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# AHEAD



**ACTION FOR HEALTH AND EQUITY  
ADDRESSING MEDICAL DESERTS**

## Consensus building methods

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How to collaboratively develop  
policy options for medical deserts

# What are medical deserts?

- Medical deserts are **isolated or depopulated areas** with significant **falling numbers** of medical practitioners and overall health **workforce shortages**.
- They are a **complex societal problem** that affects diverse groups of people with different interests.
- There are no quick fixes for medical deserts, resulting in **complex decision-making processes**.
- A single government body cannot solve medical deserts on their own. It requires **multistakeholder involvement** in decision-making.



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# What is consensus building in AHEAD?



1. Consensus building (CB) is the social process of **obtaining a general agreement** among relevant stakeholders on policy options to counteract and prevent medical deserts.



2. It does **not** necessarily mean that all stakeholders **have to agree with each other in every respect**. You can agree to disagree.



3. As the AHEAD consortium, we focus on building consensus on policy options that **focus on a wide range of locally developed innovative solutions**



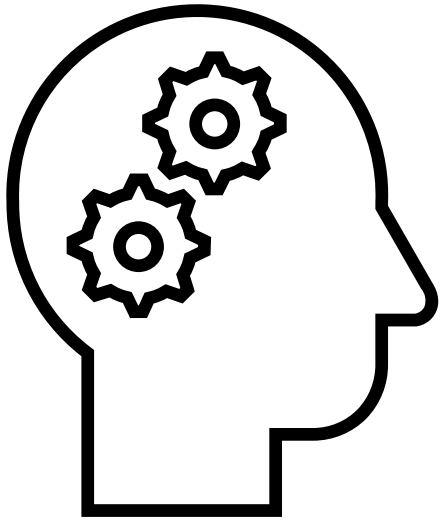
4. We expect that the participatory CB process will lead to **better decision-making** by involving **different stakeholders** in developing better solutions.

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- Methodology is **co-developed** by Athena Institute (VU Amsterdam) with AHEAD consortium partners.

# Why apply consensus building?



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**Equality:** co-created policy options are more likely to address health inequalities

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**Quality:** co-created policy options are likely to be more locally relevant

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**Legitimacy:** increased political trust or confidence in policies from all stakeholders

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**Acceptability:** stakeholders will be more likely to accept and implement policies

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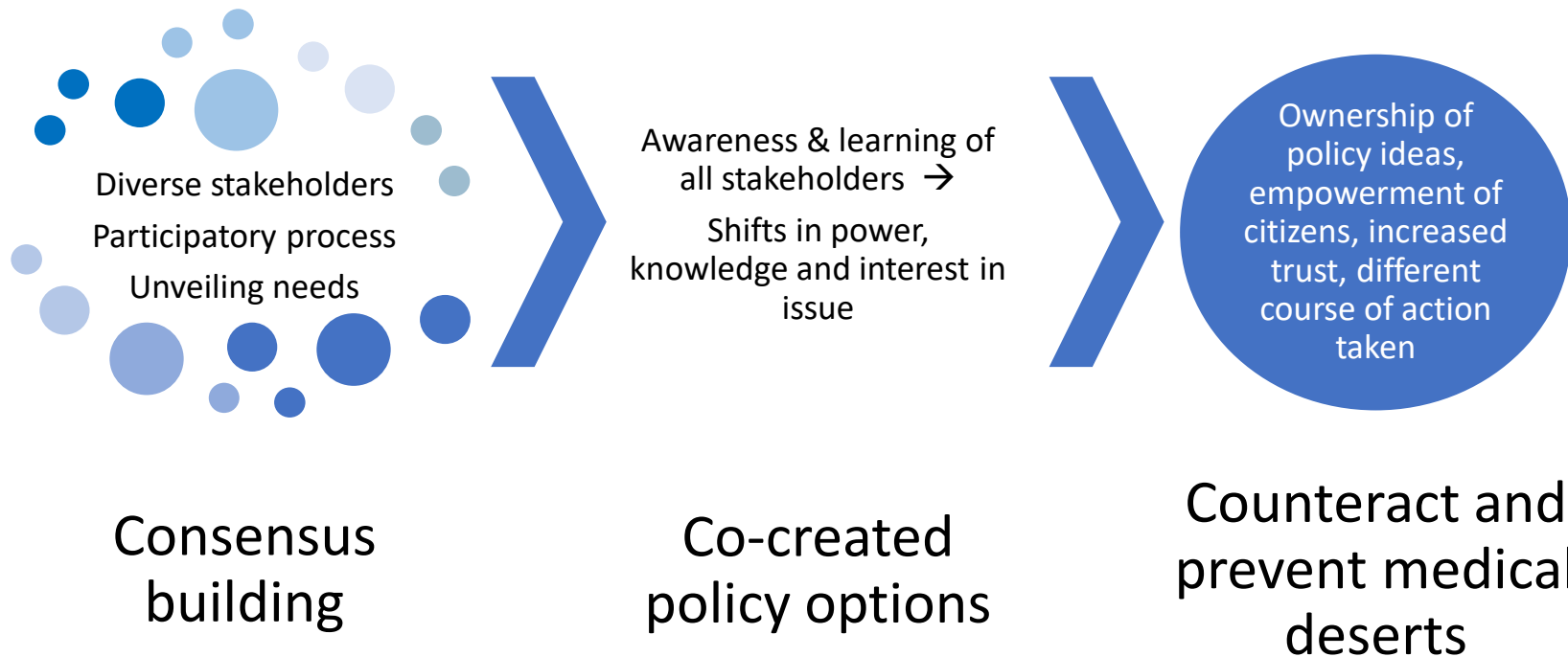
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# Our expectations

We believe that policy makers will be inspired to take action when they are aware of the community needs and have knowledge about solutions to tackle healthcare access issues (such as medical deserts).



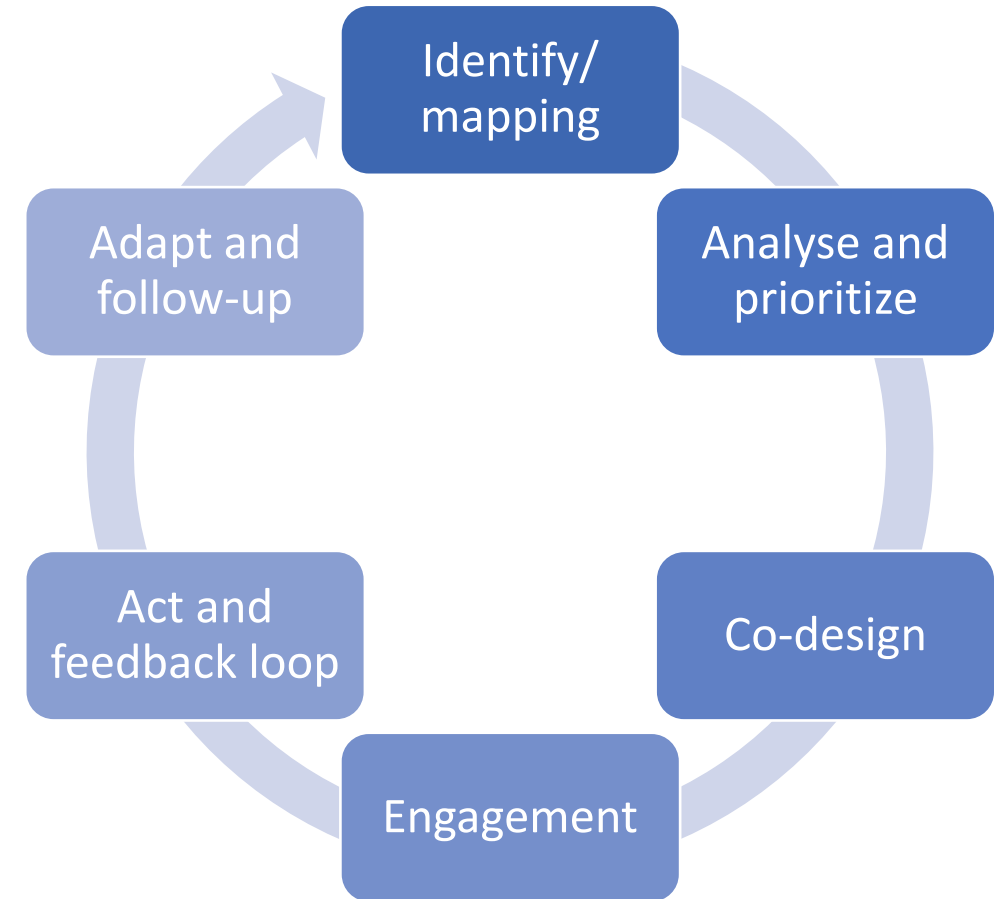
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# Involving stakeholders

- Effective stakeholder engagement is crucial.
- It involves a **proper mapping and analysis** of potential actors and the power they may hold in the CB sessions.
- Stakeholder engagement is **not a once-off event**. It requires involving stakeholders in **design as well as providing constant feedback** on the progress of the CB sessions.



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# Who are the stakeholders?

- Organisations and individuals who (could) have:
  - an **interest** in access to health services, who are affected by medical deserts, and/or
  - an active or passive **influence** on the decision-making and implementation processes.
- We aim to especially involve **under-represented groups**:
  - those who may experience health inequities for reasons such as barriers to access of health services.

## *Examples of stakeholders:*

- Health recipients
  - Community members
  - Patient organisations
- Health providers
  - Health workers
  - Health worker organisations
  - Health insurers
- Decision makers
  - Local government
  - National policy makers

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# A context-based approach

- The CB methods developed aim to achieve the **joint development** of contextually-relevant policy options between various groups of stakeholders.
- Stakeholder participation and its success depends on context. Therefore all CB methods are tailored per country based on **stakeholder mapping** and **contextual analyses** of the health landscape
- The AHEAD consortium partners and local facilitators **are trained** to organize and facilitate sessions in their countries.



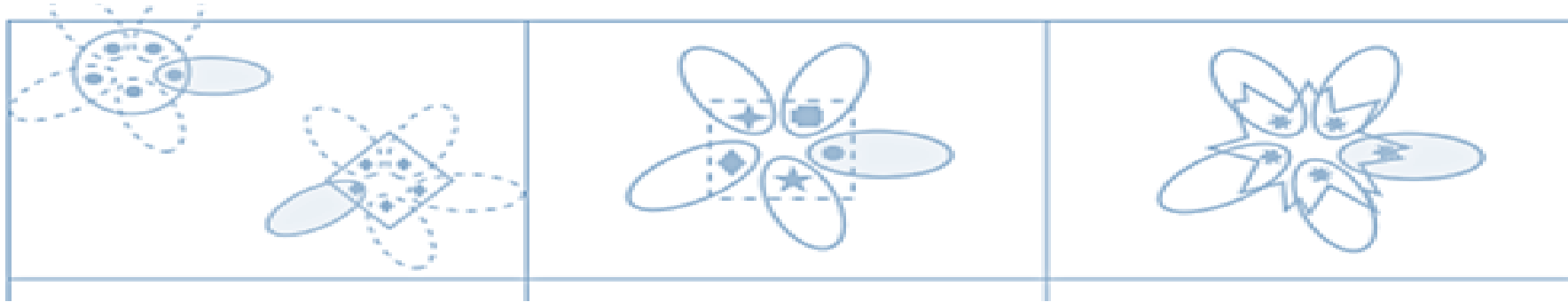
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# Step-by-step approach



## 1. Local single-stakeholder session

- 2-3 separate groups of “homogenous participants” (e.g. community members, local policy makers, health workers).
- Focus on validating identified problems and brainstorming preliminary solutions.

## 2. Local multi-stakeholder session

- A once-off multi-stakeholder group consisting of representatives from previous sub-groups.
- Focus on needs integration, joint problem solving, consensus building on policy options.

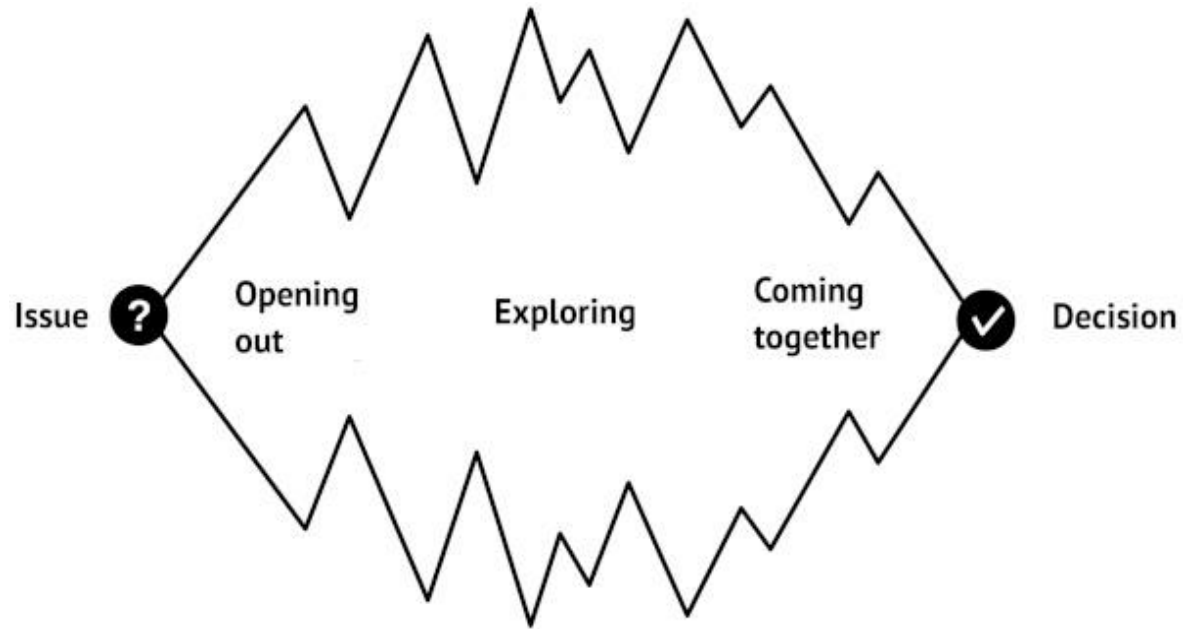
## 3. National level session

- Representatives from multi-stakeholder groups meet with political decision makers.
- Focus on codifying the policy options developed in previous phase. Output is a handout of feasible policy options to be taken forward for discussion in national dialogues.

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# The consensus building structure (1)



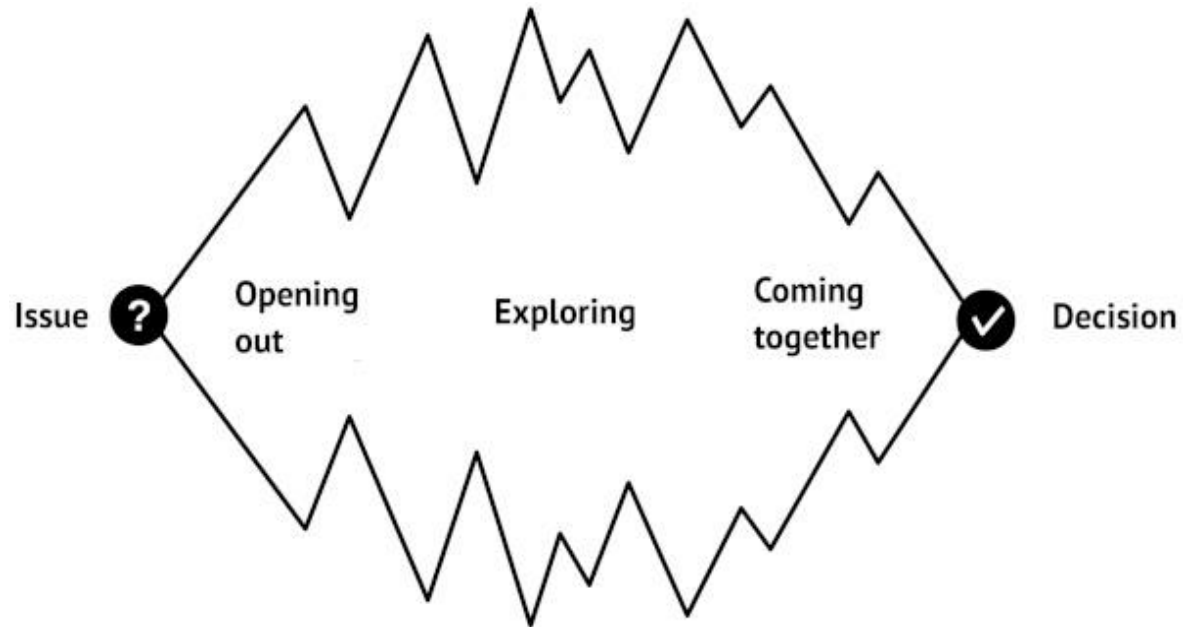
- 1. Introduce and clarify the issue:** introducing participants, explaining session agenda, outlining why we are looking at medical deserts, explaining why this locality has been identified as a medical desert, etc.
- 2. Open out discussion:** exploring the local stakeholders' experiences of living in a medical desert. Here they can share experiences, needs and opinions without rushing into decision making.

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# The consensus building structure (2)



3. **Explore ideas:** using elicitation activities to develop ideas for policy options, whilst weighing pros and cons or exploring feasibility.
4. **Come together:** finding common ground, establishing which options are most appealing and what can be combined.
5. **Decision/Consensus:** gaining consensus using voting methods and checking that proposals reflect the thoughts of the participants.

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# The consensus building structure (3)

Although the consensus building sessions follow a similar structure, they all have **different objectives** to which the activities of the sessions are tailored:

- 1. Local single-stakeholder session:** To develop and prioritise a menu of feasible policy options to address medical deserts. These should be allowed to be creative options within basic scope/parameters.
- 2. Local multi-stakeholder session:** To look at the options from the single stakeholder meetings and further narrow down to presentable options.
- 3. National sessions:** To prepare and streamline the options from the local multistakeholder group for use in the policy dialogues.

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