MISSION REPORT

Public consultation and the advancement of the health system in the Former Yugoslav Republic of Macedonia

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Stockholm, February 2010

1 Background

Health policy design and implementation requires thorough planning and expert management. The early and continued involvement of key stakeholders in this process has been associated with enhanced relevance, validity and potential effectiveness [1]. Key stakeholders, too often overlooked in national reform planning processes, include the general public and those who are most affected by reform. Involvement of the public is a fundamental component of democratic governance.

Well-designed public consultation processes can help policy makers engage the general public in identifying priority concerns, needs and areas for strategic action. Continued involvement of the public can help ensure that policy makers adhere to the specific tasks laid out and, importantly, reduce potential resistance to the changes that reform may introduce. Furthermore, public empowerment and the 'sense of control' achieved through democratic consultation processes have been associated with enhanced social capital and health [2]. A wide variety of public consultation approaches are possible and needs may change in different stages of reform processes. Additionally, processes must always be customised to country-specific conditions.

The Minister of Health of the Former Yugoslav Republic of Macedonia (FYROM) initiated an open consultative process for the advancement of their healthcare system the spring of 2009. A Steering Committee on Advancement of the Health Sector in the Republic of Macedonia was established, which included key stakeholders from government, NGOs, academia, professional associations and industry. The Terms of Reference of the Committee called for them to lead a broad consultative process and to design and implement a work programme which clearly sets out issues of importance or relevance to the current reform process. Transparency and openness to the public were identified as the main principles of work for the Committee.

The Committee gathered information in five key areas related to the reform process including governance, service delivery, financing, pharmaceuticals and patients' rights. A communication strategy is now in the process of being developed outlining the main communication and PR activities to be undertaken in the forthcoming phases of the process.

In considering the importance of good communication with the public and recognising the expertise and experience of the European Centre for Disease Prevention and Control (ECDC) in coordinating European response (including communications) to infectious disease outbreaks, the members of the Committee requested advice and assistance from ECDC in developing its next strategic steps. To this end, a two-day training workshop was held in Skopje, Macedonia, in August 2009 to accomplish the following goals: to review good practice in public consultation in Europe and beyond; provide an opportunity to exchange experiences and ideas; assist the Committee in assessing work to date; and identify current obstacles to action, ways to overcome them and next steps.

The mission team consisted of the following members: Karl Ekdahl, Head of the Health Communication Unit, ECDC; Dr Lucianne Licari, Head of Country Relations and Coordination, Director's Cabinet, ECDC; Ben Duncan, Corporate Communications Officer, Director's Cabinet, ECDC; Irina Dinca, Partnership and Country Officer, Country Relations and Coordination, Director's Cabinet, ECDC; and Franklin Apfel, consultant expert, World Health Communication Associates. In addition to workshop sessions, meetings were held with the following experts:

- Bujar Osmani, Minister of Health, FYROM;
- Snezana Cicevalieva, Director of the Department for European Integration, Ministry of Health, FYROM;
- Sam Vaknin, Adviser to the Prime Minister and Minister of Health, FYROM; and
- Ruzica Andronikoca and Alessandro Angius, Representatives of the European Commission (EC) Office in Skopje.

1.1 The workshop – overview and objectives

Forty members of the Steering Committee on Advancement of the Health Sector in the FYROM—including representatives from government, NGOs, academia, health professional, media, women's and youth associations, industry and international agencies—participated in this two-day training workshop. Day one was devoted to reviewing values, tools and experiences in public consultation and brainstorming the strengths, weaknesses, opportunities and obstacles related to the continued success and impact of the current FYROM health reform consultation process. Based on these findings, day two was designed to identify ways to overcome obstacles and plan subsequent steps.

The main objectives of the workshop were to accomplish the following:

- present the relevance of public communication and the appropriate methodology of public communication processes to the Steering Committee on Advancement of the Health Sector of FYROM;
- present lessons learnt from other countries and adjust the most appropriate models to the needs of FYROM;
- ensure discussion amongst the members of the Steering Committee on the most appropriate methods; and
- update and brief the Steering Committee about the role and mission of ECDC, and identify specific areas of support and cooperation.

Participants presented themselves, reviewed the process to date and their expectations for the workshop.

1.2 Expectations from the workshop

The participants expected the following results from the workshop:

- to learn about different approaches to public consultation;
- to explore values, tools, models and approaches;
- to identify ways of making people more trusting, politicians less apprehensive and the media more helpful;
- to get help in designing next steps and identifying the best ways to engage more people, manage input process and follow-up;
- to get help packaging the findings into concrete recommendations;
- to identify ways of ensuring that the process has some positive influence on health reform plans;
- to explore ways of transferring the findings to specific policy recommendations so as to secure public and policy-maker acceptance; and
- to identify best public consultation approaches given local realities; e.g. town hall meetings, surveys, use of internet, etc.

2 Presentations and discussions

2.1 Risk communication and management – Current ECDC activities regarding 2009 pandemic influenza A(H1N1) and other threats

Karl Ekdahl, head of the Health Communication Unit at ECDC, introduced ECDC, its mandate, responsibilities, structure and functions related to coordinating surveillance and response of communicable diseases in the 27 EU and EEA/EFTA countries, as well as other countries through the Neighbourhood Policy and the Directorate-General for External Relations (DG Relex)*. Current ECDC activities and services that could support public health and health reform in FYROM were identified and described, including the following: the launch of its new European surveillance system (TESSy) that provides a 'one-stop shop' for data flow related to communicable diseases; ECDC's Annual Epidemiological Report (covering 59 reported communicable diseases); and disease specific reports. ECDC's role in research, guideline production, risk assessment, scientific advice, microbiological laboratory support, preparedness and response was reviewed. Communication activities and work areas were described, including news reporting, website services and the journal *Eurosurveillance*, which has the capacity for rapid information updates with peer review and publication possibilities in less than two days.

* DG Relex is responsible for the Commission's relations with international organisations, such as the United Nations, the OSCE and the Council of Europe, as well as the Commission's participation in the Common Foreign and Security Policy (CFSP) and the administration of more than 120 Commission delegations in third countries, and to international organisations.

Box 1:

2009 pandemic influenza risk communication in theory

Before the pandemic:

- Precaution advocacy: persuading people to take the pandemic risk seriously.

During the pandemic:

- Crisis communication: helping people bear a difficult situation and cope wisely.

After the pandemic:

- Outrage management: addressing tough questions from angry stakeholders about why we weren't better prepared

ECDC's role and activities during the 2009 influenza A(H1N1) pandemic were reviewed. Key ECDC actions included the following: the provision of timely, evidence-based, authoritative information and guidance needed for public health action; educational and background material for the general public and media; providing support to EU Member States and the Commission; disseminating good communication practices; and working in partnership with WHO and other agencies. To this end, ECDC has established the following communication outlets and practices: the creation of a 24/7 crisis communication centre; utilised frequent press briefings, the web and *Eurosurveillance* for the dissemination of information; introduced regular podcasts and a virtual press room; and supported key EU communication networks.

Box 2:

2009 pandemic influenza risk communication in reality (I)

- It's a milder pandemic than anyone imagined, although it will be a very tough winter; moderate hazard.
- A few people excessively upset—may go in our favour.
- Most people insufficiently upset—complacency.
- Panic; political leaders possessing an excessive fear of frightening the public.

The following are some key lessons learnt about risk communication:

- Fear and concern over a perceived hazard, rather than an actual hazard, is a strong motivator for behaviour change as long as it does not paralyse [3] the populace.
- A main communication goal is to get fear and concern proportionate to hazard. When fear/concern is too low, the message suggests 'watch out'; when fear/concern is too high, message is a reassuring one: 'We'll get through this together'.
- To date, theory and reality of response are very different (see Boxes 1-3) and there is no room for complacency (see Box 4).

Box 3:

2009 pandemic influenza risk communication in reality (II)

- Example 1: Recent survey shows that almost 30% of UK nurses don't intend to be vaccinated for fear of side effects.
- Example 2: Recent focus group study on the public's acceptance of novel vaccines during a pandemic.
- Governments that have relied heavily on assuring their population that the impact of the 2009 pandemic influenza is minor and who have been advocating personal hygiene measures as a way of keeping safe from the flu, have undermined their own ability to sell people on getting vaccinated.

2.2 Values, approaches, models and tools

ECDC consultant, Franklin Apfel, reviewed values underpinning public consultation, rationales for action, models and tools. A ten-step framework for public consultation was presented (see Box 5).

(Note: Public consultation processes are always context specific. What follows are generic issues, concerns and recommendations. These will always have to be adapted to local and national realities.)

Box 4:

No room for complacency
(Situation and information: late May 2009)

- Pandemics take some time to get going (1918 and 1968).
- Some pandemic viruses have 'turned nasty' (1918 and 1968).
- When the pandemic wave hits Europe, health services will be challenged.
- There will be severely ill people and deaths in risk-groups (young children, pregnant women and especially people with underlying illnesses).
- As the virus spreads south, will it exchange genes with seasonal viruses that are resistant: A(H1N1)-H247Y, more pathogenic A(H3N2), or even highly pathogenic A(H5N1)?
- An inappropriate and excessive response to the pandemic could be worse than the pandemic itself.

2.2.1 Values and principles for involvement

The following points address key issues regarding the values and principles of involvement:

- Those involved must see the bigger picture and know why this is being done, i.e. clear objectives stated.
- Openness and honesty with clear expectations.
- Inclusive processes—connect people and their ideas in a transparent and democratic process.
- Flexibility—responsive to different needs and preferences.
- Respect for divergent views and values.
- Willingness in the system to take up and build on people's ideas.

Box 5:

Ten-step framework for public consultation [4]

1. Taking action—overcoming obstacles to action.
2. Selecting your issue—identifying issues where public involvement will enhance effectiveness of interventions.
3. Understanding your political context—identifying the key groups/people that need to be engaged.
4. Engaging citizens—researching the issue and mapping the potential roles of relevant groups/people.
5. Selecting level of public involvement—informing, listening, consulting, engaging, partnering.
6. Elaborating on strategic plans—designing process, selecting public engagement approach related to selected level (5).
7. Synthesising results—analysing input, drafting results.
8. Ongoing dialogue with participants.
9. Evaluating—reporting on activities, training, disseminating finds.
10. Building sustainable capacity throughout the process.

2.2.2 Making the case for public consultation

Some of the arguments for public consultation include the following:

- **Instrumentalist**— makes services better. Public consultation at a systems level is similar to taking a medical history at a personal level. Without input from service users, from those most affected by a problem, it is not possible to make a correct 'systems-level' diagnosis.
- **Communitarian**—builds local involvement and ownership of solutions. Makes compliance with new regulations more effective; e.g., introduction of no smoking areas in pubs and restaurants.
- **Educative—**develops knowledge and skills of participants. Effective healthcare requires active engagement of citizens. For example, outbreak management requires behaviour modifications like hand washing, vaccination, etc. Chronic illnesses require more self-care, monitoring, lifelong and home-based approaches. Navigating through increasingly complex health systems requires enhanced functional health literacy skills and information access.
- **Expressive**—part of democratic approach. Builds so-called social capital* and enhances health. The interest in public consultation reflects cultural shifts being experienced both in healthcare and other public policy sectors from a paternalistic, directive and authoritarian approach to partnership; patient-centred, empowerment and engagement strategies.
- **Increased accountability**—public can hold service providers accountable.

* Social capital can be defined as "features of social organization, such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit" [4].

- **Technological capacities**—telecommunication advances provide the technical capacity to reach and interact in cost-effective ways with large numbers of people, for people to express their opinions and participate in decision-making processes. Technological mechanisms include new social media, wikis, internet-based communication platforms and advances in mobile phone applications.

2.2.3 Obstacles to public consultation

Political interest groups, continued influence by powerful hierarchical parties, perceived threats to vested interests, and resistance to change by designated leaders are major obstacles to public consultation. Additionally, public participation takes a lot of time, is often difficult to manage and can be used by groups with a vested interest to reinforce their positions and political authority.

Table 1: Selecting levels of engagement—Continuum of involvement [1]

Information	Consultation	Engagement/dialogue	Shared decisions	Shared jurisdiction
Info in/Info out	I listen/speak You listen/speak	We talk and understand each other	We decide	We are responsible and accountable

2.2.4 Who is 'the public' in the context of health reform?

The public is any person or group with an interest in the goals and impact of policy. They range from representatives of special interest groups (e.g., patients, minority rights, rural or deprived communities, etc) to taxpayers and voters. It is important to define which groups are to be involved in relation to the objective of policy. It is vital to balance the views and needs of interest groups and those of citizens more broadly in order to achieve maximum consensus.

Table 2: Consultation design—Involvement techniques [1]

Traditional—Associated with top down approaches and more passive audiences	Emergent—Enabling greater partnership collaboration, attentive policy development and asset mapping
• Publications	• Open space
• Public meetings	• Future search
• Surveys	• E-participation
• Interviews	• Public policy dialogue
• Focus groups	• Appreciative enquiry
• Interviews	• Study circles
• Public hearings	

3 The role of public relations in public consultation

Ben Duncan, Corporate Communications Officer, ECDC, discussed the rationale and approaches for use of public relations related to public consultation processes and presented a case study from Canada on the use of public consultation (see Box 6).

Table 3: Aims and challenges associated with public consultation

Aims	Challenges
• Informing the public about how to participate in the consultation	• Fears of public about healthcare reform including cuts in services and higher fees
• Raising awareness about difficult choices facing the health system	• Fears of stakeholders including loss of money or power and new rules/bureaucracy
• Launching public debate about the future of the health system	• The health system is complex and difficult to explain the details
• Building public consensus on future health system	• Healthcare is highly political; citizens and stakeholders have strong views

3.1 Core elements of PR strategies

The following points underscore relevant aspects surrounding PR strategies:

- Define and understand audience(s)
- What to communicate:
  - Simple, powerful messages to "frame" debate
  - Factual, easy to understand, background information
  - Sound-bites
- When to communicate:
  - Key opportunities and events
- How to communicate:
  - Media
  - Website
  - Via partners, networks and other multipliers
- Evaluate impact on audience

Box 6:
Case study—Canada
Background

The Canadian healthcare system is financed by both the provincial and federal governments, with each paying 50% of costs. During the 1990s, growing concerns emerged about rising costs and the quality of service and so a commission on the future of healthcare in Canada was established in 2001. The mandate of the commission was to engage Canadians in a national dialogue on the future of the healthcare system, make recommendations on how to improve public healthcare and make it more financially sustainable.

Strategies

Public debates focused on values and included the following questions:

- What do people expect from the healthcare system?
- What are people prepared to do/pay in order to achieve this?
- Which values are most important: Equity? Choice? Quality?
- How can the debate be made relevant to the public and experts?
- Is it possible to build a vision of health reform based on consensus values?
- How to ensure the debate focuses on the integrity of the process?

It is important to encourage a broad debate to show the different views being listened to and take time to consolidate the results of the debate. Independent experts should be used to interpret contributions and the reports from meetings should be published within 48 hours.

Techniques used:

- Easy reading consultative document puts forward four "consensus" scenarios on the future of the health system.
- More public investment.
- More user-pay.
- More choice (parallel system).
- System Reform Partnerships with NGO networks and stakeholder groups.
- Regular information on the work of the commission.
- Partners help publicise consultation—given responsibility for developing reports.
- Town hall meetings in every province and territory with senior local politicians and health professionals.
- Emphasis on ordinary citizens speaking as well as stakeholders.
- 21 days of public hearings (web access/phone-in).
- Marketing via partners, web, media and print ads.
- Representative 'cross-section' defined.
- Abstracts required (10 minutes for public, 15 minutes for experts).
- 'Walk-ons', end-of-day.
- Presentation summaries posted web within 24 hours.
- Commission covers all broadcast costs—rural, open-line radio/website visits to follow-up.
- 1400 abstracts received; 631 presentations.
- Televised debates involving stakeholders with different views.
- Ordinary citizens talk to media about experiences of health system.
- Commission website with discussion documents, meeting reports and opportunities to comment .

- Other direct contacts: 6900 letters, 4500 emails, 2600 toll-free calls.

Results

- Considerable public and media debate generated.
- Process regarded as fair.
- Final report seen as objective and credible.

(For a copy of the report, click here)

4 The health reform public consultation process in FYROM

Dr Snezana Cicevalieva, Director of the Department for European Integration, Ministry of Health, FYROM, presented an overview of the consultation process to date.

4.1 The process

The process was described as rapid (spring 2009), having 'serious' momentum (many meetings with good participation of the 120 members of the Committee sub-groups), and stakeholder involvement has been broad. There was strong facilitation and support from the Ministry of Health. Activities focused on the production of a 'Green Book' of key issues which includes input from a wide variety of stakeholders. The process has all been voluntary and felt to be timely. Support was received from the Prime Minister's office. The process was described as representing a cultural shift from hierarchal approaches to participatory democratic participation; from passive receivers of change to active creators of change. The general impression from participants was one of positive empowerment and engagement. There have been hundreds of submissions to the webpage. However, some impediments were noted.

4.2 Obstacles

Participants remain somewhat sceptical of the process. They do not have previous experience with participatory processes and have concerns that political considerations may lead to their input being ignored. The media has been sceptical of the process and has not provided broad coverage of the Committee's activities or findings to date. Politicians appear somewhat apprehensive of the process, as it is perceived by some as taking away control.

5 Public consultation process in FYROM – next steps

5.1 Strength, weakness, opportunity and threat analysis of process – group work

Participants were divided into three groups and each asked to identify the strengths, weaknesses, opportunities and threats to the public consultation process initiated in FYROM.

Strengths

- Significant and active engagement from a broad group of stakeholders.
- Ministry of Health involved but just one of many.
- Transparent, open, independent process; minutes of meetings and other relevant documents are posted on website.
- A common commitment to health improvement.
- Voluntary efforts.
- Shared ownership.

- Experts assigned to each of the five sub-working groups: governance, service delivery, financing, pharmaceuticals and patients' rights.
- Structure of website makes participation easy.
- A new, fresh and exciting process.
- Good support from international agencies: WHO, USAID, ECDC.

Weaknesses

- Limited response so far from NGOs and citizens.
- Mistrust and scepticism on part of many and media in particular.
- Accessing information on aspects of system can be difficult.
- Very short time allotted to process; one year is not enough time for this large task.
- Healthcare sector—particularly doctors—does not have a tradition of listening to patients and are hard to engage.
- Capacity of group to integrate all inputs is weak.
- Human and financial resources too small for job.
- Exchange of information between sub-groups is limited.

Opportunities

- More active promotion of process in media could lead to broader public participation.
- Involvement of public figures, politicians, celebrities, etc., could enhance perceived credibility.
- Webpage and wiki activities need to be better promoted.

Threats

- Lack of funds and human resources.
- Political discord and ownership.
- Payments to participants could create conflicts of interest.
- Media sceptics.

6. Overcoming obstacles – plenary discussion

Discussions were held in a plenary session regarding ways to build upon the strengths of the process to date, address weaknesses, take advantage of opportunities and overcome obstacles. Some of the suggestions included the following:

- changing the volunteer group to standing committee status under the Ministry of Health;
- developing a new group model as an NGO to coordinate the process with official relations to Ministry of Health. This group would seek support from EU, Bilateral Aid and other funding sources. Related experiences from Malta and Romania are discussed in Box 7.

Box 7:

Case study—Malta (personal communication, Lucianne Licari, ECDC)

In the case of Malta, the Department of Health Policy and Planning was asked to study the possibility of introducing breast screening to young women as one of the free national health services. A steering committee was set up that was representative of all stakeholders, including patients as core participants. This committee reviewed other country examples as well as recent scientific literature in order to make a decision. A cost–benefit analysis using national statistics was performed and discussed amongst the committee members. Findings showed that there was no added benefit in decreasing the age of breast screening from that already indicated as part of the national health service. Despite political pressure and public demand, the steering committee took the decision to leave the age of national breast screening as it was and communicated this decision to politicians, general public and the media. The democratic, inclusive, evidence-based and transparent process allowed the decision of the steering committee to be accepted and overcome opposing opinions.

Case study—Romania (personal communication, Irina Dinca, ECDC)

In the case of Romania, public consultation was noted to be mainly at the level of public information rather than some of the more interactive approaches described. The Romanian Ministry of Health regularly posts legislation drafts on its website for

comments from the public and holds open consultation days. Some of the difficulties noted included access to the web, especially for rural populations. Another approach used in Romania was to actively engage NGOs in the design of some health strategies; e.g., the National Sexual and Reproductive Health Strategy. In this case, extensive consultations were carried out with NGOs from various sectors around goals, objectives and targets for the strategy. Experts were also widely consulted and the success of this strategy has been attributed in large part to its open and inclusive consultation process that involved various key stakeholders. Furthermore, the stakeholders felt considerable ownership over the document and therefore helped to put it into everyday practice. Public consultation has not been an easy process. Scepticism over government involvement and public passivity were obstacles that needed to be overcome. The involvement of NGOS—a very young sector in Romania (they were set up only after the fall of the Communist regime)—has been associated with greater success.

6.1 Enhance public relations and better engage media

The following is a list of concepts to contemplate when considering how to better enhance public relations and engage the media:

- PR strategy—develop public relations sub-group (in co-ordination with Ministry of Health press office or independent) to create and implement strategic communication action; i.e., regular press releases, media relations, etc.
- Communication network building—engage more communicators (media, PR spokespeople, NGO advocates, etc.) in all sub-groups.
- Create a national health reform communication network—provide briefings, training and early access to information and experts.
- Develop partnerships with media–organise training workshops for the media by international and national media specialists.
- Use “cuckoo-model”—run side events for media at relevant national health reform meetings. Link media with key spokespeople, presenters, etc.
- Explore partnership opportunities—engage media in co-publishing activities.
- Make Green Book into Green Paper. Synthesise and prioritise inputs (see below).

7. Green Book development and public consultation – next steps

Dr Franklin Apfel, consultant expert, World Health Communication Associates, presented ideas on ways to synthesise and prioritise health reform change suggestions made to date and disseminate the findings. Alternative approaches to next steps in public consultation were also explored.

7.1 Synthesising results and prioritising recommendations

At present, the Green Book represents a collection of a broad range of public input in each of the following sub-group areas: governance, service delivery, financing, pharmaceuticals and patients’ rights. Subsequent steps will require the synthesis of inputs, prioritisation of recommendations, report drafting, building consensus with stakeholders, finalising recommendations and issuing a ‘white paper’ report.

To this end, groups need to agree to an approach to synthesis. Possibilities for synthesis and synthesisers might include independence from vested interests, credibility with peers and community, and respect for diverse views. The groups will need to decide if synthesis should be done by external experts, national experts or some combination of the two. Consideration should be given to ensuring that synthesising skills are transferred to local and national experts, so as to ensure sustainability of the process.

Moreover, groups will need to decide on criteria for prioritising any problems. These criteria might include size and seriousness of problem, effectiveness of intervention and these specific factors: propriety, economics, acceptability, resources, legality (PEARL). A wide variety of prioritising frameworks exist, such as the models shown in Table 3.

Finally, groups will need to pay attention to factors associated with successful coalitions (see Box 8).

Table 3: Policy and program planning options [5]

	More important	Less important
More changeable	Highest priority for program focus	Low priority except to demonstrate change for political purpose
Less changeable	Priority for innovative program	No intervention

In deciding on priorities, the group can utilise a variety of consensus building approaches including the following:

- The Delphi technique, where group members sequentially rate issues; for example, after rating the top three issues, the remaining issues with the highest scores are re-rated by the group. Priority issues are thereby identified quantitatively.
- Town hall meetings and Consensus Conference: issues are presented to key stakeholders in a conference format and priorities are decided by consensus amongst the participants.
- Citizen juries/panels: alternative approaches or issues are presented to a representative citizens group and they act as a jury, deciding on priorities after hearing arguments from both sides.
- Deliberative polling: options are presented as a questionnaire or telephone poll and priorities are quantitatively decided by a number of votes.

(*Note: Concerns were raised in relation to current plans to do sequential Green Book consultations with the public and then professional groups. If professionals disregard or reject public opinions, the process could be undermined.)

Box 8:

Principles for a successful coalition [6]

- Choose unifying issues
- Understand and respect institutional self-interest
- Agree to disagree
- Play to the centre with tactics
- Recognise that contributions from member organisations will vary
- Structure decision-making carefully based on level of contribution
- Clarify decision-making procedures
- Help organisations to achieve their self-interest
- Achieve significant victories
- Distribute credit fairly

8. Synthesis and prioritisation – group discussions

Participants were divided into two groups to discuss issues related to synthesis and prioritisation.

8.1 Synthesis – who should do it?

Both groups felt that synthesisers should be independent and draw on a combination of international and national expertise. Previous experience with similar tasks and the ability to summarise a wide variety of contributions are essential and will probably need external input. On the other hand, familiarity with the context of public health in FYROM and language will be critical. The chairs of the sub-committee would be the logical and appropriate members involved in this process as they know the process, the members of the committee and the contributions.

8.2 Prioritising

The groups also felt that the basic criteria of the interventions should include seriousness, impact and effectiveness. Data should be evidence-based, including official and unofficial sources. Comparative data from other countries could also help.

8.3 Public consultation

The two groups felt that given time constraints and the robust involvement of stakeholders to date, the next steps related to public consultation should focus more on informational rather than higher level involvements. To this end, town hall meetings should be organised as more informational sessions rather than data gathering exercises. Stronger PR and media strategy activities are needed. Specific suggestions included the following:

- media training related to informing them about what the Steering Committee does and encouraging them to transform the messages;
- round tables, debates on TV;
- two minute TV public service announcements;
- printing flyers, leaflets; and
- travelling caravans to different cities.

9. Outcomes of the workshop

The workshop was successful in reviewing and identifying tailor-made methods of public communication for the further development of the FYROM public consultation process. A variety of country examples and lessons learnt along with the workshop promoted discussion between the members of the Steering Committee, who came to realise that the originally planned approach required modification. It was too fast, needed to broaden its support base, synthesise and prioritise recommendations and deliver concrete proposals to maintain its political base of support and enhance public acceptance.

Areas for potential follow-up support from ECDC and other EU sources were identified, including the following:

- a follow-up visit by the ECDC communication team in order to assist with the public consultation process;
- assistance in the development of the national public health system reform in the area of communicable diseases;
- training on laboratory techniques and other related training; and
- orientation visits to ECDC for various staff at technical as well as political levels in order to gain a better understanding of how ECDC works and what services it can provide.

Annex 1: References

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Annex 2: Workshop agenda

Day 1 – 26 August 2009

09:00—09:30	Official opening
09:30—10:15	Introductory session
10:15—11:00	Communicating the risks: the challenge of addressing the public in times of crisis
11:00—11:30	*Coffee break*
11:30—12:00	Driving policy through public consultation-values, approaches, models and tools
12:00—13:00	Ensuring public consultation—examples of good practice and lessons learnt
13:00—14:00	*Lunch break*
14:00—15:30	The role of public relations in public consultation
15:30—16:00	*Coffee break*
16:00—17:30	Addressing the national situation: a tailor-made approach—Strengths, weakness opportunities and obstacles (and ways to overcome them). *Working groups*
17:30	End of day
17:30—18:00	Preparation of reports and conclusions of working groups *Session for rapporteurs and facilitators only*
19:00	Dinner hosted by the Minister of Health

Day 2 – 27 August 2009

09:00—10:00	Reporting to plenary
10:00—11:00	Consensus building–Inter-sectoral working]
11:00—11:30	*Coffee break*
11:30—13:00	Designing an inter-sectoral public consultative process on the advancement of the health system of Former Yugoslav Republic of Macedonia *Working groups*
13:00—14:00	*Lunch break*
14:00—14:45	Reporting to plenary
14:45—16:00	Applying the model to pandemic influenza *Working groups*
16:00—16:30	*Coffee break*
16:30—17:30	The way forward
17:30	Closure of training workshop