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Using mixed methods to understand and tackle barriers to accessing health services

Natalia Houghton,[1] Ernesto Bascolo,[1] Andrés Coitiño,[1] Theadora S. Koller,[2] and James Fitzgerald[1]

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ABSTRACT This report describes the experience and lessons learnt from designing and implementing a combined quantitative and qualitative method to assess barriers to accessing health services. This approach was developed to study barriers to access in five dimensions: availability; geographical, financial, and organizational accessibility; acceptability; contact; and effective coverage. The study design was used in six countries in the World Health Organization Region of the Americas. The findings highlight the importance of having a well defined analysis framework and the benefits of adopting a mixed-methods approach. Using existing data and contextualizing findings according to specific population groups and geographical areas were essential for relevance and utilization of the study outcomes. The findings demonstrate the feasibility of using mixed methods to understand the complexity of access problems faced by different subpopulations. By involving decision-makers from the beginning and allowing flexibility for sustained discussions, the analysis and findings had an impact. The engagement of health authorities and key stakeholders facilitated the use of the findings for collaborative identification of policy options to eliminate access barriers. Lessons learnt from the study emphasized the need for active participation of decision-makers, flexibility in the process, and sustained opportunities for discussion to ensure impact. Giving consideration to local priorities and adapting the methods accordingly were important for the relevance and use of the findings. Future efforts could consider incorporating mixed methods into national and local monitoring and evaluation systems.

Keywords Barriers to access of health services, health systems, research design, evaluation study; Americas.

The Strategy for Universal Access to Health and Universal Health Coverage, adopted by the Member States of the Pan American Health Organization (PAHO) in 2014 (1), along with the Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains, adopted in 2022 (2), highlight the importance of transforming health systems through a primary health care (PHC) approach. These resolutions encourage Member States to renew their commitment to implement the recommendations of the High-Level Commission on Universal Health in the 21st Century: 40 Years of Alma-Ata (3) and the Compact 30-30-30 PHC for Universal Health (4), which aim to reduce barriers to accessing health services by 2030. The first step in effectively eliminating access barriers is to identify health system deficiencies that together result in obstacles for timely access to good-quality health services (5).

Policy-makers and researchers increasingly recognize the need for mixed-methods approaches to build a comprehensive understanding of barriers to accessing health services. Such approaches provide a foundation for developing effective and tailored solutions to tackle access problems faced by people. Tackling access problems is particularly important for vulnerable populations affected by poverty, social exclusion, or geographical remoteness (6). This recognition is evident through the development and refinement of methods and tools for analyzing barriers to access. An example is the World Health

[1] Pan American Health Organization, Washington D.C., United States of America. ✉ Natalia Houghton, houghtonn@paho.org

[2] World Health Organization, Geneva, Switzerland.

Organization's (WHO) handbook for conducting assessments of the barriers adolescents face in accessing health services (7), which will be followed by a handbook for the assessment of barriers to accessing health services in general. These analytical approaches build on previous country studies implemented by the WHO Regional Office for Europe (8), and subsequently extended to other regions (9).

In the Region of the Americas, PAHO's monitoring framework for universal health has been used to track progress towards universal health, including the use of mixed methods and measures of access barriers (10). Similarly, the renewal of the essential public health functions has reinforced the need for a comprehensive analysis of barriers to accessing health services (11). Other examples include the mapping and analysis of data on access barriers from household surveys in the Region of the Americas (5, 12), their association with the use of essential health services for women and children (13), and the analysis of the first level of care experience from the user's perspective (14). More recently, mixed-methods approaches have been successfully used to identify barriers to and facilitating factors for access to maternal and child immunization programs (15) and barriers faced by rural and remote communities (16).

Despite such progress, most studies on barriers to health care access have used quantitative methods. Similarly, insufficient consideration has been given to: the most appropriate framework to capture a range of supply and demand barriers; differences in national or local contexts; and integration of study findings into decision-making processes (17). Moreover, the lack of evidence on direct measures of quality of health care suggests that an evidence-based review is needed to examine and determine the important areas for strengthening health systems. Such evidence could offer guidance to health authorities on how to analyze access barriers in a comprehensive way that supports progress in universal health and incorporates assessment of these barriers into national and subnational monitoring and evaluation efforts.

Therefore, this report reviews experiences and lessons learnt in designing and implementing a combined quantitative and qualitative method to assess barriers to accessing health services. This method was specifically designed to study barriers to accessing health services in six countries in the Americas. The report provides an overview of the method, examines recommendations from the studies conducted, and discusses the feasibility of applying this mixed-methods approach in future activities. The main findings of these studies, including the barriers identified, their relationship with policy processes, and recommendations will be published separately.

MIXED-METHODS APPROACH USED

Design and framework of the method

A specific method was designed to efficiently generate evidence on barriers to accessing health services and facilitate collaborative efforts for action-oriented planning and policy-making. The approach drew on analytical frameworks and tools previously developed, including PAHO's monitoring framework for universal health (10) and WHO's handbook for conducting assessments of barriers faced by adolescent in accessing health services (7), among others (5, 12, 13). Guided

TABLE 1. Dimensions of the Tanahashi framework of barriers to accessing health services

Dimensions	Definition	Examples of barriers
Availability	Availability and sufficiency of resources (for example, facilities, human resources, medicines, and health technologies) to provide comprehensive health services	• Insufficient capacity of health services • Lack of human resources
Geographical accessibility	Availability of good-quality health services within a reasonable reach of people who need them	• Health centers far from users' homes • Lack of transport routes to primary health care centers • Difficulties in accessing health personnel in rural areas
Financial accessibility	Ability to pay for services	• Cost or co-payments of health services • Cost of medicines
Accommodation (organizational accessibility)	Organization and adequate provision of health services that allow users to receive these services when they need them	• Gender-related barriers such as lack of freedom of movement outside the home, or lack of decision-making power • Long wait times in the first level of care network • Inaccessible booking systems to make appointments
Acceptability	Willingness to seek services when they are perceived as effective or when social or cultural factors do not discourage the population from seeking such services	• Rural people's perceptions of health • Barriers linked to language or dialects • Lack of cultural relevance of the practices of health providers • Lack of traditional and complementary approaches to medicine
Contact	Willingness to contact health services when available, geographically and financially accessible, and acceptable	• Lack of information about health services and risk factors
Effective coverage	Ability to use health services in a timely manner when necessary and at a level of quality commensurate with the desired effect and potential improvement in health	• Users seeking inappropriate services such as medications without a valid prescription • Inaccurate diagnoses • Lack of referral to second- and third-level services • Low adherence to treatments • Impoverishment by catastrophic health expenditures

Source: prepared by authors based on Tanahashi (19).

by these resources, a triangulation design was chosen, wherein quantitative and qualitative data were collected in parallel and these data were used together in the analysis (18). To operationalize the concept of access, the Tanahashi model of effective coverage was used, which allowed for the examination of supply and demand barriers (19). In this model, access is influenced by supply and demand factors with five inter-related dimensions: availability, accessibility, acceptability, contact, and effective coverage, that is, the ability to use health services when needed in a timely manner and at a level of quality necessary to obtain the desired effect and potential health gains (5). Each dimension has barriers and facilitating factors for access that affect the use of health services (Table 1).

Implementation of the mixed-methods studies

The mixed-method studies were conducted between October 2020 and January 2022 in six countries of Latin America and the Caribbean: Colombia, Costa Rica, Dominican Republic, Guyana, Honduras, and Peru. These countries were selected based on a range of factors, including their different health system structures, geographic location, and socioeconomic characteristics. The inclusion of a range of countries enabled the identification of barriers that exist in different contexts, thereby providing a more complete understanding of the obstacles to access faced by populations with varying degrees of social vulnerability. The process was adapted for each country to ensure responsiveness to identified priorities and contexts; however, the analysis framework, methods, and tools used were the same (Table 2). The studies were carried out in four phases.

Phase 1: definition of governance, collaborative planning, and study adaptation. An interinstitutional team responsible for conducting the study was established. Depending on the country, the team comprised experts and technicians from national and subnational health authorities, PAHO and WHO regional and national offices, and national academic institutions. Advocacy and awareness-raising activities were undertaken by the research team to create a shared knowledge base on the priority issues of access and reach a consensus on what the study focus would be and how to appropriately adapt the method to the specific national or local context.

TABLE 2. Overview of the country studies

Country	Study focus	Articles reviewed, n (time period)	Sample, n (survey used)	Key informants, n	Facilitating factors	Hindering factors
Colombia	Effect of the Mandatory Health Plan in the evolution of access barriers	59 (2010–2020)	77 400 households (Encuesta Nacional de Calidad de Vida 2020)	7 informants interviewed	Support from a national team with experience in health policy analysis	Active involvement of the Ministry of Health hindered by governmental change and transition
Costa Rica	Analysis of access barriers as input for the development of a plan to strengthen Essential Public Health Functions	6 (2004–2020)	2 004 households (Encuesta Nacional de Salud 2006)	12 workshop participants	Direct involvement of the Ministry of Health facilitated communication between study partners	Lack of information on access barriers from household surveys
Dominican Republic	Analysis of access barriers as input for the preparation of a plan to strengthen the benefit plan and Essential Public Health Functions	14 (2010–2020)	11 464 households (Demographic and Health Survey 2013)	7 informants interviewed	Support and commitment from the Ministry of Health and support team for the interviews with experience in using the method in another country	Difficulties in contacting high-level informants and lack of updated quantitative data
Guyana	Access to maternal and child health services in rural areas and strengthening of primary health care	23 (2010–2021)	5 632 households with 4 996 women 15–49 years (Guyana Demographic and Health Survey 2009)	21 informants interviewed	High participation of regional directors and technicians in the country	Lack of stable means of communication (internet, telephone networks) delaying implementation of interviews
Honduras	Access to essential health services and strengthening of the comprehensive approach to primary health care	27 (2010–2020)	26 643 households with 74 043 persons, 20 841 of whom were women 15–49 years (National Demographic and Health Survey 2019)	23 workshop participants	Not applicable; research focused on access barriers	Changing political context and intermittent participation of government actors
Peru	Implementation of the Universal Health Insurance law, reduction in access barriers, and post-pandemic challenges	111 (2009–2020)	36 856 households (Encuesta Nacional de Hogares 2021)	22 informants interviewed	High-level informants who facilitated the analysis of policy initiatives. Good availability of survey data	Political situation hindering greater involvement of authorities from the Ministry of Health

Source: prepared by authors based on data used in the studies.

TABLE 3. Terms and criteria used in literature search on barriers to accessing health services

	Search terms					Inclusion criteria
Level 1	Country					• Published in Spanish or English • Focused on the selected country • Primary studies that reported the method used • Within the scope of the study topic and focus
Level 2	Health system(s), health service(s)					
Level 3	Barriers, facilitators, acceptability, financial barriers, availability, contact, effective coverage	Equity, inequity, quality, reform	Access, demand, supply, satisfaction	Primary health care, first level of care	Terms related to to focus of the study	

Note: The repositories searched were: PubMed, Scientific Electronic Library Online (SciELO), and Latin American and Caribbean Health Sciences Literature (LILACS).
Source: Prepared by authors based on literature review method.

Phase 2: parallel collection of quantitative and qualitative data. The collection of quantitative and qualitative data was carried out through a literature review, cross-sectional analysis of household survey data, and in-depth interviews.

The literature review was done based on the recommendations of the PRISMA statement (Preferred Reporting Items or Systematic Reviews and Meta-Analyses) to synthesize quantitative and qualitative information from open-access studies that met the selection criteria (Table 3). The snowball technique was used and gray literature was included – for example, technical reports from national agencies, international organizations, and foundations. The full text of the selected articles was extracted and analyzed by the study teams. Inconsistencies and disagreements on inclusion were resolved by consensus.

At the same time, a cross-sectional analysis of data obtained from the household surveys available for each study country was undertaken (12). The main variables considered were: the population who needed health care but did not seek care because of barriers in availability, accessibility (financial, geographical, and organizational), acceptability, contact, and effective coverage; women who reported financial, organizational, and gender-related barriers to access; and utilization rates of tracer health services. Stata, version 15.1 statistical software (StataCorp LP, College Station, Texas, United States) was used to analyze the data sets shown in Table 2.

In addition, semi-structured interviews and focus groups were conducted. A purposive sampling strategy was used to balance representation and diversity of opinions from health authorities and stakeholders at each decision-making level. In each country, an interview guide with open-ended questions was developed to collect information. For example, in Peru, three guides were developed on different categories of informants interviewed: i) national decision-makers; ii) regional-level decision-makers; and iii) experts representing public health, academia, scientific societies, and professional groups (Table 2).

Phase 3: analysis. To synthesize the quantitative and qualitative data, thematic analysis was used to group the barriers according to the framework. Therefore, relevant information was extracted from the data sources, analyzed in a matrix using Excel (Microsoft, Redmond, USA), and validated with a second group of reviewers to ensure the correct application of the classification criteria. The matrix incorporated the five dimensions from the analytical framework. Additionally, the types of barriers specific to each country were listed as a second-level categorization. To provide context to each dimension, the matrix linked them with qualitative data on the policy processes and external factors that were observed to have either positive or negative effects on the barriers. In the next stage, the thematic constructions were synthesized into analytical themes that represented the general dimensions of access using a descriptive deductive approach. Finally, the preliminary results were analyzed thematically following recommendations on mixed-methods methodology (20). Interpretation of the relevance of the findings was done by a consensus of the analysis team in collaboration with the health authorities.

Phase 4: policy dialogue. Policy dialogues were held to encourage the use of the results by health authorities and key stakeholders, and the inclusion of the findings and recommendations into future policies. The dialogues comprised: participants from different areas of the ministries of health, including planning, monitoring and evaluation agencies, and decision-making bodies (national directors, deputy ministers, and chief medical officers); representatives from regional and local health authorities; health service managers; civil society representatives (including members working with and/or representing vulnerable subpopulations); and participants from academic institutions. Points of discussion brought up during the dialogues were used as input for the final study report, which included a description and analysis of the access barriers identified, as well as a series of policy recommendations aimed at reducing and eliminating those barriers.

LESSONS LEARNT

The lessons were developed during the evaluation meetings of the interinstitutional team responsible for each country study. Based on these lessons, recommendations were drafted on integrating mixed methods into national and subnational efforts to monitor and evaluate barriers to accessing health services (Table 4).

Design and method

Lesson 1. The analysis of access barriers must be supported by a defined and explicit framework to structure the studies and achieve a common message. A common framework for analyzing access barriers in different countries was important to guide and structure the country studies. First, it allowed for the construction of a common language to discuss and analyze access problems during the different study phases. Second, it aided the adoption and adaptation of the mixed-methods approach

TABLE 4. Recommendations on integrating mixed methods (quantitative and qualitative studies) into monitoring and evaluation of barriers to accessing health services

Generate participatory and institutional examples of monitoring and evaluation of access barriers at the different levels of the health system, with the participation of civil society, to guarantee universal and accessible access to health services and strengthen social accountability.
Promote and adopt mixed methods to gain a holistic understanding of access barriers and assess their potential application at the national, subnational, and local levels, highlighting the objective of supporting collective analysis and transformation of information into actions to reduce access barriers.
Generate flexible guidelines and protocols for the use of quantitative and qualitative data to analyze access barriers to promote decentralization of implementation of such assessments and their possible adaptation to other research fields in health systems and services.
Adapt data collection protocols and instruments to local contexts to determine if health systems respond to the needs of different communities and to identify solutions adapted to the local situation.
Incorporate the equity dimension and its intersection with other areas of social vulnerability in the analysis of access barriers to allow effective action on the problem of access experienced by vulnerable populations.
Include the participation of civil society organizations, health personnel, and the populations affected by access barriers, both as key informants on access barriers and to help identify and prioritize interventions to overcome them.
Use the available data as much as possible and strengthen the collection of quantitative data from household surveys on health needs, user experiences, barriers to access, and use of health services.
Organize opportunities for dialogue between government and civil society actors to promote discussion on and inclusion of findings from assessments of access barriers in capacity-building, definition of health priorities, and design of health sector and intersectoral plans.

Source: prepared by authors based on the results.

as an analytical and advocacy tool to strengthen actions aimed at reducing and eliminating access barriers. Finally, the framework facilitated the triangulation of quantitative and qualitative information and the development of certain elements that will contribute to future studies, such as the dictionary of codes for thematic analysis and tools for analysis and representation of survey results.

Lesson 2. The use of mixed methods allowed a holistic analysis of all access barriers, both the magnitude of the barriers and their inter-relation, and with a focus on equity. The combination of quantitative and qualitative data was an essential element for complementing the analysis of the magnitude of access barriers to give a full picture of their diversity and inter-related nature. The use of mixed methods also allowed for a better understanding of the needs of and challenges faced by populations in vulnerable situations and opportunities to manage the challenges. The analysis of household surveys helped measure the magnitude and distribution of access problems for different population groups. At the same time, the thematic analyses of the literature review and interviews enriched the characterization of the access barriers and revealed obstacles that were not adequately captured by the quantitative data but which had a substantial influence on health service-seeking behavior. The results led to a broader understanding of the factors that affect access, particularly those infrequently considered in health service research and policy-making, such as those related to acceptability. Integrating the findings from the different data sources made it possible to compensate for the lack of updated and disaggregated quantitative data on unmet health needs and associated barriers.

Lesson 3. It is important to use existing data as much as possible and to contextualize them according to population groups and specific geographical areas. A key challenge in analyzing access barriers is the lack of disaggregated data needed to identify and tackle inequities in health access. To address this issue, the mixed method used secondary information, including from the literature and existing household surveys, which can be disaggregated by relevant equity categories. To explore the relevance of different categories of access barriers to specific communities and localities, the mixed method focused on selecting information relevant to those specific populations and areas. Furthermore, the triangulation of data, together with qualitative information from published studies and the participation of key local actors, contributed to a comprehensive understanding of access barriers. The use of secondary data also reduced the time and costs that are generally associated with collecting and analyzing primary data and mixed-methods studies as these require a considerable amount of work and input from researchers in different academic fields.

Use of the findings

Lesson 1. To ensure that the analysis has an impact, decision-makers should be involved from the beginning of the process, with flexible schedules and opportunities for discussion allowed for to encourage participation and ownership. The involvement of national and subnational health authorities in the initial planning and design of each study was essential for promoting their ownership and participation. The establishment of oversight committees in charge of conducting and coordinating each study and the organization of frequent technical meetings helped ensure that the evidence was responsive to national and subnational needs and priorities and that the most relevant key informants and decision-makers could be accessed. Although occasionally this process required several rounds of communication and greater flexibility, when health authorities took a proactive role, greater adoption of the process and study results was observed.

Lesson 2. Understanding and adapting the studies to the priorities and local context helped guarantee their relevance and the use of the findings. The studies on access barriers exemplify the need to understand and consider local health priorities and contextual factors, such as those in rural areas and indigenous communities, before selecting or customizing interventions. The mixed method used promoted the participation of key stakeholders, including local health authorities and civil society

representatives (for example, tribal leaders), whose knowledge about the local context was used to ensure that local health needs were prioritized and addressed using culturally appropriate interventions.

Lesson 3. The policy dialogue stage helped facilitate the translation of results into a roadmap with actions that should lead to overcoming access barriers. The policy dialogues with ministerial authorities and key stakeholders facilitated the use of the findings in policy evaluation initiatives oriented towards the transformation of health systems. The dialogue also enabled advocacy efforts to highlight the relevance of equitable access in initiatives to transform health systems. In some countries, the mixed method made it possible to integrate the results into the development of plans to strengthen public health capacities and PHC models. In other cases, the results and recommendations were used in the discussion of the new legislation and PAHO country cooperation strategies. These outcomes demonstrate the potential for the mixed method to go beyond just an academic exercise and become a resource for decision-making.

Lesson 4. The participation of health service users and non-users who are directly affected by access barriers would have allowed more robust and people-centered assessments and policy dialogues. The participation of health authorities as key partners for the implementation may have generated a bias for inclusion of more government informants among the interviewees. Thus, the participation of representatives from civil society, nongovernmental organizations, and the community in focus groups and interviews is vital to compensate for such bias, ensure greater representativeness of perspectives, and contribute to transparency. As previously mentioned, future studies need to incorporate the views of health system users and non-users who are directly affected by access barriers.

DISCUSSION

This report identified the recommendations and lessons learnt from the use of a mixed method developed to analyze barriers to access of health services as a step towards achieving universal access to health and universal health coverage. These analyses are an essential component of health system performance assessments, and can inform efforts to transform and strengthen health systems and ensure equitable access to good-quality health services. The method sought not only to characterize access barriers, but also to gain input from health authorities on how to tackle these barriers and promote transparency and accountability. Even in contexts with limited amounts of data, the use of the mixed method helped identify a range of relevant access barriers and their magnitude, inter-relationships, and determinants, as well as the policy actions and features of the country's context that affected them. Furthermore, the integrated analysis helped validate the results, ensuring the internal validity of the study findings and improving the overall depth of the analysis. The participatory aspect of the mixed method also made it possible to present policy options to give a new impetus to the process of health system transformation to reduce barriers in access to health services.

These points highlight the usefulness of integrating qualitative elements into analyses of access barriers to capture their diversity, intersectionality, and complexity. The combined use of quantitative and qualitative methods produces information on the full range of access barriers (including supply and demand, financial, and non-financial barriers) and reflects the multifaceted nature and different dimensions of access to health services (6, 17). Additionally, these approaches are crucial to understanding the realities of communities that experience barriers and provide indications on how to address those realities (6). These approaches also allow for a better characterization of the complex, multidimensional nature of health systems and services and help identify inconsistent patterns that may arise when applying qualitative or quantitative methods separately (21); that is, they reinforce the strengths and counteract the weaknesses of separate quantitative and qualitative approaches (22). Through the integration of results, these approaches can provide more reliable study conclusions (23).

The report contributes to the global and regional discussion on assessing unmet needs and access barriers by demonstrating the strength of mixed approaches in capturing the combination of all barriers at national and subnational levels. Similarly, it suggests the feasibility of integrating the mixed-methods approach into current monitoring and evaluation initiatives. Barriers to access need to be evaluated more holistically, particularly from the perspective of users and people affected by access problems. Thus, the equity dimension and its intersection with other areas of social vulnerability need to be incorporated, and collaboration throughout health system governance is essential to improve access to health services in rural areas and remote communities (16, 24).

The use of the mixed method has some limitations. First, the quantitative component used surveys that may not have continued over time or may lack consistency in response options on reasons for not seeking care, and they do not generally include reasons related to the availability and effective coverage of health services. Additionally, the indicators of access barriers are limited to what is available in each survey. As a result, household surveys help measure access barriers and identify specific reasons why users may forego care at various times, but they may not be able to build a complete picture of the connection between timely receipt of care and desired outcomes (12). For these reasons, the quality of quantitative data obtained from household surveys must continue to be improved. Second, the literature review is affected by the research agenda and financing of public health research, which may lead to a bias in which specific dimensions of access are overestimated. Finally, the participation of health service users and non-users as sources of information on the main access barriers, as well as in the identification and prioritization of options to overcome them, must be guaranteed in future studies.

Conclusions

The lessons learnt from the studies in the six countries emphasize the need for active participation of decision-makers, flexibility in the assessment process, and sustained opportunities for discussion to ensure impact. Contextualizing the study to local priorities and adapting the methods accordingly was also important to ensure relevance and utilization of the findings. Future efforts should explore incorporating mixed-method approaches into national and local monitoring and evaluation systems.

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analyzed the data and wrote the manuscript with input from all authors. All authors reviewed and approved the final version.

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Aplicación de métodos mixtos para la determinación y abordaje de los obstáculos que dificultan el acceso a los servicios de salud

RESUMEN En este informe se describen la experiencia y las enseñanzas extraídas a partir del diseño y la aplicación de un método que combina elementos cuantitativos y cualitativos para evaluar los obstáculos que dificultan el acceso a los servicios de salud. Este enfoque se ideó para poder analizar estos obstáculos mediante cinco dimensiones: disponibilidad; accesibilidad geográfica, económica y organizativa; aceptabilidad; contacto; y cobertura efectiva. El diseño del estudio se utilizó en seis países de la Región de las Américas de la Organización Mundial de la Salud. Los resultados pusieron de relieve la importancia de contar con un marco de análisis bien definido, así como las ventajas de adoptar un enfoque basado en métodos mixtos. El uso de los datos existentes y la contextualización de los resultados en función de grupos poblacionales y áreas geográficas específicos fueron aspectos esenciales para el interés y la aplicación de los resultados del estudio. Los resultados demuestran la viabilidad del uso de métodos mixtos para comprender la complejidad de los problemas de acceso que afrontan los diferentes subgrupos poblacionales. La involucración desde un primer momento de las personas responsables de la toma de decisiones y la flexibilidad para llevar a cabo deliberaciones prolongadas propiciaron una mayor repercusión del análisis y sus conclusiones. La participación de las autoridades de salud y de las principales partes interesadas favoreció la aplicación de los resultados para determinar, en un marco de colaboración, las opciones políticas necesarias para eliminar los obstáculos que dificultan el acceso. Las enseñanzas extraídas de este estudio subrayan la necesidad de una participación activa de las autoridades responsables de la toma de decisiones, de que el proceso sea flexible y de la existencia de oportunidades permanentes de deliberación para asegurar su eficacia. El hecho de tener en cuenta las prioridades locales y adaptar los métodos en consecuencia fue un elemento importante para el interés y la aplicación de los resultados. Las iniciativas futuras podrían considerar la incorporación de métodos mixtos a los sistemas nacionales y locales de seguimiento y evaluación.

Palabras clave Barreras de acceso a los servicios de salud; sistemas de salud; proyectos de investigación; estudio de evaluación; Américas.

Uso de métodos mistos para entender e enfrentar as barreiras de acesso aos serviços de saúde

RESUMO Este relatório descreve a experiência e as lições aprendidas com o delineamento e implementação de um método combinado (quantitativo e qualitativo) para avaliar barreiras de acesso aos serviços de saúde. Essa abordagem foi desenvolvida para estudar barreiras de acesso em cinco dimensões: disponibilidade; acessibilidade geográfica, financeira e organizacional; aceitabilidade; contato; e cobertura efetiva. O desenho do estudo foi usado em seis países da Região das Américas da Organização Mundial da Saúde. Os achados destacam a importância de ter uma estrutura de análise bem definida e os benefícios de adotar uma abordagem de métodos mistos. O uso de dados existentes e a contextualização dos achados de acordo com grupos populacionais e áreas geográficas específicas foram essenciais para a relevância e a utilização dos resultados do estudo. Os achados demonstram a viabilidade de usar métodos mistos para entender a complexidade dos problemas de acesso enfrentados por diferentes subpopulações. O envolvimento de tomadores de decisão desde o início e a flexibilidade para discussões contínuas permitiram que a análise e os achados tivessem impacto. O envolvimento das autoridades sanitárias e das principais partes interessadas facilitou a utilização dos achados na identificação colaborativa de opções de políticas para eliminar as barreiras de acesso. As lições aprendidas com o estudo enfatizaram a necessidade de participação ativa dos tomadores de decisão, flexibilidade no processo e oportunidades contínuas de discussão para assegurar seu impacto. Foi importante levar em consideração as prioridades locais e adaptar os métodos de acordo com essas prioridades para garantir a relevância e o uso dos achados. Futuros esforços podem considerar a incorporação de métodos mistos em sistemas nacionais e locais de monitoramento e avaliação.

Palavras-chave Barreiras ao acesso aos cuidados de saúde; sistemas de saúde; projetos de pesquisa; estudo de avaliação; América.