Role of the Indigenous health worker in the delivery of comprehensive primary health care in Canada, Australia, and New Zealand: a scoping review protocol

Richard Violette1 • Jean Spinks2 • Fiona Kelly3 • Amanda Wheeler1,4

1School of Human Services and Social Work, Faculty Of Health, Griffith University, Brisbane, Australia; 2Centre for Applied Health Economics, School of Medicine, Griffith University, Brisbane, Australia; 3School of Pharmacy and Pharmacology, Faculty of Health, Griffith University, Gold Coast, QLD, Australia; and 4Faculty of Medical and Health Sciences, University of Auckland, Auckland, New Zealand

ABSTRACT

Objective: To identify and describe Indigenous health workers’ roles, functions, activities, and involvement in decision-making in the provision of primary health care for Indigenous peoples and communities in Canada, Australia, and New Zealand.

Introduction: The Indigenous health worker workforce is the cornerstone to providing culturally safe primary health care for Indigenous peoples and communities. Yet, wide ranging role variation has created a general lack of understanding of who Indigenous health workers are, what Indigenous health workers do, and how to best coordinate their roles and skills with other care providers to further improve the health care experience and outcomes for Indigenous peoples and communities.

Inclusion criteria: This review will consider full text, peer-reviewed publications and gray literature that includes Indigenous health workers who identify as belonging to, and are recognized as such by their communities, any First Peoples group in Canada (First Nations, Inuit, Mètis), Australia (Aboriginal, Torres Strait Islander), and New Zealand (Māori); and which describe their role in the provision of primary health care to Indigenous peoples and communities, in clinical and non-clinical settings, in both mainstream health systems and within community-controlled primary health care sectors.

Methods: MEDLINE, CINAHL, Scopus, Embase, Informit (Indigenous Collection, New Zealand Collection, Rural and Remote Health Database, APAIS-ATSIS, Aboriginal and Torres Strait Islander health bibliography), Sociological Abstracts, and Australian Indigenous HealthInfoNet will be searched for studies. Additional sources of unpublished literature, including government websites and community-controlled health organization websites in Canada, Australia, and New Zealand, will also be searched. Articles in English and French will be included, with no set date restrictions. Screening and selection will follow JBI methodology and findings will be summarized in tabular form accompanied by narrative text.

Keywords: Aboriginal and/or Torres Strait Islander Health Worker; Community Health Representative; First Nations; Indigenous Health Worker; Inuit; Māori Community Health Worker; Mètis; primary health care


Introduction

The Indigenous health worker (IHW) workforce is the cornerstone to providing culturally safe primary health care for Indigenous peoples and communities. A growing body of evidence suggests that the holistic and context-adapted strategies to improving service delivery employed by this unique workforce leads to improved outcomes for Indigenous peoples in a variety of clinical and social areas, such as chronic disease management, prevention, and health promotion. Yet, a deficit-based narrative nested within a Western bio-medical paradigm around the roles and value of the IHW workforce still persists in the literature. While the role was originally conceived as a cultural broker to increase the effectiveness of non-Indigenous health professionals by providing a liaison with Indigenous communities, the broader role and value of this workforce has been underemphasized in the literature.

Correspondence: Richard Violette, r.violette@griffith.edu.au
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communities, IHWs are now essential care providers in their own right in both mainstream health systems and within community-controlled primary health care sectors.

Broadly speaking, IHWs collectively share several fundamental characteristics that define them as a unique professional category, including their Indigenous identity, lived experience, and belonging to the communities in which they practice. Other shared characteristics include their holistic approach to primary health care, cultural safety and security, local community knowledge, and the bridging of Western and Indigenous ideals of health and wellness. Altogether, it is this unique cultural, social, and linguistic knowledge that sets them apart from other health professions and underpins their ability to engage their communities in culturally safe, comprehensive primary health care.

Another important shared characteristic is their loosely defined scope of practice. The scope of practice of a profession is defined as “the full spectrum of roles, functions, responsibilities, activities and decision-making capacities which individuals who make up the profession are educated, competent and authorized as part of that profession to perform.” While most health professions benefit from a clearly defined scope, including related permitted activities, this is not the case for the IHW. In Australia, the National Framework for Determining Scope of Practice for the Aboriginal and/or Torres Strait Islander Health Worker and Health Practitioner Workforce has established the scope of practice of an Aboriginal and/or Torres Strait Islander health worker as “that which they are educated, authorized and competent to perform,” yet the framework also explicitly recognizes that their scope of practice is influenced by a number of contextual factors that includes “their education and qualifications; the regulatory environment; the health service setting; their knowledge and skills gained through accredited education/training and on the job training and experience; their level of work experience; the type of role; the specific job requirements as determined by the needs of the health service and the local Aboriginal/Torres Strait Islander community,” as well as “the type and level of supervision and support they receive.” This points to one of the many paradoxes of this vital Indigenous workforce. On one hand, this loosely defined scope of practice results in widespread role variation, role expectations, and role incongruence across health systems. Yet, on the other hand, it is precisely the flexibility, adaptability, reflexivity, and responsiveness to changing local circumstances acknowledged by their scope that is the ultimate hallmark of their important role in improving outcomes for Indigenous peoples and communities.

An unintended consequence of this striking paradox is that the holistic and context-flexible approach to primary care delivery of IHWs remains widely misunderstood, and IHWs are consistently under-recognized, under-supported, and ultimately under-utilized. Clearly, any attempt to describe the pivotal role of IHWs in primary health care demands a much more flexible approach that recognizes the complex and dynamic context in which they practice. While their professional scope is, of course, couched within legislation, policy, and qualifications, the influence of the wider context of Indigenous health must be acknowledged as a key factor that shapes how IHWs provide primary health care in their communities and what roles they play in both clinical and non-clinical care settings.

Thus, there is still a general lack of understanding of who IHWs are, what IHWs do, and how to best coordinate their roles and unique skills with other care providers to further improve the health care experience and outcomes for Indigenous peoples and communities. Further complicating this lack of clarity is that definitions of IHW roles continue to evolve across time, national and local geographies, organizations, level of professionalization, and service delivery models, while simultaneously remaining rooted in locally specific contexts of care and local health priorities.

A preliminary search of PROSPERO, MEDLINE, the Cochrane Database of Systematic Reviews, and the JBI Database of Systematic Reviews and Implementation Reports was conducted and no current or in-progress scoping reviews or systematic reviews on the topic were identified. This scoping review will be complementary to two recently published reviews: a scoping review examining the characteristics of Indigenous primary health care models of service delivery and a systematic review of factors influencing Aboriginal and/or Torres Strait Islander health worker accountability relationships.

The objective of this scoping review is to identify and describe the IHWs’ roles, functions, activities,
and involvement in decision-making in the provision of holistic and comprehensive primary health care for Indigenous peoples and communities in Canada, Australia, and New Zealand within the existing literature.

**Important note on terminology**

The term “Indigenous” was selected as the most appropriate international term to describe individuals and communities who are, and consider themselves to be, continuous with the First Peoples of the lands now known as Canada, Australia, and New Zealand. The term “Indigenous health worker” was selected as the most inclusive term to collectively describe community health representatives (Canada), Aboriginal and/or Torres Strait Islander health workers (Australia), and Māori health workers (New Zealand) as a broad professional category.

While these terms are certainly problematic due their homogenizing effect, they are used in this protocol with the utmost respect for the incredibly rich diversity of First Peoples and communities, each with their own unique culture, language, traditions, and history. The use of these terms is not meant to erase this incredible diversity. All efforts will be made in the review to ensure that specific individuals, groups, and communities are correctly referenced in the text, examples, and citations in the same manner in which they self-identify.

**Review questions**

What are the IHWs’ roles, functions, activities, and involvement in decision-making in the provision of primary health care for Indigenous peoples and communities in Canada, Australia, and New Zealand?

1. Are there any differences in the roles of IHWs who practice in mainstream health systems compared to those practicing within the community-controlled, primary health care sectors?
2. What are the similarities and differences of IHW roles across national jurisdictions?

**Inclusion criteria**

**Participants**

This review will consider peer-reviewed and gray literature that include IHWs who identify as belonging to, and are recognized as such by their communities, any Indigenous peoples group in Canada (First Nations, Inuit, Métis), Australia (Aboriginal, Torres Strait Islander), or New Zealand (Māori), and whose practice is focused on providing comprehensive primary health care to Indigenous peoples and communities within either mainstream health systems or the community-controlled, primary health care sector. For the purposes of this review, cognate job titles such as Indigenous navigator and health liaison officer will be considered separate professional categories and will not be explicitly included; however, it is anticipated that IHW roles as navigator and liaison will figure prominently in the review results.

**Concept**

The concept of interest for this review is the role of the IHW in the provision of primary health care for Indigenous peoples and communities in Canada, Australia, and New Zealand. Peer-reviewed and gray literature will be included if it describes the participation of IHWs in the provision of care to Indigenous peoples and communities, and includes descriptions of their functions, activities, roles, and involvement in decision-making within this care provision.

**Context**

This review will include peer-reviewed and gray literature that describe the role of the IHW in the provision of primary health care to Indigenous populations, peoples, and communities in clinical (e.g., health center, clinic, hospital) and non-clinical settings (e.g., home, court, school) located in both mainstream health systems and within the community-controlled, primary health care sectors of Canada, Australia, and New Zealand.

These three countries were selected for this review as they share similar health care structures; have fostered Indigenous self-determination through a transfer of Indigenous primary health care to community-control and leadership; and all three maintain an integral and vital IHW workforce in their respective systems. This scoping review is also aligned with the workforce strengthening aim of the Trilateral Cooperation Agreement on International Indigenous Health Research between the Canadian Institutes of Health Research (CIHR), the National Health and Medical Research Council of Australia (NHMRC), and the Health Research
Renewed in 2017, this is the third five-year agreement. The Alma-Ata declaration (1978) suggests that primary health care is a holistic macro-level policy derived from a social model of health that is both a person-focused and population-based vision of health and wellness. Implicit in this holistic perspective, primary care privileges horizontal integration through strategies aimed at connecting patients, health services, social services, and other care providers to improve the overall health of people and populations.

“Indigenous populations are communities that live within, or are attached to, geographically distinct traditional habitats or ancestral territories, and who identify themselves as being part of a distinct cultural group, descended from groups present in the area before modern states were created and current borders defined. They generally maintain cultural and social identities, and social, economic, cultural and political institutions, separate from the mainstream or dominant society or culture.”

Indigenous community-controlled health organizations are “operated by the local Aboriginal and Torres Strait Islander communities which control it through a locally elected board of management... providing holistic and culturally competent primary health care to Aboriginal and Torres Strait Islander peoples across Australia.” Indigenous community-controlled, primary health care systems in Canada (eg, First Nations and Inuit health authorities), Australia (eg, Aboriginal community-controlled health organizations/services), and New Zealand (eg, Māori primary health services) evolved from the inability of mainstream health services to adequately meet the needs of Indigenous communities and are rooted in broader movements of Indigenous sovereignty, self-determination, and self-governance.

A recent systematic review of Indigenous primary health care systems and service delivery models suggests that characteristics such as accessible health services, community participation, continuous quality improvement, a culturally appropriate and skilled workforce, flexible approaches to care, holistic health care, and self-determination and empowerment are shared across most Indigenous community-controlled systems, and perhaps most importantly, that culture underpins all aspects of service delivery.

Types of sources
This scoping review will consider quantitative, qualitative, and mixed methods study designs for inclusion, but meta-analyses and reviews will be excluded. In addition, conference proceedings, theses, editorials, and commentaries will be considered for inclusion. Gray and unpublished literature will include reports, case-studies, and program evaluations, but job descriptions and job advertisements will be excluded.

Methods
The proposed scoping review will be conducted in accordance with JBI methodology for scoping reviews.

Search strategy
The search strategy will aim to locate both peer-reviewed and gray literature. In consultation with a Griffith researcher health resource librarian, keywords and index terms were identified, piloted in both MEDLINE (EBSCOhost) and CINAHL (EBSCOhost), and assessed for catchment and overlap prior to developing the final search strategy (see Appendix I). The search string syntax, including all identified keywords and MeSH 2021 index terms, will be adapted for each included information source. The reference lists and citations of articles included in the review will be screened for additional publications. While excluded from the review, the reference lists of meta-analyses and reviews will also be screened. Articles published in English and French will be included as both the primary author and the second independent reviewer are French-Canadian. No date restrictions will be applied as the IHW is a role that has a long history but has not yet been featured extensively in the literature.

The databases to be searched include MEDLINE (EBSCOhost), CINAHL (EBSCOhost), Scopus (Elsevier), Embase (Elsevier), Informit (Indigenous Collection, New Zealand Collection, Rural and Remote Health Database, APAIS-ATSIS, Aboriginal and Torres Strait Islander health bibliography), Sociological Abstracts and Australian Indigenous HealthInfoNet. Additional sources of gray literature to be searched include, but are not limited to, government websites (eg, National Indigenous Australians Agency, Indigenous Services Canada, Ministry of Māori Development-Te Puni Kōkiri), Aboriginal community controlled peak community
organizations and jurisdictional health service websites (Australia; eg, Lowitja Institute, National Aboriginal Community Controlled Health Organisation, Queensland Aboriginal and Islander Health Council), First Nations and Inuit health authority websites (Canada; eg, First Nations Health Authority, Sioux Lookout First Nations Health Authority) and Māori primary health organization websites (New Zealand; eg, Ngā Mataapuna Oranga).

**Study selection**

Following the search, all identified records will be collated and uploaded into EndNote v.X8 (Clarivate Analytics, PA, USA) and duplicates across databases will be removed. Titles and abstracts will be screened by two independent reviewers for assessment against the inclusion criteria for the scoping review. Following this initial screening, the full text of potentially relevant publications will be retrieved and uploaded into EndNote. The full text of selected citations will be assessed in detail against the inclusion criteria by two independent reviewers fluent in both French and English. Reasons for exclusion of full text publications that do not meet the inclusion criteria will be recorded and reported in the scoping review. Any disagreements that arise between the reviewers at each stage of the selection process will be resolved through discussion, or with a third reviewer. The results of the search will be reported in full in the final scoping review and presented in a Preferred Reporting Items for Systematic reviews and Meta-Analyses for scoping reviews (PRISMA-ScR) flow diagram.30

**Data extraction**

Data will be extracted from papers included in the scoping review by two independent reviewers using a data extraction tool developed by the reviewers. The data extracted will include specific details about the year, author(s), country (Canada, Australia, New Zealand), local jurisdiction (province, state), Indigenous peoples group and/or community involved (via self-identification), type of health service (mainstream, community controlled), publication type, study details and design (if applicable), IHW characteristics, IHW involvement, whether data was collected directly from the IHW, clinical role descriptions (functions, activities, decision-making), non-clinical role descriptions (functions, activities, decision-making), and author comments on IHW involvement in study as relevant to the review question. A draft extraction tool is provided (see Appendix II). The draft data extraction tool will be revised and improved as necessary during the process of extracting data from each included paper. Modifications will be detailed in the full scoping review. Any disagreements that arise between the reviewers will be resolved through discussion or with a third reviewer. Authors of papers will be contacted to request missing or additional data, where required.

**Data presentation**

The extracted data will be presented in tabular form by country, type of health service, and broad role domains accompanied by narrative summary and synthesis describing how the data relate to the objectives and questions of the scoping review. Country-specific narrative summaries will accompany the tabulated results and will describe the roles specific to each jurisdiction. Extracted data will then be synthesized across jurisdictions organized by broad role domains, including traditional health; cultural brokerage; clinical care and Western medicine; health education and promotion; environmental health; community care; administration, management and control; and policy development and program planning.31 Due to the scoping nature of the review, these domains will be refined by the reviewers throughout the review process and it is expected that additional domains will emerge and be presented in the final scoping review. Additional tables and figures will be used to facilitate presentation and usability of synthesized results. The PRISMA extension for scoping reviews (PRISMA-ScR) will be used to guide the review and the reporting of results.30

**Acknowledgments**

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References


17. Topp S, Edelman A, Taylor S. "We are everything to everyone": a systematic review of factors influencing the accountability relationships of Aboriginal and Torres Strait Islander health workers (AHWs) in the Australian health system. Int J Equity Health 2018;17(1):1–17.


# Appendix I: Search strategy

## MEDLINE (EBSCOhost)

Search conducted on Jan 18, 2021

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## Appendix II: Draft data extraction tool

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