**Scoping Review Protocol on Innovation in Indigenous Primary Health Care Models**

**Review Question:** What is known about innovation in Indigenous primary health care models internationally?

**Timeframe:** September 2020-March 2021

**Relevance of the Review:**

Primary health care (PHC) is essential for promoting health and wellness and reducing health inequities. PHC plays an important role in life expectancy, chronic disease management, community health, maternal and child health, and many other aspects of health and wellness. Indigenous populations have poorer health outcomes compared to their non-Indigenous counterparts. Innovations in Indigenous PHC services arose from mainstream health services being unable to adequately meet the needs of Indigenous communities and Indigenous peoples (Harfield, et al., 2018). However, there is limited knowledge of the characteristics that contribute to the success of Indigenous-driven models for PHC. The term ‘models of care’ broadly defines the way health services are delivered. An Indigenous model of care outlines best practice care and services for Indigenous communities and utilizes the strengths and collaborative skills of many health professionals and traditional healers. Moreover, an Indigenous model of care fosters relationships and collaboration between care providers, patients, families, and caregivers, and ensures Indigenous knowledge, local context, equity of access, and integration of services is supported.

The objectives of this scoping review are to: a) identify key characteristics and features of *Indigenous-led* or *Indigenous-focused* PHC models for advancing PHC delivery and meeting the health needs of Indigenous peoples; and b) contextual or environmental enablers that support innovations in Indigenous PHC models (e.g., supportive policy environment, federal, provincial, state/territory relations, community readiness, governance, infrastructure and workforce supply). We will also include a consideration of key contextual factors such as historical trauma, colonization, geography, and racism to understand the factors influencing successfully support Indigenous primary healthcare.

**Building on similar past reviews to guide our scoping review:**

Harfield et al. (2018) publication on ‘Characteristics of Indigenous primary health care services delivery models identified eight characteristics of Indigenous PHC service delivery models - accessible health services, community participation, continuous quality improvement, culturally appropriate and skilled workforce, flexible approach to care, holistic health care, and self-determination and empowerment. *Culture* was the most prominent characteristic underpinning all of the other seven characteristics.

What our review adds: (1) We have a broader and more comprehensive search strategy including a wider range of Indigenous population groups, such as South American Indigenous populations and African tribes. (2) In addition to *characteristics* of Indigenous PHC we are interested in understanding the *environmental enablers* that support implementation of innovations in Indigenous PHC models and their sustainability (e.g., supportive policy environment, federal, provincial, state/territory relations, community readiness, governance, infrastructure and workforce supply).

**Key Concepts and Search Terms:**

* Key characteristics (e.g., values, principles, and components) of *Indigenous-led* or *Indigenous-focused* PHC models for advancing Indigenous PHC services in Canada and globally
* By *Indigenous-focused* we are referring to the adoption of western programs/services/interventions for an Indigenous context (key questions to consider is ‘who’ developed and implemented the program)
* By *Indigenous-led* we are referring to programs/services/interventions that are driven by Indigenous peoples (i.e., designed, delivered and implemented by and for an Indigenous community or population)
* Our definition of PHC is aligned with the Alma Ata Declaration on Primary Health Care [https://www.who.int/publications/almaata\_declaration\_en.pdf] (see excerpt below)

**Contextual Factors:**

* Historical (past trauma, colonization, systemic inequities)
* Indigenous realities and experiences with the health system – e.g., racism and discrimination
* Variation across models of care (e.g., fly-in/remote delivery, urban setting)

**Directly copied from Alma Ata Declaration on Primary Health Care:**

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion ~~of food supply~~ and proper nutrition; an ~~adequate supply of safe water and basic sanitation~~; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. ~~involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;~~
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;
6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need; and
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional.

**Outcomes of interest:**

* Impact(s) on health policy;
* Impact(s) on Indigenous health outcomes;
* Impact(s) on service delivery;
* Integration with speciality care (e.g., palliative, geriatric/LTC, cancer care, rehabilitation, addiction) or public health.
* Resource allocation – resource inequities/disparity of resources – what are the ways in which inequities in resources shape health systems?
* Impacts on organization of care
* Level of community engagement
* **Outcome** refers to intended or unexpected intervention outcomes (de Weger et al., 2018). They can be at various levels – micro, meso, and macro.

**Review Methodology:** Scoping Review will be conducted to determine the scope or coverage of a body of literature on the topic. Scoping review questions are purposefully broad for examining emerging evidence when knowledge about a topic is unclear. Our search will include primary empirical studies (qualitative, quantitative, or mixed methods), reviews of empirical studies (i.e., systematic reviews), and unpublished dissertation/theses

\* grey literature search will be completed by AHS Indigenous Wellness Core

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| --- | --- |
| Inclusion | Exclusion |
| Publications included in the review if they: | Publications excluded if they are: |
| * Describe development, implementation or evaluation of interventions/services/programs that are Health Promotion, Prevention, Treatment OR Rehabilitation oriented | * Focused on the non-Indigenous population |
| * Delivered in Indigenous community settings or specified for Indigenous peoples | * Focused on western models of care |

**Journal Databases:** CINHAL, Medline, Embase, Social Sciences index, Allied health index, Multi-disciplinary index, Indigenous specific (will look further into which databases would be applicable)

*\*Covidence will be the review manager used for screening and reviewing articles*

Outputs from the scoping reviews:

* A typology of innovations (setting; type of model of care, process, implementation, etc.)
* Evidence summary shared with providers, policy and decision-makers

**Source Appraisal**

**Secondary screening exclusion criteria: Full text**

* Intervention location/country: Did the source report on a PHC program, service or intervention implemented in an Indigenous community setting or specified for Indigenous peoples in a particular country/region/jurisdiction? If no, exclude.
* Language: Is the source available in full text in English, Spanish, French, or Italian? If no, exclude.
* Study design: Did the source report on an empirical study (qualitative, quantitative, or mixed-methods), review of empirical studies, theoretical study, implementation studies, and/or dissertation/theses? If no, exclude.
* Population: Did the PHC intervention focus on a program/service/intervention delivered in Indigenous community settings or specified for Indigenous peoples? If no, exclude.
* Intervention: Does the source describe a PHC program/service/intervention aimed at promoting health, preventing disease or illness, and addressing the social determinants of health (SDOH) and health equity. Exclude if not.
* Outcome: Does the source describe PHC, health/well-being- or equity-related outcomes? And/or does the source describe contextual factors (i.e., supportive policy environment, resource distribution, etc.) that support innovations in Indigenous PHC models? And/or does source describe the integration of PHC with speciality care, public health. If no, exclude.

**Categorize the intervention/program/service to:**

**1. Integration of care;** connecting the primary health **care** (defined by the Alma Ata Declaration on Primary Health Care) with other health service systems (such as long-term **care**, mental health or oral care)

**2. Adoption of western program/service/intervention for Indigenous context**

**3. De novo program/service/intervention:** New or novelprogram/service/intervention

**Data Extraction: Full text**

Table 1. Data Extraction Dictionary

| Data extraction category | Data extraction fields | Notes |
| --- | --- | --- |
| *Source identifying information* | * citation information (i.e., authors, title, publication year, journal details, url) * discipline (e.g., economics, health, sociology) * stated research question and/or purpose * status of article (i.e., published, in press, unpublished) * keywords * type of study (e.g., process evaluation, outcome evaluation, theoretical, retrospective, prospective) |  |
| *Description of study sample and/or participants* | * sample size or number of participants (if appropriate) * inclusion/exclusion criteria * age * Indigenous setting/population * gender and/or sex * place of residence (rural, urban) * sampling and recruitment procedures |  |
| *Study design and methods used* | * methodological approach (e.g., qualitative, quantitative) * study outcomes (including description of outcomes) * data collection methods (include specific measures and tools and timing of measures) * indicators used or measured * analysis methods * theoretical models used to interpret or contextualize the findings |  |
| *Intervention description* | * country, region, and/or city where the program/service/intervention was implemented * program/service/intervention setting (e.g., school, community, health centre, clinic, hospital) * who developed and implemented the program/service/intervention * Indigenous focused or Indigenous-led * other stakeholders involved * program/service/intervention name * program/service/intervention aim(s) * dates of program/service/intervention (date started – date ended) implemented * target population (urban, rural or remote) * other program/service/intervention descriptors * other relevant contextual details (e.g., fly-in/remote delivery, urban setting, historical factors, colonization, racism, discrimination) * description of program/service/intervention delivery, including description of how Indigenous-focused programs/services/interventions was tailored to the Indigenous population or setting * Characteristics of the PHC program/service/intervention described (**refer to** **Harfield characteristics of Indigenous PHC**) * Community engagement process (informed, consulted, involved, collaborated, empowered) * Process measures (**refer to Donabedian model**) * Program/intervention theoretical foundation or conceptual framework (stated by the authors) | The contextual details will capture the social, economic, and political environment within which the program/service/intervention was designed or implemented. |
| *Study findings and/or results* | * study outcomes and/or process results (intended and unintended) * qualitative themes or concepts identified within the study * authors’ interpretations of their data * author-identified limitations * explanatory models developed * facilitators/enablers to success of the PHC program/service/intervention * identification of key characteristics of the PHC innovation * barriers to success of the project (e.g., contextual changes that hindered the delivery, implementation and sustainability of the project) | example, in-depth descriptions and/or quotes. |

**Grading of Indigenous PHC Programs/Services/Intervention**

Included studies will be graded using the *Ways Tried and True Framework* – made for ‘public health interventions’ but can be extrapolated to primary health care interventions. There are 4 points per category; suggest we use the assessment rubric (0 points if item not described/ cannot assess based on available information)

* community-based
* wholistic
* integrates Indigenous cultural knowledge
* builds on community strengths and needs
* partnerships and collaboration
* effectiveness

**Donabedian Model**

**Outcome measures:** these reflect the impact on the patient and demonstrate the end result of your improvement work and whether it has ultimately achieved the aim(s) set. Examples of outcome measures are reduced mortality, reduced length of stay, reduced hospital acquired infections, adverse incidents or harm, reduced emergency admissions and improved patient experience.

**Process measures:** these reflect the way your systems and processes work to deliver the desired outcome. For example, the length of time a patient waits for a senior clinical review, if a patient receives certain standards of care or not, if staff wash their hands, recording of incidents and acting on the findings and whether patients are kept informed of the delays when waiting for an appointment.

**Structure measures:** these reflect the attributes of the service/provider such as staff to patient ratios and operating times of the service. These are otherwise known as input measures.