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Editorial

Dear EuroNet Members, Friends and Colleagues,

Thank you for showing interest in our work by taking time to read the 11th issue of the EuroNet MRPH newsletter.

In the current issue you can find a number of interesting articles, opinions and updates by EuroNet members from around Europe. Topics covered in the present newsletter range from infectious diseases and vaccination issues, health informatics, to public health education and training.

EuroNet MRPH is based on three main pillars of activities: networking, research and international internships. A lot has been (and will be) done in each of this domains.

Thanks to an immense engagement by our French colleagues, in early April we held the spring meeting in Strasbourg, France. Besides amazing lectures, valuable EuroNet "*housekeeping*" work and a unique opportunity to present the EuroNet Platform in the European Parliament, this meeting saw the biggest ever number of EuroNet delegates in one meeting.

A cooperation between EuroNet and Canadian PHCP, prudently initiated by our previous president Fiona, was solidified by signing a Memorandum of Understanding and we look forward to start identifying and using all the opportunities made possible with this new collaboration.

The Association of Public Health Schools in Europe, ASPHER, has also recognized EuroNet as an important "*player*" in the Public Health residency and education landscape and invited us to participate in their annual Dean's retreat as well as continue cooperation on a number of interesting topics.

Next big thing for EuroNet is of course our summer 2017 Meeting in Motovun, Croatia. Join us!

Damir, Alberto, Lilian, Damiano
Euronet MRPH 2017 Board

Health equity: how to build it? The successful experience of a course in Italy

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In the last few decades, there has been a clear and constant improvement in the health of the Italian population. Nevertheless, there are still significant differences in the health outcomes of the various social groups: the people that are wealthier, educated, resident in non-deprived areas, and endowed with socio-economic resources and opportunities, generally, have the best health profile.

The first residential course "Health inequalities: recognize, evaluate and contrast them" took place in Rome from 18th to 20th May 2017.

The course was organized by a group of Public Health Residents in collaboration with the Consulta, a Public Health Residents' association, which is a section of the SItI (Italian Society of Hygiene and Preventive Medicine) devoted to residents, and the Service of Epidemiology ASL TO3 - University of Turin. The purpose of the course was to:

- introduce and design initiatives to contrast avoidable health inequalities, with particular reference to the objectives of the Italian National Prevention Plan;
- to enable participants to measure health inequalities and to identify the mechanisms that generate health inequalities and the most effective interventions and policy measures;
- to prevent and/or counteract them, through Health Equity Audit methods and tools.

Interactive teaching methods were really appreciated by all participants who came from 17 Italian Universities of 11 different Regions. The group will rely on networking to improve the training and develop research projects.

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3. Giuseppe Costa, Morena Stroscia, Nicolás Zengarini, Moreno Demaria. 40 anni di salute a Torino, spunti per leggere i bisogni e i risultati delle politiche

Croatian National Public Health Information System

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Highly functional Public Health Information System (PHIS) is the basis for Public Health policy making as well as health care system management in general. Establishing a National PHIS is an integrated effort to collect, process, report and use health information and knowledge to influence policy-making, programme action and research. Croatian Institute for Public Health (CPIH) set out to plan, develop and implement a new National PHIS in 2014.

Croatian National Public Health Information System (Nacionalni javnozdravstveni informacijski sustav - NAJS) is a cloud platform of information services and processes developed and managed by the Croatian Institute of Public Health, which supports:

- Management of health registries (design, collection of data, analytics and information production),
- Strategic planning, process coordination and management (human and material resources),
- Early detection and rapid response (infectious diseases, epidemics and vaccination side effects surveillance),
- Chronic disease surveillance (cancer, psychoses, HIV/AIDS),
- National citizen services (vaccination track as part of the eCitizen and national EHR projects),
- Healthcare quality control and management (e.g., pregnancy track and eNewborn projects and effect on perinatal mortality rate) and
- Other advanced services and processes.

Situation found, prior to establishment of NAJS platform, was a cluster of legacy public health registries and records lacking cohesion, developed historically in a piecemeal way and shaped by administrative, economic, legal or payer influences.

CIPH, as a national public health information authority, operates as one of the stakeholders in the wider healthcare information management context. This commits CIPH to continuous improvement of its interoperability capacity towards other healthcare institutions as well as other public institutions and private economic entities.
NAJS hosts all patient registries managed by CIPH on one platform. The platform also includes all solutions and services that help to support the functioning of these registries. In this way, NAJS provides an environment for improved interoperability on all levels of registry management and the conditions for a more efficient use of resources and improving the professional purpose of registries.

The expert ICT subsystem, within the platform, consists of 15 patient registries divided into seven business domains as shown in Table 1.

Table 1: List of NAJS platform domains and registries

Business domains	Registries
	Croatian infectious disease reporting system
	Legionellosis registry
	Tuberculosis registry
	Vaccination (side effects) registry
HIV / AIDS domain	HIV/AIDS registry
Healthcare resources domain	National registry of healthcare providers
Causes of death domain	Cause of death registry
	Suicide registry
Disability domain	Persons with disabilities registry
Malignancies domain	Cancer registry
Hospital domain	Hospitalization, rehabilitation and day-care registry
	Terminations of pregnancy registry
	Birth registry
	Psychosis registry

NAJS platform also includes and uses a number of shared services:

- Intra- and interdomain linkage (achieved through unique person identifiers);
- Linkage to external resources and services;
- Centralized codebook managements system;
- Centralized file upload system and;
- Customer support Service Desk application.

Intra and interdomain linkage between registries provides users and other stakeholders with new analytical capabilities thus improving registries' primary purpose by linking individual data and indicators between registries.

Linkage to the services of external resources enables easier, faster and more accurate data collection, sharing and use of data from the registries. External resources, linked to the NAJS platform, include:

- Unique person identifier service of the Ministry of Finance;
- The data from the Croatian Pension Insurance Institute;
- The data of the Croatian Health Insurance Fund;
- Linkage to eNewborn project and;
- The spatial data infrastructure of the State Geodetic Administration.

Repeatedly mentioned traceability at the level of central file upload, codebook management and customer support is an important tool for increasing the efficiency of the platform functioning in the current setting as well as in analysing and improving the platform in the future.

All NAJS domain functionalities have to meet specific business needs either by:

- Improving surveillance capacities,
- Enabling standardization of data in accordance to international monitoring and reporting obligations,
- Linking and sharing with NAJS domains or basic state registries or
- Ensuring continuity of reporting.

Slovenia declared free from rabies: a new approach to rabies prevention

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Slovenia has declared itself free from rabies in 2016, since no case of indigenously acquired rabies virus infection has been confirmed in wildlife or domestic animals during the past two years, which is in accordance with Terrestrial Animal Health Code of World Organization for Animal Health (OIE) (1,2). The self-declaration of Slovenia being free from rabies brought some changes to the management and treatment of animal bite victims. We expect to see a decrease in the number of vaccine doses for post-exposure prophylaxis, since now there is a very low risk of contracting rabies after an animal bite in Slovenia.

WHO recommendations for rabies prevention

The most effective measures for preventing human rabies deaths are eliminating the risk of rabies at its source by vaccinating dogs and wildlife animals and allowing access to appropriate post-exposure treatment (3). Since their development more than four decades ago, concentrated and purified cell-culture and embryonated egg-based rabies vaccines have proved to be safe and effective in preventing rabies. The indication for post-exposure prophylaxis depends on the type of contact with the suspected rabid animal (4).

Rabies in Slovenia

Dog-mediated rabies in Slovenia was eradicated soon after World War II. Vaccination of dogs against rabies has been compulsory since 1947 and together with the implementation of strict measures to manage the stray dog population, it resulted in the elimination of dog-mediated rabies in 1954. Oral rabies vaccination of foxes and wildlife was implemented in 1988. Vaccine baits were first distributed manually. In 1995, a new strategy to combat rabies was implemented. The aircraft distribution of rabies vaccine baits began and has been in place since then. As a result of the new strategy, the number of rabies cases significantly decreased. Nevertheless, individual cases were detected in the areas along the southern and eastern borders until 2013, when the last case of indigenous rabies was diagnosed in Slovenia (2).

Data on human cases of rabies in Slovenia are available since 1946. 14 persons died from rabies in the years 1946 to 1950. The last case of human rabies in Slovenia was confirmed in 1950 (5).

Current recommendations and practices in Slovenia

Since Slovenia was declared free from rabies, there have been some changes in managing and treating animal bite victims. The number of post-exposure vaccination doses has decreased, which is expected and in accordance with the decreased risk of contracting rabies in Slovenia.

Besides implementing changes in the national guidelines for preventing rabies, there is also a need to review laws and regulations and adjust

Barbara Din

them to the new epizootic situation of rabies in Slovenia. We are obligated to abide by the current laws, which do not take into consideration the new free-of-rabies-status. It would be a waste of resources to administer unnecessary post-exposure vaccination.

Even though Slovenia was declared free from rabies, risk assessment still needs to be performed by a medical expert for every bite victim, because the risk of rabies importation from neighbouring countries remains. Despite the favourable epizootic situation, it is vital to continue with the effective veterinarian measures, as this is the only way, Slovenia will retain the free-of-rabies status.

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Hepatitis A: the role of sexual transmission in progression of the outbreaks in Europe

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Hepatitis A is an acute, usually self-limiting infection caused by the hepatitis A virus (HAV). Transmission is predominately by the faecal-oral route, either by consumption of contaminated water or food-products or through direct contact with an infectious person (1). Transmission through sexual exposure has been associated with outbreaks in men who have sex with men (MSM) since the 1970s (2). The main risk factor is related to direct oral-anal contact during sexual activity (3).

Between 1 June 2016 and 16 May 2017, 15 EU countries (Austria, Belgium, Denmark, Finland, France, Germany, Ireland, Italy, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden and the United Kingdom) have reported three clusters involving 1 173 HAV confirmed cases, associated with three different HAV genotypes. Each of these clusters involve between ten and fifteen different EU Member States. Most cases are reported among HAV-unvaccinated adult MSM, although evidence already exists for secondary cases among the general population (3).

Recent scientific evidence indicates unvaccinated MSM as the European population group most at risk of being affected by these clusters (4,5). In particular, anonymous sex, multiple sex partners, sex-on-premises venues and social networking (dating apps) are revealed as factors associated and potential drivers of these outbreaks (4).

The multinational dimension of these clusters highlights the interconnectedness of MSM in Europe and the need to increase coverage of hepatitis A vaccination in this group (3,5). The actual level of immunity among the MSM population in Europe remain unknown (3). It has been estimated that a level of immunity greater than ~70% among the MSM population would prevent sustained transmission and future outbreaks (6).

It's also important to provide post-exposure prophylaxis to identified contacts of cases that are linked to the outbreaks in order to prevent secondary cases (3). In the context of a global hepatitis A vaccine shortage, information on vaccine availability should be included in health promotion programmes targeting MSM, particularly at sex venues (7).

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Measles outbreak in Portugal

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Measles is a disease with a possibility of elimination given its exclusively inter-human transmission and the existence of an effective and safe vaccine; however, it remains endemic in several Asian and African countries. In Europe, the World Health Organization (WHO) in 2005 implemented the Measles Elimination Program, targeting the year 2010(1).

This target changed to 2015 as the epidemiological situation worsened, with outbreaks in the majority of European countries (1,2). Although the situation in WHO region, the elimination of measles in Portugal, was achieved in 2015, with the last known cases in 2005, and in all, the infection originated abroad (3).

This goal reached with the introduction of measles vaccine on National Vaccination Program (NVP) in 1973, keeping it until today (3,4). Besides a national coverage of 97%, the existence of unvaccinated communities placed Portugal at risk of the occurrence of a measles outbreak (4-6).

Following the measles outbreak of Europe in current year, Portugal reported for the first 3 months, 134 notifications with 28 confirmed cases. Of these cases, 18 (64%) were aged ≥ 18 years, 17 (61%) were unnvaccinated, 12 (43%) were healthcare workers, 13 (46%) were hospitalized and one deadly case in a 17-year-old girl who was not vaccinated (6).

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Gaps in Vaccination Coverage: Increasing awareness about Measles Outbreaks in Europe

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Measles is an acute, highly contagious viral disease capable of causing epidemics. Infectivity is close to 100% in susceptible individuals and in the pre-vaccine era measles would affect nearly every individual during childhood. Immunisation has dramatically reduced the incidence of measles in Europe, but despite overall high immunisation coverage, measles continues to cause frequent outbreaks. Globally, measles remains a leading cause of childhood deaths and an estimated 160000 children die each year from complications of the disease (1).

Between 1 April 2016 and 31 March 2017, 30 EU/EEA Member States reported 6597 cases of measles. The highest number of cases was reported by Romania (3072), Italy (1314) and Germany (711) – respectively 47%, 20% and 11% of the EU/EEA cases in the 12-month period. In 11 EU/EEA Member States the number of cases reported in just 3 months in 2017 has exceeded the number of cases reported during the entire 2016 (2).

Of all cases with known age (5876), 2426 (41%) were children less than 5 years of age, while 2208 (38%) were aged 15 years or over. Of all cases with known vaccination status (6133), 88% were unvaccinated and 8% were vaccinated with one dose. The proportion of unvaccinated cases was highest among children below one year of age (95%). In the target group for the first dose of routine childhood MMR vaccination (1-4 year-old), 85% of the cases were unvaccinated and 11% were vaccinated with one dose. Sixteen deaths due to measles were reported during the 12-month period, all in Romania (2). In April and May 2017, 2 additional deaths occurred due to measles: 1 in Germany and 1 in Portugal (3).

Measles continues to spread across Europe because the vaccination coverage in many EU/EEA countries is suboptimal: in 12 of 27 EU/EEA countries it was below 95% for the first dose and, for the second dose, in 15 of 23 EU/EEA countries reporting data. Infants are particularly vulnerable to complications of measles and are best protected by herd immunity which is achieved when population coverage for the second dose of a measles-containing vaccine is at least 95% (2).

Immunisation is the only effective preventive measure against acquiring measles, so routine immunisation needs to be strengthened by facilitating access to vaccination, and mechanisms to identify people who are not or are incompletely vaccinated are needed (2). Due to this outbreak countries are already reinforcing their legislation: Italy will be making vaccinations mandatory for all school children (4), in Portugal all schools will need to inform the Local Health Authority if the student don't

have the immunisation schedule updated (5) and in Germany who fail to seek medical advice on vaccinating their children could face fines of up to €2500 (6). It's important to continue to ensure timely surveillance of measles because it helps guide public health actions and is critical to disease control.

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Public Health in complex emergencies: measles immunization

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Many different scenarios can be thought as a Complex - Humanitarian - Emergency (CE), ranging from acute or chronic conflicts causing population displacements, droughts resulting in famine, to infectious diseases' epidemics and so on. The Inter-Agency Standing Committee (IASC) defined a CE as "a humanitarian crisis in a country, region, or society where there is a total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single agency and/or the ongoing UN country programme" (1). Despite efforts to provide medical and public health services to populations affected by CE, significant morbidity and mortality persist, where health needs of children and adolescents are critical to the success of relief efforts and reduction in mortality. The highest excess morbidity and mortality often occurs during the acute phase of the emergency. Death rates of over 60-fold the baseline have been recorded in refugees and displaced people, with over three-quarters of these deaths caused by communicable diseases (2). Measles has been one of the major causes of child deaths in CE and further contributes to mortality by exacerbating malnutrition and vitamin A deficiency. Many deaths attributed to diarrheal disease and pneumonia may also be associated with measles. In the past, measles case-fatality ratios in children in humanitarian

emergencies have been as high as 20-30% (3). As a result, measles outbreaks are a major killer during complex emergencies, accounted for 53% and 42% of deaths in refugees in eastern Sudan and Somalia in 1985, respectively (4).

The current strategy for preventing the spread of communicable disease in CEs focuses on the provision of sanitation, clean water, and access to basic medical therapies. Measles is the only vaccine applied nearly universally in CEs. All other vaccines are considered for implementation using a decision-making tool designed by the Strategic Advisory Group of Experts on Immunization (SAGE) at the WHO, which uses a three-part algorithm of geographic factors, disaster types, and host factors to select appropriate vaccines in acute humanitarian emergencies (5).

The main goal of a measles vaccination campaign is to prevent outbreaks, and therefore it should aim for 100% coverage. As population movements in CEs are frequent and data on baseline vaccination coverage could be unreliable, the target group for a measles vaccination campaign is every children from 6 months to 14 years regardless of their immunization status. At a minimum, children from 6 months through 4 years of age must be immunized. The choice of the ages covered will be influenced by vaccine availability, funding, human resources and local measles epidemiology (8). Besides the vaccine an appropriate dose of vitamin A shoud be given as soon as possible. When planning a measles vaccination campaign, 3 steps are to be considered: estimate the target population, define immunization strategy, based on local context and needs and estimate resource needs in terms of vaccines, equipment and logistics and human resources (6).

Because of these strategies, early immunization against measles has significantly decreased all-cause morbidity and mortality and measles now rarely ranks among the top three causes of death in CE (7). The successes of measles campaigns led to a joint statement by the WHO and UNICEF that measles vaccination be considered an urgent priority in complex emergencies, and that expanding immunization to all children 6 months through 14-years is a “right to survival and good health” (6).

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Italy makes 12 vaccines mandatory for school children

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Since the social trend in portraying vaccines as disease-causing and consequential vaccination compliance's decrease spreading across the country, the Italian government framed a new decree law to break down this not comforting scenario.

The entering-into-effect regulation was launched on May 19th: its aim is to grant a homogeneous vaccination rate in all twenty Italian regions, through «measures designed to contain, reduce, and prevent risks for public health, with particular reference to epidemiological safety conditions in term of prophylaxis and vaccination coverage», as reported by the Italian Ministry of Health.

Hence, the government opts to enforce vaccination policies making as mandatory up to twelve vaccines: polio, diphtheria, tetanus, hepatitis B, pertussis, B and C meningococcal, Haemophilus influenzae type b, measles, rubella, mumps, and varicella vaccines are compulsory for the effects of the law.

Besides, the main change introduced by the new regulation concerns the control of the children's vaccination status before school registration, delegated to school leaders themselves. Starting from the next academic year, principals are asked to report the presence of non-vaccinated pupils to Local Health Agencies; these will have to notify cases to the circuit Family Court: Termination of Parental Rights is supposed to imposed to these pupil's parents.

The decree law also promote new educational health campaigns to make people school personnel aware of the meaning of Prevention.

More details at www.salute.gov.it.

VACCINATIONS RATES IN ITALIAN PEDIATRIC POPULATION

		Vaccine	Coverage rate*
Previously mandatory	NOW MANDATORY	Diphtheria	*94.04*
		Hepatitis B	*93.77*
		Poliomyelitis	*94.10*
		Tetanus	*94.31*
Previously recommended		H. influenzae type B	*93.51*
		Measles	*88.02*
		Meningococcal type B	*7.69*
		Meningococcal type C	*81.27*
		Mumps	*87.94*
		Pertussis	*94.00*
		Rubella	*87.97*
		Varicella	*39.16*

* Source: Ministry of Health, Italy, 2016 (2013 cohort, 36 months population)

When the (intern)ship comes in*

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Practice of public health is dictated by major and often very sudden changes of social, environmental and cultural milieu. For young professionals making their way in such a dynamic profession it is of vital importance to learn from the best and develop their skills at the most progressive and established public health institutions across Europe. Competent workforce is after all a necessary condition for a successful public health practice. Potentials for career, academic as well as personal development that such esteemed public health institutions hold can be best utilised by visiting those institutions and learning under supervision of experienced public health professionals.

Acknowledging this premise, EuroNet MRPH is setting the Internship programme high on its priority list. Advocacy and coordination of public health resident's internship opportunities has nonetheless been a focal point of EuroNet MRPH endeavours for quite some years. Working group running the Internship Programme in year 2017 has, much like working groups in past years, devised a number of ambitious goals with which we aim to upgrade the quality of the programme we offer to our colleagues, members of national associations of public health residents, constituents of EuroNet MRPH. The goals can be loosely divided into two sets.

The common denominator of the first one are the internal processes of the Internship programme.

Two major goals in this set are systematisation and improvement of traceability of the work done by the Internship working group and analysis of past internship requests. With latter we hope to obtain valuable information which will allow us to optimise our workflow and consequently improve the experiences of residents in the Internship programme. That brings us to the second set of goals which address satisfaction with services EuroNet MRPH provides to residents in the Internship programme.

One of the most exciting changes we plan to introduce this year are internship placements at international nongovernmental and intergovernmental institutions. Another ambitious goal is introduction of an internship tutor position, which will be held by a senior resident in a city or a region hosting an EuroNet resident.

An internship tutor would provide administrative and social support for the visiting resident. The last but not the least of the goals is an update of the subpage on Internship Programme on the EuroNet MRPH website.

If all goes well, by this time next year you, dear reader, will be having a casual drink after work with your internship tutor while discussing the project you embarked on at the renowned international organisation you visited with the EuroNet MPRH Internship Programme.

*Bob Dylan's song

Survey on satisfaction with residency program in Public Health in Slovenia

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One of the main goals of the Association of Public Health Residents of Slovenia is to advocate for higher quality of residency training. In order to do so we determined the level of satisfaction with residency program in public health in Slovenia, and investigated relationships between medical residents in public health (MRPH) and their supervisors with an online survey.

In Slovenia the duration of the public health residency is 4 years and it consists of rotations at authorised medical services providers, such as the National Institute of Public Health, The National Laboratory of Health, Environment and Food, Institute of Oncology and others. During those rotations we are introduced to basic core public health skills and also to particularities of various specific public health areas. Theoretical education is acquired mostly during the 2-semester post-graduate public health course, provided by the department of public health, Faculty of medicine, when the residents produce several written tasks and write one systematic review article. The course is completed by a thesis and a written exam.

An online survey addressing various aspects of satisfaction with the residency training was distributed among Slovenian residents in the beginning of year 2017. The survey was comprised of questions on satisfaction with main supervisor and residency in general, quality of individual rotations, and satisfaction and quality of post-graduate course. Residents also had opportunity to express their experiences and suggestions for improvement of the residency program with free-form comments. The data was collected and analysed in March 2017.

Results show that the residents are in general satisfied with the residency program in Slovenia. They gain a lot of new knowledge and skills during majority of rotations and the workload is usually just big enough so they don't get bored neither do they burnout. The part of the residency perceived as imposing the biggest workload on them was the post-graduate course. But the workload payed off since the course got the highest knowledge attainment score. Residents were also very satisfied with the support and accessibility of their mentors. The biggest flaw of the residency program, judging on the free-form comments, was inability to organise the residency program (length of rotations, omission of certain rotations etc.) according to residents' own interests.

Present MRPH study is the first of its kind in Slovenia and it provided us with very important information on residents' satisfaction with the residency program. We were able to include all current MRPH in Slovenia in the survey and identify the major factors that influence residents□ satisfaction. We hope to use the results of this study to further improve public health residency in Slovenia in cooperation with the residency coordinators.

All you need to know about Euronet MRPH in 2017

Overview

EuroNet MRPH connects Public Health residents in Europe. Its primary mission is to define a common core of competencies and knowledge for European Public Health residents in order to enhance national education programmes and promote their standardisation.

Organisation

EuroNet MRPH was founded in June 30th, 2011. It is a unique independent organisation representing nine national associations of residents in Public Health throughout Europe. Each country is represented by 6 elected members. Residents from non-member countries can also participate in EuroNet activities.

New Statutes

The new statutes has been approved by the Dublin AGM (November 2016). This will streamline the organisation increasing its efficiency and enabling it to better address current challenges in Public Health.

Mission Statement

EuroNet MRPH stands for the European Network of Medical Residents in Public Health. It constitutes the network of European National associations of Public Health training programs, including medical and non-medical residents. It is a non-profit, international, independent and non-governmental association. EuroNet MRPH aims to create a professional network among European residents in Public Health in order to share information on educational programs, to facilitate exchanges and common activities, as well as to develop a body of scientific research

AIMS

- Encourage initiatives by national associations of residents in Public Health which share our missions;
- Initiate and collaborate in common projects;
- Enhance professional skills by organizing and coordinating European congresses and meetings for residents in Public Health;
- Define and achieve a common core of professional competences in Europe;
- Promote and facilitate foreign internships in Europe for residents in Public Health;
- Strengthen the role of public health professionals in Europe by communicating on their specific competences to the medical and non-medical communities.

Activities

- Exchanging working practices and scientific knowledge;
- Presentations at training events, national and international conferences;
- Facilitation of collaborative projects between European residentes;
- 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, 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

- Public Health Informatics
- Conflict of interest research project
- Internship development
- Change of statute working group
- Burnout of PH
- Platform crowfounding project

Board Members/Leaders for 2017

- **President** *Damir Ivankovic*
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- **Research** *Sorina Dana Mihailescu*
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- **MALTA:** *Stefan Buttigieg (individual)*
- **POLAND:** *Paulina Nowicka (individual)*


Hrvatsko društvo za javno zdravstvo

Collège de Liaison des Internes de Santé Publique 


Association of Public Health Medicine Registrars in Ireland

Consulta degli Specializzandi 


Landelijk Overleg Sociaal-Geneeskundigen in Opleiding

Comissões de Médicos Internos de Saúde Pública 


Association of Public Health Residents of Slovenia

Asociación de Residentes de Medicina Preventiva y Salud Pública 


The Education Committee of the UK Faculty of Public Health

Malta (individual) 


Poland (individual)

Official Partners

Public Health Physicians of Canada PHPC MSPC Médecins de santé publique du Canada

ASPHER
The Association of Schools of Public Health in the European Region

epha

CFHI
child family health international

EURONET PLATFORM

SAPHMA
South African Public Health Medicine Association

EUPHAnxt

EURONEWS MRPH

Send your contributions for the next newsletter to communication@euronetmrph.org