

EuroNews-MRPH

The Newsletter of the European Network of Medical Residents in Public Health

New EuroNet team 2016

All you need to know about new EuroNet MRPH team. PAGE8

Coming Soon

The Summer Meeting in the Netherlands. Call for Abstracts PAGE 10



Spring meeting
2016

Zagreb
Croatia



Dear Friends and Colleagues,

there's been a lot of exciting developments and opportunities for EuroNet and its members this year and I am sure this progress will continue. Our new Executive Committee has brought fresh ideas, energy and enthusiasm and we had an incredibly successful meeting in Zagreb last April. The Croatian team hosted an unforgettable and most enjoyable event, and for the first time, during a dedicated scientific session, each EuroNet member country presented some work-based or scientific projects generating much interest and discussion. We plan to continue this exchange of ideas and knowledge in our next meeting this year in Holland. Looking forward to seeing you all there on the 9-11th of July!

Zagreb also brought the announcement of the innovative IEDC and EuroNet scholarship to the Young Manager's Programme. We look forward to awarding this incredible opportunity to a EuroNet member and hearing all about it on their return. We hope that our new communication strategy discussed at the meeting will increase our reach, coverage and membership and help us achieve our aims of sharing resources, information and encouraging collaborations across Europe. One such collaboration is

set to start soon and will explore the health informatics competencies of Public Health Residents across our member states.

This year, our collaborations with EUPHANxt continue and we look forward to a fruitful year together. We're delighted to be in discussion with colleagues from Canada, USA, South Africa and Europe to begin building an International Network of Public Health Residents that will connect us with like-minded colleagues across the globe. Become a member of our Facebook group and join in the discussions!

I want to thank all the contributors to this newsletter and all the members of our Executive Committee and working groups for all their work so far. Let's keep working together to make EuroNet bigger and better each year and contribute in a meaningful and lasting way to Public Health across Europe.

See you in Holland!

Fiona Cianci
President 2016, Ireland

Sugar Tax

Last March the UK government announced that it will introduce a tax on sugary drinks in 2018. This announcement has been welcomed by health organisations and public health specialists, such as the NHS and Public Health England. The tax will only affect sugary drinks and it will be a two tier tax, with a levy for drinks with a sugar content over 5 grams per 100 millilitres and a higher one for those with over 8 grams per millilitre.

This type of tax has been successfully implemented elsewhere in the world. Mexico, who

introduced this measure in 2014, has seen a 12% reduction in sugar drinks consumption.

It is hoped that the tax will rise over 500 million pounds per year and will help to reduce the rising rates of overweight, obesity and diabetes in the country. The UK ranks amongst the worse countries in the world in both obesity and diabetes, and the average consumption of sugar is well above the daily recommendations.

The British Soft Drink Association argue that there is no evidence of the effectiveness of the tax, which

will hit the poorest harder than the other groups, and are considering legal action against the government. This tax will be part of a wider national obesity strategy that will be announced by the government further on this year.

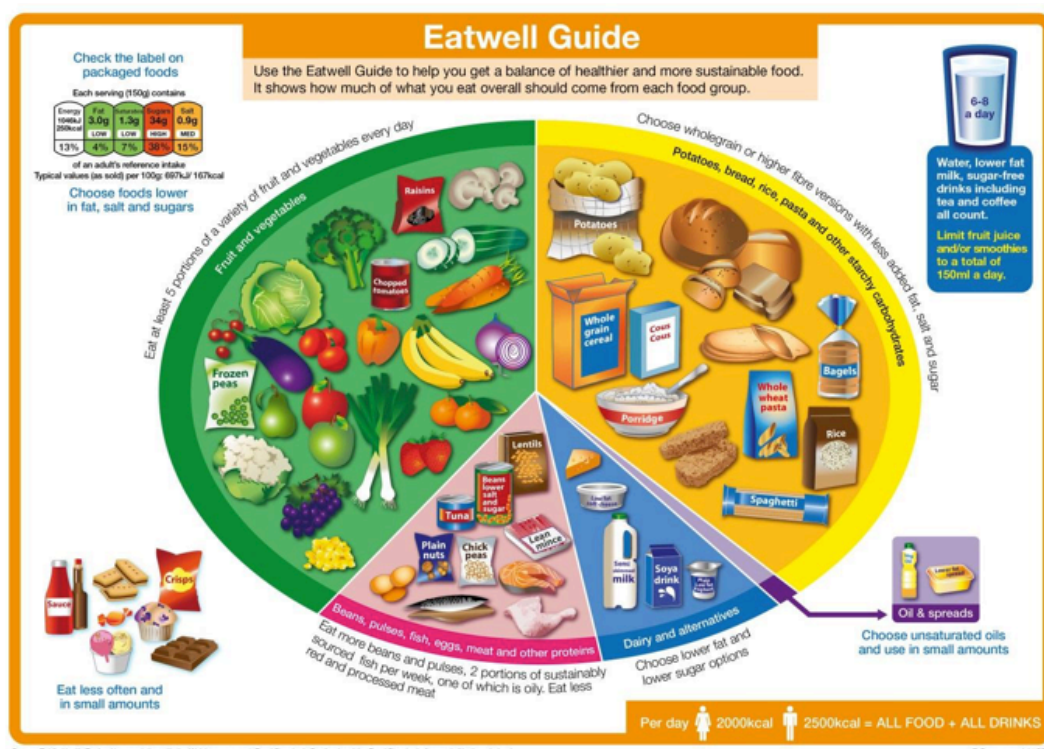
For more information see <https://www.gov.uk/government/publications/sugar-reduction-from-evidence-into-action>

Dr Alberto Mateo
Public Health Trainee, North West England.

EatWell Guide

In March of this year, PHE (Public Health England) launched an updated Eatwell Guide. The new guide shows the revised proportions of the food groups that help meet official advice and nutrient requirements. It replaces the eatwell plate and reflects updated dietary recommendations from the Scientific Advisory Committee on Nutrition (SACN) report on Carbohydrates and Health in 2015.

There is greater prominence for fruit, vegetables and starchy carbohydrates, preferably wholegrain. PHE recommends consuming 30 grams of fibre. Currently, people in the UK eat less than 2 thirds of this. Sugary soft drinks have been removed and foods high in fat, salt and sugar have been moved to the periphery of the guide, reflecting advice that they are not an essential part of a healthy and balanced diet. Currently in the UK adults have twice as much sugar as is



recommended and children have over 3 times.

The advice that only a 150ml serving of fruit juice counts as 1 of the recommended 5 portions of fruit and vegetables a day is now extended to include smoothies. The Eatwell Guide now displays drinks recommendations which make clear that adults should be aiming to have 6 to 8 glasses of fluids per day

ideally from water, lower fat milks, and unsweetened tea or coffee.

For more information see:
www.gov.uk/government/news/new-eatwell-guide-illustrates-a-healthy-balanced-diet
www.gov.uk/government/publications/sacn-carbohydrates-and-health-report

Ruth du Plessis
Public Health Trainee, UK

Telemedicine and virtual healthcare in Ireland

Virtual healthcare and telemedicine have burgeoned in Ireland in recent years, with many private companies offering online services including video General Practitioner (GP) consultations, prescriptions for medications and home testing kits for sexually transmitted infections (STIs). As an example, there are now at least seven different online companies offering STIs testing to individuals in Ireland without the need to see a doctor or health worker. Some of these companies are based in Ireland, others are based in other countries such as the UK.

Health insurance companies have come on board and many now have contracts with online GP consultation services offering video consultations with one of these companies as part of their health insurance package.

So what are the implications for health and health care in Ireland from the advent of such companies? Certainly there are

potential benefits to using online platforms in health and health care.

They have the potential to improve access to patients who live in rural or remote areas. In the area of STIs testing they may increase testing and treatment of STIs particularly in young people. Telemedicine may increase the number of patients who can be seen and treated during a given period of time, important at a time when many GPs in Ireland are emigrating to other countries.

Virtual platforms have been used to improve communication and delivery of healthcare between services. In Ireland, a pilot programme between family doctors and hospital specialists involving an online forum for discussion and advice on cases has been used to reduce admissions to hospital.

However, this new and developing field raises many questions for health and healthcare. Because these are private companies, without an established relationship with patients, the loss of the central

pillars of primary care that include continuity of care, the management of multi-morbidities, the doctor-patient relationship and the delivery of a holistic model of care are concerns. Testing for STIs through this system may also affect notification, contact tracing and sexual health promotion. Other questions arise; for example will rates of antibiotic prescribing increase, given that physical examination will not be possible in a video consultation for a respiratory tract infection?

There are many questions to be answered as to how the advent of such systems of delivering healthcare can affect health and healthcare in Ireland, both good and bad. It's an opportunity for Public Health in Ireland to engage with the issue as it is likely that telemedicine and virtual healthcare will continue to expand both in Ireland and internationally.

Chantal Migone
EuroNet MRPH Ireland

HIV Upsurge among People who Inject Drugs in Dublin

In 2015, a routine surveillance in Dublin identified a greater than expected number of recently acquired cases of HIV in people who inject drugs (PWID). Subsequent investigation revealed that between January 2014 and December 2015 60 cases of HIV had been notified in PWID in the Dublin region. Of these, 39 were confirmed to have recently acquired HIV; 74% (n=29) were registered homeless and 59% (n=23) were male. The cause of the outbreak was considered to be the use of a new psychoactive substance (NPS) 1-phenyl-2-(1-pyrrolidinyl)-1-

pentanone (α -PVP), also known as "snow blow", which was being used by 'chaotic' PWID. Snow Blow was independently associated with HIV infection, and there was a dose response effect. Sex with PWID and sharing needles were also independently associated with HIV infection.

Control measures included awareness raising among clinicians and PWID, intensive case finding and contact tracing, early treatment of HIV infection in those most at risk, greater promotion of needle exchange, frontline worker training and sensitisation about safe

injecting and safe sex. Notifications gradually reduced to background levels and the incident was closed in February 2016. However, many of the risk factors which predisposed to the upsurge – drug use, homelessness – remain, and longer term measures are required if a recurrence of HIV in this vulnerable population is to be prevented.

For more information see article: Giese et al., Euro Surveill. Oct 8 2015; 20(40).

Ronan Glynn
on behalf of the outbreak control team

BCG Vaccination Policy in Portugal: What is at stake?

Since May 2015, Portugal has faced problems in providing vaccines against tuberculosis (BCG vaccine), compromising compliance with the guidelines of the National Vaccination Programme. New vaccine doses are now available, but since they're coming in limited quantity, it was necessary to prioritize BCG vaccination of neonates and infants of recognized high-risk groups for tuberculosis. This change of strategy in the BCG vaccination may be of exceptional character, but is it only a matter of time before it becomes permanent? What is at stake?

The BCG vaccine, first used in 1921, remains the only licensed vaccine against tuberculosis (TB), providing protection against severe forms of TB in children, including tuberculous meningitis and disseminated TB. However, its protective effect against pulmonary TB, the most common manifestation of this condition, is much more modest and variable. It also does not prevent reactivation of latent tuberculosis infection, therefore having little impact on TB transmission in the community

The BCG vaccine is one of the most widely used vaccines worldwide and has been given mainly to all newborns, following a universal strategy, to all newborns (except if contraindicated). By the 1980s and the 1990s, significant decrease in tuberculosis incidence led several countries to change this vaccination policy to selective vaccination of newborns and infants of recognized high-risk groups for TB.

Indeed, the World Health Organization (WHO) Position Paper on BCG vaccine states that such changes may occur in countries with low endemicity of tuberculosis, provided that the criteria set by the International Union Against

Tuberculosis and Lung Disease are observed, and other disease control measures are strengthened - early diagnosis (enhanced surveillance), appropriate treatment (quality of and access to health care), contact tracing, among others.

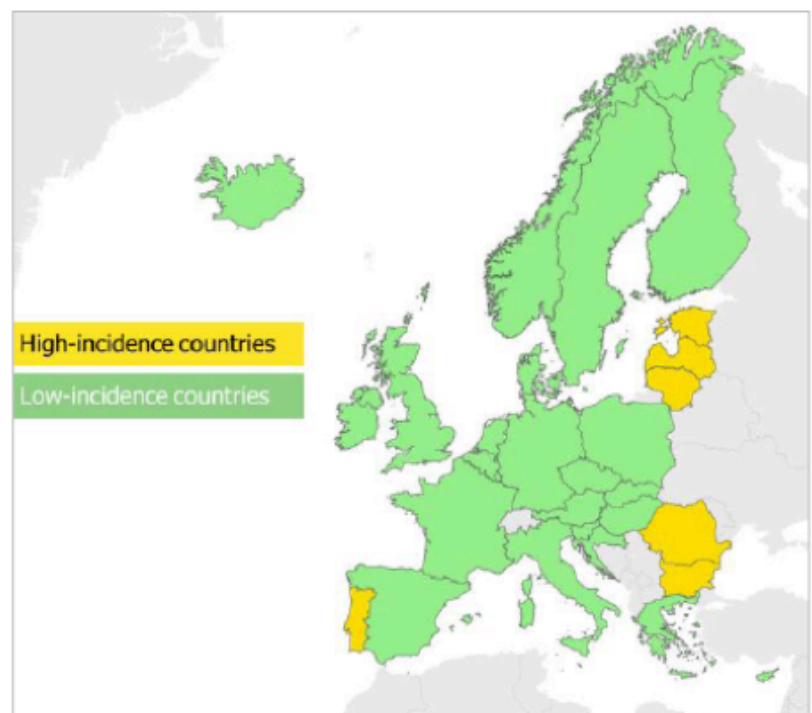
Portugal already meets some criteria for suspending the universal BCG vaccination, namely, an efficient notification system and an average annual notification rate of tuberculous meningitis in children aged less than 5 years below 1 per 10 million population, during the last 5 years. In relation to tuberculosis burden, there was a notification rate of 21.8 cases per 100 000 population in 2014, which places the country near the threshold to become a low incidence TB country, according to the European Centre for Disease Prevention and Control (reporting rate <20 cases / 100 000 inhabitants – figure 1). Still, even though this is the national scenario,

there are 4 districts – Lisbon, Porto, Setúbal and Algarve – with TB incidence rates far higher than the national average.

Under these circumstances, although we are closer to the path towards pre-elimination of TB, we cannot overlook the presence of tuberculosis in our community, so it is important to maintain and improve disease control strategies. Nevertheless, for as long as the constraints in the supply of vaccines remains, we have no choice but to prioritize vaccination of neonates and infants of high-risk groups for tuberculosis, since they benefit, individually, from vaccination.

Ana Lúcia Figueiredo

Public Health Trainee, Portugal



High-incidence countries: countries reporting 20 or more TB cases per 100 000 population; low-incidence countries: countries reporting under 20 TB cases per 100 000 population

Lies, damned lies, and statistics. Hacking the P-value.

In chapters from 'my Autobiography' Mark Twain says: "there are three kinds of lies: lies, damned lies, and statistics." [1] Twain's statement about the use and the misuse of statistics couldn't have been more farsighted.

On February 2016, 177-year-old American Statistical Association (ASA) released a statement [2] (followed by a scientific publication [3]) issuing guidelines of p value to conduct and interpret quantitative science. P-value is misused.

P-value is usually used to test (and possibly dismiss) the "null hypothesis". If the statistical test of two groups or pair of characteristics results in a P-value below 0.05, the null hypothesis is usually dismissed, (depending on the level of significance intended): there is a relationship between the two groups (or the two characteristics) that is not attributable to mere chance. On more practical basis, we want to test the association between two factors, for example age and injectable drug use in two comparable groups issued from a specific population. If our statistical test results in a p-value of less than 0.05, the association between the two factors is usually statistically significant. However, a significant P-value doesn't provide any information about the strength of the relationship between the two factors, neither about its direction.

Criticism of the p-value is not new. On February 25th, 2015, the journal Basic and Applied Social Psychology issued an editorial [4] banning P-values and confidence intervals from all future papers. Undoubtedly these drastic steps could seem counterproductive but they have the merit to start the

debate. Without proposing a ban of P-value results, the American Statistical Association observes "good statistical practice is an essential component of good scientific practice". Meanwhile its executive director, Ron Wasserstein, explains that "well-reasoned statistical arguments contain much more than the value of a single number and whether that number exceeds an arbitrary threshold. The ASA statement is intended to steer research into a 'post $p < 0.05$ era". In other words, P-value should not substitute scientific reasoning but it should come together with numerical and graphical summaries of data, interpretation and understanding of the phenomenon under study and its results in context.

Wrong P-value reporting is helping "bad" science being published: without information and with only P-value results, nonsignificant data can easily make its way through publication. Stanford meta-researcher John Ioannidis and colleagues found an increasing number of articles reporting P-values over time[5]. Almost all articles and abstracts with P-values reported statistically significant results while confidence intervals, Bayes factors, or effect sizes were rarely mentioned. The explanation to this phenomenon has already its own name: publication bias (for statistical significance). Daniël Lakens in a 2015 paper published by PeerJ [6] defines publication bias as 'tendency to publish statistical significant results, both because authors are more likely to submit these results and reviewers and editors to evaluate more positively these manuscripts'. In the way

publication bias sacrifices reproducibility (the ability to recompute results) and replicability (the chances other experimenters will achieve a consistent result) to publication itself[7], addressing this issue is urgent.

Statistics are a core part of Public Health and although P-value debate could be perceived as "pure statistics", it is not.

Public Health ranges from epidemiology to hygiene, from biostatistics to health promotion. It is not a unitary, monolithic discipline and it requires a multidisciplinary approach to the "P-value gate", in order to provide the best answers to each subdiscipline.

Specialists in public health should join the debate, proposing solutions.

Damiano Cerasuolo
Euronet France

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[1] https://en.wikipedia.org/wiki/Lies,_damned_lies,_and_statistics

[2] <http://www.amstat.org/newsroom/pressreleases/P-ValueStatement.pdf>

[3] Ronald L. Wasserstein, Nicole A. Lazar. The ASA's statement on p-values: context, process, and purpose. The American Statistician. <http://dx.doi.org/10.1080/00031305.2016.1154108>

[4] David Trafimow & Michael Marks (2015) Editorial, Basic and Applied Social Psychology, 37:1, 1-2, DOI: 10.1080/01973533.2015.1012991

[5] Chavalarias D, Wallach J, Li A, Ioannidis JA. Evolution of Reporting P Values in the Biomedical Literature, 1990-2015. JAMA. 2016;315(11):1141-1148. doi:10.1001/jama.2016.1952.

[6] Lakens D. (2015) On the challenges of drawing conclusions from p-values just below 0.05. PeerJ3:e1142 <https://doi.org/10.7717/peerj.1142>

[7] Jeffrey T. Leek and Roger D. Peng Opinion: Reproducible research can still be wrong: Adopting a prevention approach. PNAS 2015 112 (6) 1645-1646; doi:10.1073/pnas.1421412111

Computer literacy and public health education: from an Italian project to an Euronet MRPH workgroup

Public health informatics (PHI) has been defined as the systematic application of information and computer science and technology to public health practice, research and learning.

While most fields of training received by residents in Public Health (PHR) are widely known, there is a gap in knowledge concerning the applied medical informatics, computing and technology skills (both theoretical and practical) required to a Public Health specialist. Indeed, those skills are necessary for the public health practice, for instance to support informed decisions regarding software, technologies and for data managing. Therefore, a clear definition of the demanded operative competencies and the relative training in PHI is needed.

A first list of competencies was defined by the CDC in August 2002. Another list was redacted in 2014 by the Council on Linkages Between Academia and Public Health Practice (together with other competencies required to the PHR). In Italy, the residency lasts 4 years. During this period, the residents receive a mandatory "core education" (mainly with courses and seminars) provided by their own school. Moreover, they can attend different public health services (mainly in hospital and primary care settings).

Last year the Italian Public Health residents' association instituted a workgroup in "Public Health Informatics". The team drafted a list of competencies and elaborated a questionnaire, investigating the perceived acquired skills, the informatic workplace, the personal attitude towards mobile technology

and the satisfaction for the received education. The questionnaire was administered to the members of the Committee for a pilot study. Some observations from that preliminary study were extremely interesting. For instance, in Italy, despite a course dedicated to PHI, required by the ministerial decree which regulates Public Health residents' education, it is offered only in two-thirds of the schools of specialization in Public Health. While most of the schools provide a proper informatics workplace, this is not always true for the place of training, where it is often defined as "not accessible" or "inadequate". Moreover, the acquired competencies were not considered satisfactory, particularly those concerning research tools (utilization of statistical software, database management, knowledge of computational epidemiology and so on), electronically medical records' ethical and legislative's implications, and emergent technologies such as those involved in telemedicine.

In conclusion, in Italy we found big differences from school to school

and some huge gaps in the PHI education and in residents' acquired skills. The next step will be to define the competencies and to assess the training in Public Health Informatics for residents in Public Health of the EuroNet countries. During the last EuroNet meeting in Zagreb, a workgroup in "Public Health Informatics" was instituted. The team is currently composed by 9 members from 5 countries: France, Spain, Croatia, Poland and Italy. The group is in charge of adapting the questionnaire to each Country and creating a standard and reliable tool to assess education (in terms of courses and programmes).

Our aim is to expand this rising network. We hope to extend the participation to other countries. If someone coming from different countries or with relevant technical skills in this field is interested in collaborating, they can contact Paola Anello, the contact person of the workgroup.

Francesco D'Aloisio
Paola Anello
EuroNet MRPH, Italy



Scottish International Development Policy

To coincide with Global Goals for Sustainable Development, Scottish Government is reviewing its international development policy. In 2005 the government developed its first strategic international development work, initially developing a partnership with Malawi (a country that has had long historical links with Scotland), but over the following ten years included six other countries in sub-Saharan Africa and south Asia.

Scotland is considering the future direction of international development, work on climate change, and has focused on areas where Scotland has traditionally had

areas of strength. This includes health, education, and renewable energy. Furthermore, there are changes within Scotland itself – last month, a new national centre for climate change and resilience has opened, and there is a move to integrate more overseas experience within junior doctor education. Scotland has learned from its international partners too, introducing microfinance in its most deprived areas in conjunction with Professor Muhammed Yunus and the Grameen Bank from Bangladesh.

Although the Scottish contribution to international development is modest

(£9m/year), it is based upon strong long-term relationships, using natural links and expertise from Scotland, and a belief that the same model and values used with the context of international development can be used across all government policy. It will be interesting to see how this targeted approach to development is evaluated in future years.

For more information see:
<http://www.globalgoals.org>

Andrew Rideout
Public Health Trainee, Scotland

‘Parc Matters’

Parc Prison is Britain’s biggest custodial establishment, housing around 1700 men at any one time. This year the British Red Cross and Public Health Wales have linked up with G4S for a new project called Parc Matters!

Parc matters’ is a 4-month programme, with an on-going 12-month calendar of health events. Initially prisoners are trained as British Red Cross volunteers, and in the 12 months which follow the volunteers focus on different health topics; educating their peers in the prison about disease prevention, health protection and healthy behaviours. There is a focus on mental health, wellbeing and building a community spirit in the prison alongside improving physical health.

Parc matters is based on an award-winning programme implemented by the Irish Red Cross, the Irish Prison Service and Education Training

“I’d like to continue with the Red Cross on the outside if possible. I don’t want to go back to the old me, the old lifestyle – that will never happen.”

(Red cross volunteer with Parc Matters)

Boards. The project, which began in Wheatfield Prison in 2009, has seen a significant increase in health awareness and prisoner’s wellbeing. It was extended to all 14 prisons in Ireland in 2014 and since its implementation has recruited over 720 Irish Red Cross volunteer prisoners. It benefits over 4,000 prisoners daily and 12,000 indirectly including staff and the families of the prisoners.

The Parc Matters programme has been hugely successful so far in

Wales. We hope to continue to roll it out following the Irish model. Watch this space!

Joanne McCarthy
Public Health Trainee, Wales

All you need to know about EuroNet MRPH - 2016

Overview

The European Network of Medical Residents in Public Health (EuroNet MRPH) was founded in 2011 and is led by residents in Public Health across Europe. It is a unique independent organization representing associations of medical residents in public health throughout Europe. Over two thousand medical residents in public health are represented, through their National Member Associations (NMA).

EuroNet MRPH was created to empower its members to take their vision and ideas forward. Engaging in EuroNet MRPH encourages both professional and personal collaborations irrespective of geographical or cultural differences.

Mission Statement

Our mission statement is to promote professional excellence among medical residents in public health in Europe by exchanging scientific knowledge and training opportunities and by facilitating collaborations.

History

The initiative emerged in 2008 when French and Italian residents decided to collaborate on a common survey protocol to investigate public health residents' views and satisfaction with their respective training programmes.

This successful experience brought about the idea of extending this kind of collaboration to other projects and countries. Spanish residents joined the group in 2009.

The first meeting that saw the establishment of the network was held in Paris, France, in June 2011. The first members of this new organization were the Collège de Liaison des Internes de Santé Publique (CLISP, France), the

National Member Associations (NMA)

Hrvatsko društvo za javno zdravstvo (HDJZ)	
Collège de Liaison des Internes de Santé Publique (CLISP)	
Association of Public Health Medicine Registrars in Ireland (APHRI)	
Consulta degli Specializzandi (SITI)	
Comissões de Médicos Internos de Saúde Pública (CMISP)	
Asociación de Residentes de Medicina Preventiva y Salud Pública (ARES)	
Landelijk Overleg Sociaal-Geneskundigen in Opleiding (LoSgio)	
The Education Committee of the UK Faculty of Public Health	

Consulta degli Specializzandi (SITI, Italy) and the Asociación Española de Residentes de Medicina Preventiva y Salud Pública (ARES, Spain).

Since then the network has expanded to include the Specialty Registrars' Committee (SRC) of the Faculty of Public Health (UK) on November 2011, the Comissões de Médicos Internos de Saúde Pública (Portugal) on May 2012, the Association of Public Health Medicine Registrars in Ireland (Ireland) on March 2014 and Hrvatsko društvo za javno zdravstvo (Croatia) in 2015. The network is looking to expand further.

Leadership

EuroNet MRPH is composed of the Executive Desk (ED) and the Executive Committee (EC).

Each NMA delegation is composed of six residents. Two of them sit on the ED. There are rotating posts (president, vice-president, secretary, treasurer and communications lead and internships lead).

The ED has regular tele-meetings. The ED and the EC meet at least three times

a year to make key decisions on EuroNet's strategic priorities, vote on EuroNet's policies, exchange knowledge and work on various



New ED 2016

President: Fiona Cianci

Vice-President: Alberto Mateo

Secretary: Alicia González Antelo

Treasurer: Damiano Cerasuolo

Research: Paola Anello

Communications: Miguel Cabral

Internships: Damir Ivankovic

Aims

- To strengthen the role of public health residents in Europe
- To advocate for improvements in training programmes
- To facilitate internships in European and international organisations
- To define and achieve a common core of professional competences for Public Health residents in Europe
- To provide a platform to link medical residents across Europe working on public health projects
- To continue the expansion of the network

All you need to know about EuroNet MRPH - 2016



Activities

Exchanging working practices and scientific knowledge

- Presentations at training events, national and international conferences
- Facilitation of collaborative projects between European residents
- Maintenance of a website with information about residency programmes in each member country and past and ongoing EuroNet projects
- Publication of a quarterly newsletter « EuroNews MRPH » disseminated through the NMA networks

Facilitating training opportunities across borders

- Maintenance of a database of placements in each member country that is available on the website
- Facilitation and information sharing regarding placements at international organisations (e.g. WHO, ECDC, EPHA, EUPHA)
- Dissemination of information through social media (twitter, facebook, linkedin)

Current Working Groups

- *Competencies in Public Health Informatics;*
- *internships development.*

**Want to join us?
Want to start a european project?**

EuroNet MRPH always welcomes **observers** to its meetings.

Please contact your National Association or your NMA liaison officer!

Team 2016 EXECUTIVE DESK



Residents 1 assuming an official position per country 1 NMA Liaison Officer

EXECUTIVE COMMITTEE



Residents per country



IRELAND

Fiona Cianci – ED – President
Naomi Petty-Saphon – ED
Eve Robinson – EC
Chantal Migone – EC
Lois O'Connor – EC
Abbey Collins – EC



SPAIN

Alicia González Antelo – ED – Secretary
Elena Ojeda – ED
Efraín Pantoja – EC
Paula Peremiquel – EC
Julio Muñoz – EC
Fátima Mori – EC



FRANCE

Damiano Cerasuolo – ED – Treasury
Hélène Rossinot – ED
Paul Bregeant – EC
Pauline Boucheron – EC
Laetitia Satilmis – EC
Jordan Scheer – EC



PORTUGAL

Miguel Cabral – ED – Communication Lead
Rita Sá Machado – ED
Francisco Pavão – EC
Tiago Adrego – EC
Sara Cerdas – EC
Guilherme Duarte – EC



ITALY

Paola Anello – ED – Webmaster, Research Lead
Michela Longone – ED
Davide Golinelli – EC
Eleonora Porzio – EC
Giuseppe Spataro – EC
Francesco Aquino – EC



UNITED KINGDOM

Alberto Mateo – ED – Vicepresidency
Ruth Du Plessis – ED
Caroline Tait – EC
Joanne McCarthy – EC
Andrew Rideout – EC
Helen Green – EC



CROATIA

Damir Ivankovic – ED – Internships Lead
Vesna Stefancic – ED
Maja Vajagic – EC
Zeljka Drausnik – EC



THE NETHERLANDS

Titia Van't Hof – ED
Ashis Brahma – EC
Lilian van der Ven – EC
Daisy Ooms – EC

Coming soon



**EURONET
MRPH**

**Summer Meeting
The Netherlands
8-9-10 July 2016**

**Location:
Dennendijk 12 Warnsveld**



three days, two nights together in a farmhouse

- scientific meeting
- please send a presentation, name and an abstract you want to talk about to the email below.
Min 1 per country!
- public health speaker (s)
- at night BBQ and campfire
- near "hanzesteden" Zutphen & Deventer
- social program

for more information: euronetmrphnetherlands@gmail.com





Landelijk Overleg Sociaal-Geneskundigen in Opleiding

Get involved!

EuroNet MRPH is present in 8 countries in Europe. The easiest way to start your EuroNet MRPH career and be part of us is approaching your national representatives by viewing the contact details of your NMA. Then you can have a look at our core activities to check out the different areas we are involved in.

If any questions arise, feel free to contact us !

euronetmrph.org

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MRPH