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Rapid methods for identifying barriers and solutions to improve access to community health services: a scoping review protocol

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ABSTRACT

Objectives Low attendance rates for community health services reflect important barriers that prevent people from receiving the care they need. Services and health systems that seek to advance Universal Health Coverage need to understand and act on these factors. Formal qualitative research is the best way to elicit barriers and identify potential solutions, however traditional approaches take months to complete and can be very expensive. We aim to map the methods that have been used to rapidly elicit barriers to accessing community health services and identify potential solutions.

Methods and analysis We will search MEDLINE, Embase, the Cochrane Library and Global Health for empirical studies that use rapid methods (<14 days) to elicit barriers and potential solutions from intended service beneficiaries. We will exclude hospital-based and 100% remotely delivered services. We will include studies conducted in any country from 1978 to present. We will not limit by language. Two reviewers will independently perform screening and data extraction, with disagreements resolved by a third reviewer. We will tabulate the different approaches used and present data on time, skills and financial requirements for each approach, as well as the governance framework and any strengths and weaknesses presented by the study authors. We will follow Joanna Briggs Institute (JBI) scoping review guidance and report the review using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews.

Ethics and dissemination Ethical approval is not required. We will share our findings in the peer-reviewed literature, at conferences, and with WHO policymakers working in this space.

INTRODUCTION

Rationale

Many health programmes experience large mismatches between people identified with a clinical need and those who attend services. A recent international systematic review of non-attendance across all medical specialities estimated that 23% of clinic appointments are missed, with the highest rate observed in Africa (43%).1 Low attendance rates often reflect significant barriers faced by users.2 Marginalised populations are often the least likely to receive care.3 4 Improving access to ensure that all individuals and communities receive the care they need lies at the heart of Universal Health Coverage—a core element in the Sustainable Development Agenda.5 6

Complex supply and demand factors govern access to health services and multiple frameworks have been developed, typically defining access as the ability to perceive, seek, reach, pay for and engage with care.7-11 Access is increasingly being extended through the use of digital services and remote consultations.12 13 While these services are useful, they come with their own set of barriers and equity issues, and cannot fully replace the central role played by in-person clinical providers.12 14 When it comes to identifying barriers to attending in-person clinical services and potential solutions, WHO has noted that ‘it is the experts who identify the problems and formulate interventions, while the problems and solutions as perceived by those at particular risk rarely constitute
the base for action’. Efforts to improve attendance rates should be grounded in an understanding of both supply-side and demand-side barriers, elicited through engagement with affected communities. The WHO Primary Health Care (PHC) Operational Framework defines engagement as ‘the process of involving people and communities in the design, planning and delivery of health services, thereby enabling them to make choices about care and treatment options or to participate in strategic decision-making on how health resources should be spent’. Turk and colleagues note that health service interventions ‘must be done with, and not simply done to, the people affected’.

Research evidence aligns with common sense in finding that involving communities in the development of services improves health outcomes and sustainability. For-profit enterprises seem to understand the value of engaging with their customers: many companies use focus groups and market research to continually hone their products and services to meet the evolving needs of their customer base. Our sense is that health programmes are less active in this space. Ideally—given the scale of the problem—health system managers would be able to deploy affordable, rapid and methodologically sound tools to engage with the groups that face the highest barriers to accessing care in order to elicit their ideas for service improvements. In reality, existing qualitative elicitation and coproduction techniques commonly take more than a year to plan, execute, analyse and report. They require formal ethical review, formally trained qualitative researchers, the use of specialist software and qualitative expertise to interpret and apply the findings. These resource requirements are prohibitive for most health system managers, and in many low-income settings there is not a ready supply of specialist expertise. This can lead to well-conducted but one-off engagement activities where the findings are inappropriately generalised to other groups or at the other end of the spectrum are tokenistic and/or methodologically flawed efforts to gather and act on service user feedback.

METHODS AND ANALYSIS

Guidelines

Our review will be conducted in accordance with the JBI methodology, based on the principles of Arksey and O’Malley and Levac and colleagues. Our review will be reported in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist Extension for Scoping Reviews (PRISMA-ScR, online supplemental file). Scoping reviews are the most appropriate method for mapping and characterising the available evidence in a given area, and follow five steps:

1. Defining the research question/s
2. Identifying relevant studies
3. Study selection
4. Charting the data
5. Collating, summarising and reporting the results

An iterative approach will be taken towards searching the literature, refining the search strategy, reviewing articles for inclusion, and extracting relevant data.

Participants

As we are concerned with barriers to access, we will focus on methods that seek to engage with those who are eligible for a given service but have not managed to attend. As such, we

Aim and objectives

We will perform a scoping review of the literature to identify, categorise and evaluate the methods that are being used to rapidly elicit barriers and potential solutions from service users in any community-based health service. We want to understand the strengths and weaknesses of the different methods that have been used, their resource requirements, and their governance frameworks as described by their users.

Responding to the need for rapid, affordable and scientifically robust approaches that can be used to continually improve health services, we ultimately aim to identify the minimum viable product in this space. We want to identify approaches that provide sound, non-tokenistic and actionable intelligence with minimal time, money, equipment, personnel, and skill requirements.
We primarily define ‘access’ in terms of whether people are able to physically reach (ie, attend) a clinical provider to get the care they need. This includes attending prebooked appointments as well as presenting to services that do not require appointments. We will include outreach services and home-based care, but exclude virtual/digital remote consults. We will also exclude compulsory care such as when patients are sectioned for mental healthcare, and services where no interaction with a clinician is required, such as automated services to obtain self-testing kits.

Types of sources
We will include all empirical study types that report on the use of a given method to elicit barriers or potential solutions within a maximum of 14 days between commencing fieldwork and generating the findings.

We will exclude methodological texts, reviews, letters and conference abstracts. We will also exclude systematic reviews, but we will search their reference lists and include any underlying primary studies that meet our inclusion criteria.

Patient and public involvement
No patient and public involvement.

Search strategy
The search strategy will be built around rapid community-based methods and access to health services30 40 (box 1). The search will be limited to human studies published since 1978; the year of the Alma-Ata Declaration on Primary Health Care. The search will be conducted in English but we will include full-text studies published in any language. We plan to complete the review by mid-2023. The search strategy results will be presented in a PRISMA flowchart that will show how studies were eliminated until final search yield that will constitute the basis for synthesis.

We will search the following information resources: the Cochrane Library, MEDLINE Ovid, Embase Ovid and Global Health Ovid. The first 20 pages of Google Scholar will also be screened. The search strategy, including all identified keywords and index terms, will be adapted for each included database and/or information source. Box 1 presents the search strategy for Medline. The Supplementary file (online supplemental appendix) presents the tailored search strategies for all databases. We will check the reference lists of included studies and relevant systematic reviews to identify any additional potentially relevant reports of studies. Key authors will be contacted to uncover additional or upcoming studies.

Study/Source of evidence selection
Following the search, all identified citations will be collated and uploaded into Covidence (Veritas Health Innovation, Melbourne) and duplicates will be removed. Following a pilot test, titles and abstracts will then be screened by two independent reviewers (HA and RJ) for assessment against the inclusion criteria. Studies that clearly do
The results of the search and the study inclusion process will be reported in full in the final scoping review and presented in a PRISMA flow diagram.\textsuperscript{41}

**Data extraction**

Two review authors (HA and RJ) will independently extract study characteristics and data from the included studies using a data extraction form developed by the reviewers. The data extraction form will be piloted on three studies by the same two review authors and required amendments will be made by consensus.\textsuperscript{42} We anticipate a broad scope of included studies, so data charting will be an iterative process throughout the review. The data extraction tool will be modified and revised as necessary during the process of extracting data from each included evidence source. Any discrepancies will be resolved by group discussion. Modifications will be detailed in the scoping review. Where required, authors of papers will be contacted to request missing or additional data.

The data extracted will include specific details about the participants, concept, context, study methods and key findings relevant to the review question:

- Article title.
- Journal title.
- Authors.
- Country.
- Language.
- Publication year.
- Study type.
- Type of approach (eg, focus group) and description:
  - Setting.
  - Participants.
  - Facilitators.
- Main output if anything other than a prioritised list of potential service modifications.
- Methodological strengths and limitations, as documented by the authors.
- Resource requirements:
  - Number of personnel, and essential skills/level of training.
  - Number of days for each person, full time equivalent.
  - Total number of days taken from conception to findings; including planning, recruitment, engagement and analysis stages.
  - Equipment.
  - Total financial cost.
- Framework used to structure interaction and elicit barriers and solutions.
- Method of recording (notes, audio, etc).
- Other practical requirements or qualitative considerations reported in-text.
- Ethics and governance requirements.
- Level, form, frequency and intensity of participation:
  - Level of participation will be assessed using the five categories used by WHO: inform, consult, involve, collaborate and empower.

**Box 1 Search terms used for Medline**

1. Health Services Accessibility/
2. Health Equity/
3. Social Determinants of Health/
4. (social adj2 determinant adj2 health$).tw.
5. ((health$ or social$ or racial$ or ethnic$) adj5 (inequalit$ or inequit$ or disparit$ or equit$ or disadvantage$ or depri$)).tw.
6. (disadvant$ or marginal$ or underserved or under served or impov-erish$ or minorit$ or racial$ or ethnic$)).tw.
7. barrier$.tw.
8. (solution$ or improve$ or strateg$ or access$ or challeng$).ti.
9. Community-Based Participatory Research/
10. Community-Institutional Relations/
11. (communit$ adj3 (engag$ or participat$)).tw.
12. CBPR.tw.
13. (participat$ adj2 health adj2 research$).tw.
17. (ethnograph$ or communitarian$).tw.
18. Interviews as Topic/
19. Patient Health Questionnaire/
20. Self Report/
21. Q-Sort/
22. Q-Sort.tw.
23. Q-methodolog$.tw.
24. (system adj2 dynamic adj2 model$).tw.
25. (nominal adj2 group$ adj2 technique$).tw.
26. or/1–25
27. Problem Solving/
28. ((rapid$ or agile) adj2 (appraisal$ or assessment$ or approach$ or evaluation$ or evaluate$ or technique$ or tool$ or method$ or re-search$)).tw.
29. or/27–28
30. 26 and 29
31. in vitro.tw.
32. (assay$ or microb$).tw.
33. Critical Care/
34. or/31–33
35. 30 not 34
36. limit 35 to humans
37. limit 36 to (comment or editorial or letter)
38. 36 not 37
39. limit 38 to yr='1978-
40. limit 39 to yr='1978-
41. Community-Organizational/
- Form will be assessed using the four categories used by WHO: community-oriented, community-based, community-managed and community-owned.
- Frequency is defined as the number of discrete interactions between the project team and the service users.
- Intensity represents the extent to which participants interact, exchange information and influence decision-making in participation processes.43
  - Power relations, prevailing knowledge and beliefs and cultural barriers,16 described by the authors.
  - Any documented power relations, prevailing knowledge and beliefs and cultural barriers.

Data analysis and presentation
We plan to conduct a formal narrative descriptive synthesis without meta-analysis. We will stratify the synthesis by methodological approach. We will present a summary table of the different methods used, grouped by discipline. We will also tabulate the resource requirements, form of participation and methodological strengths and limitations. Quantitative resource requirement data will be presented in whole numbers, days and 2022 US dollar amounts as appropriate. Ratios will be used to compare costs between approaches. Qualitative outcomes will be presented narratively. Methods used to engage with service users and service user representatives will be presented separately.

We will not conduct methodological quality assessment of included studies, in keeping with usual practice for scoping reviews.27 29

Limitations
Our review focuses on methods that operate extremely rapidly, using a 14-day cut-off. This choice has been driven by our collective experience working with health service and system managers. We are aware that effective community engagement can often take (much) longer than 14 days, and that expediency may come at the cost of the value and nuance of the findings that are delivered. Nevertheless, just because it is unlikely that there are many robust approaches that can deliver meaningful and non-tokenistic findings within a very short timeframe, we feel it is still worth examining the literature to understand this space. There is a risk that rapid approaches produce oversimplified findings that further compound issues for marginalised groups. We will be careful to assess these risks.

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Contributors LNA conceptualised and planned the study with SK, IG, JE, NT and AB. IG and LNA designed the search terms with input from RJS, HA, SK, JE, JR and NT. LNA wrote the first draft with JR, HA, IG, SK, JE, NT, JR and AB critically revised iterations of the manuscript. All authors read and approved the final protocol.

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Competing interests None declared.

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