Eye care delivery models to improve access to eye care for Indigenous people in high-income countries: protocol for a scoping review

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ABSTRACT

Introduction Globally, there are an estimated 370 million Indigenous people across 90 countries. Indigenous people experience worse health compared with non-Indigenous people, including higher rates of avoidable visual impairment. Countries such as Australia and Canada have service delivery models aimed at improving access to eye care for Indigenous people. We will conduct a scoping review to identify and summarise these service delivery models to improve access to eye care for Indigenous people in high-income countries.

Methods and analysis An information specialist will conduct searches on MEDLINE, Embase and Global Health. All databases will be searched from their inception date with no language limits used. We will search the grey literature via websites of relevant government and service provider agencies. Field experts will be contacted to identify additional articles, and reference lists of relevant articles will be searched. All quantitative and qualitative study designs will be eligible if they describe a model of eye care service delivery aimed at Indigenous populations. Two reviewers will independently screen titles, abstracts and full-text articles; and complete data extraction. For each service delivery model, we will extract data on the context, inputs, outputs, Indigenous engagement and enabling health system functions. Where models were evaluated, we will extract details. We will summarise findings using descriptive statistics and thematic analysis.

Ethics and dissemination Ethical approval is not required, as our review will include published and publicly accessible data. This review is part of a project to improve access to eye care services for Māori in Aotearoa New Zealand. The findings will be useful to policymakers, health service managers and clinicians responsible for eye care services in New Zealand, and other high-income countries with Indigenous populations. We will publish our findings in a peer-reviewed journal and develop an accessible summary of results for website posting and stakeholder meetings.

INTRODUCTION

Rationale

In 2009, there were an estimated 370 million Indigenous people living in 90 countries. Historically, many Indigenous people have borne both colonisation and assimilation polices, and today, throughout the world, Indigenous people continue to be marginalised due to contemporary colonialism and institutionalised racism. Consequently, Indigenous people tend to die younger than non-Indigenous people, and disproportionately experience poverty and poor health.

Indigenous people face a range of barriers to accessing healthcare. These barriers include a lack of facilities in or near Indigenous communities, cultural and language differences with healthcare providers, marginalisation leading to reduced engagement with non-Indigenous services and financial barriers. In 2015, the United Nations Permanent Forum on Indigenous Issues (UNPFII) reiterated the need for models of care that ensure healthcare services are culturally, linguistically and geographically appropriate for Indigenous people. The UNPFII report also outlined the need for participation by Indigenous people in the design and implementation of health policies and programmes so that all people are able to exercise their right to receive good healthcare and achieve equitable health outcomes.

The barriers to healthcare outlined above apply to Indigenous people in need of eye
Fig. 1. Conceptual framework for access to health care (reproduced from Levesque et al).
METHODS AND ANALYSIS
This protocol for this scoping review is reported according to the relevant sections of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)-ScR guidelines.11

Scoping review questions
We aim to answer the following questions:
1. What service delivery models to improve access to eye care for Indigenous populations in high-income countries have been described in the published or grey literature?
2. What service delivery models to improve access to eye care for Indigenous populations in high-income countries have been evaluated in the published or grey literature?
3. For each model found in questions 1 and 2 above,
   - What is the context in which the model is implemented? (E.g. target population and distribution, geographic area, health practitioner availability and distribution, duration of model.)
   - What is the nature and extent of indigenous engagement and leadership during development and implementation? (E.g. use of a rights-based approach, level of Indigenous people decision-making and input.)
   - What were the enabling health system functions? (E.g. human resources (number, cadre, frequency of service), medicines, surgeries, spectacles, facilities/location, ophthalmic equipment, language of delivery (including translation if appropriate).)
   - What were the access dimensions from the Levesque access model (figure 1) were addressed? (Both demand and supply side.)
   - What were the service outputs? (E.g. number of consultations, number of spectacles dispensed, number of surgeries performed.)
   - In cases where the model was evaluated:
     - How was it evaluated?
     - What was the effect on access?

Eligibility criteria
This scoping review will include primary research studies describing eye care service delivery models to improve access for Indigenous people according to the definitions outlined above. The review will include qualitative, quantitative and mixed methods studies of all study designs. There will no time limit on publication dates and no language limitations. Studies will be limited to those taking place in high-income countries as defined by the World Bank.17 Only studies where the full text is available will be included.

Search strategy
We will search MEDLINE, Embase and Global Health using search strategies developed by Cochrane Eyes and Vision’s Information Specialist. The search strategies for all databases are included in online supplementary file 1. All databases will be searched from their inception date and no language limits will be used. We will examine reference lists of all includable articles to identify further potentially relevant reports of studies. In addition, we will search the grey literature via websites of relevant government and service provider agencies (e.g. National Aboriginal Community Controlled Health Organisation). Field experts will be contacted to identify additional articles.

Study selection
Two reviewers (two of HB, JR, JB, LMH or AMB) will independently screen the titles and abstracts of identified studies to exclude publications that clearly do not meet the inclusion criteria. The full text article will be retrieved for review if the citation seems potentially relevant and two of these reviewers will independently assess each article against the inclusion and exclusion criteria. Any discrepancies between the reviewers will be resolved by discussion, and a third reviewer will be consulted if necessary. A PRISMA flow diagram will be completed to summarise the study selection process.

Data charting
A custom form will be developed in Excel for data charting. The form will be piloted on five studies by each of HB, JR, JB, LMH and AMB, and required amendments agreed by consensus. We anticipate a broad scope of included studies, so data charting will be an iterative process throughout the review and the data charting form will be amended as required. These amendments will be discussed by the reviewers and the form amended at each stage where necessary. Each included study will be charted independently by at least two reviewers. Any discrepancies between the reviewers will be resolved by discussion, and a third reviewer will be consulted if necessary.

We plan to contact study authors in the case of unclear information and will make up to three attempts by email.

Data items
The following data items will be collected during the data charting process:
1. Publication characteristics: title, year of publication, study design, country of origin, study setting.
2. Characteristics of service delivery model:
CONCLUSION

The aim of this review is to summarise the nature and extent of the existing literature on service delivery models to improve access to eye care for Indigenous people in high-income countries. To our knowledge, there has been no previous synthesis of this literature. This review is part of a project to improve access to eye care services for Māori in Aotearoa New Zealand. We will use the findings in a Delphi process involving Māori eye care service users, policymakers, health service managers and clinicians to identify the most promising strategies to improve access to eye care services for Māori. In subsequent research we intend on implementing and assessing the effectiveness of the prioritised strategy. Beyond New Zealand, we believe the findings of this review will be useful to policymakers, health service managers and clinicians responsible for eye care services in other countries with indigenous populations.

Ethics and dissemination

Ethical approval is not required, as our review will only include published and publicly accessible data.

We will publish our findings in an open-access, peer-reviewed journal and develop an accessible summary of the results for website posting and stakeholder meetings. Data generated from this review will be made available upon reasonable request.

REFERENCES

