut's remote corners, nurses form the backbone of health care. *The Globe and Mail*. Retrieved from: <http://www.theglobeandmail.com/news/national/the-north/in-nunavuts-remote-corners-nurses-form-the-backbone-of-health-care/article16480170/>
- Institute of Public Administration of Canada. *Healthcare Governance Models in Canada A Provincial Perspective Pre-Summit Discussion Paper*. (2013). Retrieved November 2, 2016 from The Institute of Public Administration of Canada website: www.ipac.ca/documents/ALL-COMBINED.pdf
- Galloway, T. & Saudny, H. (2012). *Inuit Health Survey 2007-2008: Nunavut Community and Personal Wellness* [pdf]. Retrieved from: https://www.tunngavik.com/files/2012/09/IHS_NUNAVUT-FV-V11_FINAL_AUG-15_2012.pdf
- Government of Nunavut. (2016). *Consensus Government*. Retrieved from: <http://www.gov.nu.ca/consensus-government>
- Government of Nunavut. (2016). *Nunavut FAQs*. Retrieved from: <http://www.gov.nu.ca/eia/information/nunavut-faqs>
- Government of Nunavut. (2016). *Nunavut 101*. Retrieved from: <http://www.nunavutnurses.ca/english/living/nunavut101.shtml>
- International Harm Reduction Association (HRI). (2010). *What is harm reduction? A position statement from Harm Reduction International*. London, UK: International Harm Reduction Association
- Luce, J., & Strike, C. (2011). A cross-Canada scan of methadone maintenance treatment policy developments. *Ottawa, ON: Canadian Executive Council on Addictions*.
- Marchildon, G. P., & Torgerson, R. (2013). *Nunavut: A Health System Profile*. McGill-Queen's Press-MQUP.

Mayan, M. (2009). *Essentials of qualitative research*. Walnut Creek, CA: Left Coast Press.

Morgan, B. (2013, January 4). Nunavut in 2012: a look at the year that was. *Nunatsiaq News*. Retrieved from: http://www.myvirtualpaper.com/doc/nortext/130104_nnlayout_1-28_vr/2013010201/11.html#10

Nunavut Bureau of Statistics (2012). *Nunavut Age Group Distribution and Median Age by Community* [pdf]. Retrieved from: <http://www.stats.gov.nu.ca/Publications/census/2011/StatsUpdate,%20Nunavut%20Age%20Group%20Distribution%20and%20Median%20Age%20by%20Community,%202011%20Census.pdf>

Sheldon, C., Ferris, L. E., & Strike, C. (2013). Hopeful Result, Unclear Implications: A Comment on Canada (Attorney General) V. PHS Community Services Society. *Health Law Review*, 21(2), 15.

Statistics Canada. (2012). *Focus on Geography Series, 2011 Census*. Retrieved from: <http://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-pr-eng.cfm?Lang=eng&GC=62>

Statistics Canada. (2016). *Population by year, by province and territory*. Retrieved from: <http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo02a-eng.htm>

Varga, Peter. (2014). Opponents pack beer-wine store meeting in Nunavut's capital. *Nunatsiaw Online*. Retrieved from http://www.nunatsiaqonline.ca/stories/article/65674opponents_pack_liquor_store_meeting_in_nunavuts_capital/

Wild, T. C., Pauly, B., Belle-Isle, L., Cavalieri, W., Elliott, R., Strike, C., ... & Hyshka, E. (2017). Canadian harm reduction policies: A comparative content analysis of provincial and territorial documents, 2000–2015. *International Journal of Drug Policy*, 45, 9-17.

World Health Organization (WHO). (2014). *Consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key 28 populations*. Geneva, Switzerland.

