EURONEWS MRPH

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

EuroNet MRPH Spring Meeting

April 2019, Torino, Italy

Editorial

Dear EuroNeters,

We want to welcome you to this new adventure that will be 2019 in EuroNet.

In this newsletter you will find a description of activities, thoughts and experiences of EuroNet and its members as well as more detailed information about the upcoming Spring meeting in Torino.

EuroNet is meant to be a place where residents can achieve goals, learn together, improve training and help each other overcome the difficulties of the residency.

Over the years EuroNet has grown as a community, gaining experience, representation positions and country members. But, above all,

it has been a neutral territory where residents could express their concerns and establish strong ties. This year, the privilege of coordinating, representing and organizing ideas within EuroNet rests with us, four women: Laura – President- , Gisela – Vicepresident -, Maria Francesca – Treasurer – and Ana – Secretary.

Together, the Board and Leads (Flavia, Joana, Angelo and Robin) started 2019 with a few ideas in mind and the challenge to achieve a smooth communication between us, to be able to cooperate, work hard and organize effectively. After two months of intensive e-mailing, teleconferences and a few wonderful discussions we came out with a common action plan.

In this document we have not only set down our vision, dreams and common goals for the association but also, established a clear path through which these will come true. All the activities and evaluation methods are thought to be practical and informative in order to contribute to a better distribution of responsibilities, to the

improvement of association's transparency and, above all, to consolidate the trust national commissions, national associations and each resident place in

us. We would like to take this chance to thank all the Board and Leads for all the work done so far.

It has been a really wonderful and fulfilling experience.

Nothing could have been done though, without the efforts of the precedent boards and leads, which were always on the call to answer any question, narrow uncertainties and tackle any new challenge.

We would like to take this opportunity to thank them for their dedication and support.

As the last president said in the December 2018 newsletter, we all have the same goal: improve EuroNet.

Let's focus on this goal, let's all work together.

See you all in Torino,

The Board

The Spring Meeting is coming!

The Organisation Team

Dear EuroNetters,

As the spring meeting approaches (Torino, 11-13th of April), we'd like to share some you some practical information about the meeting venues and the programme.

But first things first, so let's start with a brief introduction of what EuroNet meetings are and what to expect if you join us.

Most of you reading this newsletter will probably already know that EuroNet meetings are a wonderful opportunity to meet public health residents from other EU countries, creating valuable networks for our present formation and future careers; moreover, it provides to the participants the chance to actively get involved in the different projects that the working groups inside EuroNet carry on throughout all the year.

Another important point that helps to make EuroNet meetings so special is the social programme; even those of you who still have not joined a meeting might have heard about some legendary stories about very big data, pineapples, absinthe voids, huge paellas, not-so-hot tubs in the snowy Slovenian mountains and many more which are better not to be shared on this occasion.

If you want to know more about previous meetings, take a look at our newsletters on http://EuroNetmrph.org/.

Coming to Torino, the meeting opening session will probably take place in the “Aula Magna del Rettorato” (Via Po 15) on Thursday 11 April.

The meeting should start by 14:00 and it will include a brief introduction of the meeting, a presentation of the new board and leads and their action plan for 2019 and a first session to allow the different Working Groups to update and work on their projects.

The following day and on Saturday morning the meeting venue will be the **"Aula Magna di Igiene" (Via Santena 5 bis)** and the two sessions (morning and afternoon) will be about the two most voted topics during the poll in January: Data Science and Public Health policies regarding fake news, alternative medicine and anti-scientific issues.

For the first topic we will have as our guests some experts from the Institute for Scientific Interchange (ISI Foundation) of Torino and from the Politecnico di Torino, while for the second topic we are waiting for confirmation by guests, although the idea is to use the formula of discussion groups: on these premises, if any of the participants want to share some issues related to PH policies, at a national or international level, and their impact on society and on the clumsy world of anti-scientific movements, please let us know (contacts at the bottom of the article). Examples of these would be how to cope with vaccination coverages, how

to deal with alternative treatments, what can be done on a more training and

educational level for PH residents and how we think such issues should be addressed – both as residents and as future professionals.

On the last morning the General Assembly will take place, together with another WGs session, then all free to enjoy what Torino has to offer!

And this allows us to get through a crucial topic: Social Programme!

On one of the two meeting evenings (Thursday or Friday) we will have a world famous "Aperitivo": this usually consists of a formula where with the first drink you get

access to a buffet including a wide range of food, from starters to sweets, served hot and cold; we will choose the location after the subscription form will be closed, options include the beautiful locations of Piazza Vittorio Veneto or a terrace on the Po river. On the other night we will have a more regular dinner in one of the restaurants or trattorie in the city center. For Alberto and for those who call themselves brave, a steaming-hot Bagna Cauda is already waiting.

For those who are staying for the weekend, you can choose whether to have lunches and dinners all together or consider yourself free to enjoy a short holiday, we will ask this via the form just to have an idea.

Anyway, both Angelo and Robin will be fully available all weekend to take you around the city for sightseeing, visiting famous monuments

and wineries, buying the best chocolate to take back to those you really care about.

The night will of course be the moment to get into the Torino nightlife, crazy bars and venues are already waiting for the EuroNet invasion!

We have arranged an agreement with the Tomato Backpacker hostel (https://www.tomato.to.it/) for cheaper fares, but the number of places is limited. We will give you the details on how to book in the registration's opening mails. In case you won't be able to find accomodations at Tomato, the area delimited by Via Po, the Po river, Corso Dante and Via Nizza, along the metro line or the bus line 18, is the best in terms of transports and proximity to city center (you can find the map on the EuroNet website).

Can't wait to meet you there!!

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Internships Team 2019 – Call for action!

Internships Lead
Robin Thomas

Dear EuroNetters,

A new year has just begun and the new board is working hard to make 2019 another amazing one for EuroNet!

I want to start this first communication as new Internships Lead by thanking my predecessor Julio and all the people that have been working hard on the Internships projects during 2018, your work has been precious for the development of the 2019 plan, and any future collaboration on the new projects will always be truly appreciated.

The main goals for 2019 are resumable in the following points:

- To increase the number of Internships applications
- To develop new communication and application strategies about internships and mobility for Public Health residents inside the EU
- To strengthen and expand collaboration with partners and with the National Associations of Public Health residents

The main actions to achieve these goals will require a strong involvement of endeavoured residents, not only those who already are actively participating to EuroNet activities (members of National Commissions), but also of those who still are not fully engaged, but play a role inside their National Associations or simply are interested in working on mobility and helping their colleagues achieving internships periods.

Another important action, in order to try to raise the number of possible positions, is to engage in new partnerships that could provide internships and trainings or grants for summer schools and similar projects. At the same time, strengthening the already existent collaborations, in continuity with the previous board´s excellent work, might also lead to new opportunities of this kind.

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The results of this work can contribute to the formation of a working group, to the creation of workshops about this theme or can be used for whatever other useful scopes that will cross our path.

So, to be short, the plan is settled, now I need YOU!!!

If you are interested in joining the Internships Team, just send me an email (internships@EuroNetmrph.org), I will be extremely pleased to welcome you in the team and we can start working together.

There is of course a lot of room for plan improvement and for you to add new ideas, the work to do is not little but it´s going to be fun, interesting and never overwhelming!

And keep in mind that during the meeting in Torino we will have time to know each other and have the chance to organize the main part of the work.

This call for action is of course open to any PH resident, whether this is the first time you are reading the newsletter or not, just join if interested or simply curious!

Join the Internships, Stay for the Net!

A National Immunisation Information System in Italy

Vincenza Gianfredi
PH resident, University of Perugia, Italy

The Ministry of Health has recently established a National Immunisation Information System (IIS), through the Ministerial Decree of 17 September 2018 published in the Gazzetta Ufficiale n. 257/2018[1]. The aim of the electronic registry is to facilitate estimation of vaccine coverage, monitor the nation-wide implementation of the National Immunisation Plan (NIP) throughout the national territory; and to provide information both to the international bodies and for administrative tasks.

The need to create a single IIS from 21 regional registers was agreed upon in the State-Regions Conference of 19 January 2017, and highlighted on the National Immunisation Plan 2017-2019[2]. The Ministerial Decree of 17 September 2018 defines the information that all Italian regions and autonomous provinces must provide to the Ministry of Health, including:

1) vaccinated individuals;

2) individuals to be vaccinated;

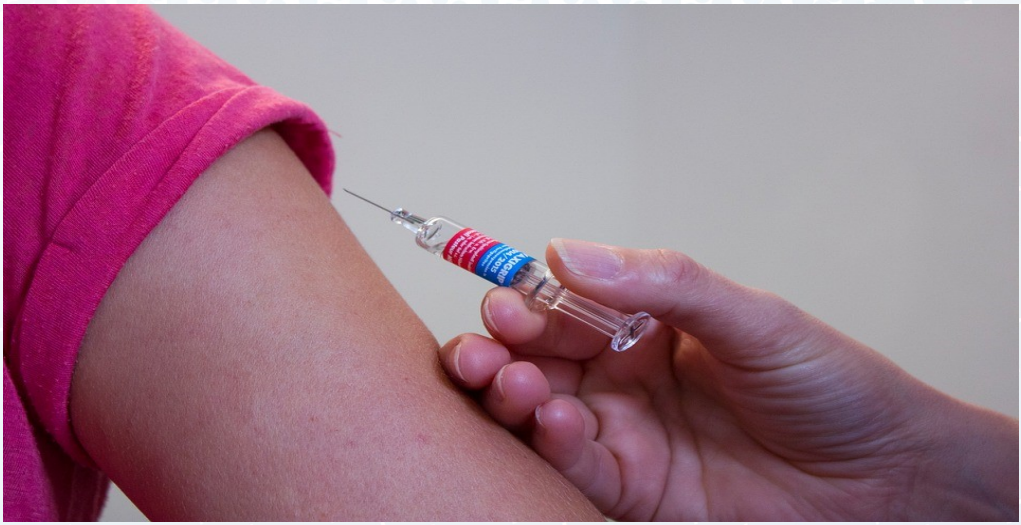
3) subjects already immunised after natural infection;

4) subjects temporarily or permanently exempted for health reasons;

5) doses and timing of administrated vaccines.

The IIS should be linked to the national databases of communicable diseases and adverse events.

The national IIS will aggregate individual records from the regional registries and, through a more precise estimate of vaccination coverage, will improve the monitoring activities of the



programs in place, and identify areas where extraordinary interventions are required. Furthermore, in order to maintain updated regional vaccine registries, the national IIS will make available to the Regions information related to citizens who will modify their residence. The Ministry of Health will have access only to anonymised information. The first upload of files from the regional authorities is expected by April 2019.

The last update of Italian regional IISs characteristics and functionalities are presented elsewhere[3].

References

1 Ministero della Salute [Ministry of Health]. Decreto del Ministero della Salute: Istituzione dell'Anagrafe nazionale vaccini [Decree of Ministry of Health: Establishment of a National Immunisation Information System] 17 September 2018 published in the Gazzetta Ufficiale n. 257/2018

2 Ministero della Salute [Ministry of Health]. Piano Nazionale di Prevenzione Vaccinale 2017-2019 [National Plan of Vaccination Prevention 2017-2019]. 3 Apr 2018. Rome: Ministry of Health; 2018. Available from: http://www.salute.gov.it/imgs/C_17_pubblicazioni_2571_allegato.pdf

3 D'Ancona F, Gianfredi V, Riccardo F, Iannazzo S. Immunisation Registries at regional level in Italy and the roadmap for a future Italian National Registry. Ann Ig. 2018 Mar-Apr;30(2):77-85. doi: 10.7416/ai.2018.2199.

Colorectal cancer screening: a Public Health priority in Portugal

Fábio Ricardo Elias Sousa Gomes
PH resident Aveiro, Portugal

In Portugal, as in the rest of Europe, the incidence of cancer has been steadily increasing at a rate of about 3% per year.[1,2] This increase is mainly related to the aging of the population and with changes in habits and lifestyles.[3]

According to the 2018 edition of Health at a Glance: Europe report (Organization for Economic Co-operation and Development - OECD), Portugal has one the lowest avoidable mortality rates in Europe, reflecting greater efficacy in the treatment of patients.[4]

However, cancer disease remains the second leading cause of death in Portugal after cardiovascular disease[5,6], and the leading cause of premature death (defined as death before the age of 70).[7]

Colorectal cancer is currently one of the major forms of cancer in the world, with significant mortality and morbidity associated. In general, it is more common in older people (most patients are over 60 years at the time of diagnosis, being unusual in people with less than 40 years), in males and in urbanized regions.

According to the latest data from the

International Agency for Research on Cancer (World Health Organization), colorectal cancer is currently the third most frequent type of cancer in the world and the second largest cause of death by cancer.

In Europe, it is the second most common type of cancer and the second deadliest. In Portugal, it is the second most frequent type of cancer in males (18,8% of the new cases, after prostate cancer) and females (16,2% of the new cases, after breast cancer) but ranks first in the most prevalent types of cancer for both genders.[8]

In 2018, Portugal has diagnosed 10 270 new cases of colorectal cancer (more than 20 cases per day), corresponding to 17,6% of the total number of new cases of cancer in the country.8 Despite the increasing therapeutic success in oncological disease, the number of deaths caused by this type of cancer has been increasing, especially in the most advanced ages.5,6 It is currently the second most deadly type of cancer (following lung cancer), accounting for approximately 4214 deaths (about 12 individuals per day)[8] and about 12 years of potential life lost.[9]

The reduction of the mortality and morbidity associated with oncological disease depends mainly on preventive strategies and the early detection of the disease. However, the early stages of colorectal cancer are usually asymptomatic or produce little symptoms. The first manifestation of disease is often the asymptomatic loss of small amounts of blood in the stool, not visible to the naked eye, making

the early detection difficult. For this reason, many countries now offer systematic population screening programs.

Most cancers of the colon and rectum develop from polyps or adenomas. These lesions are benign but have a significant risk of developing dysplasia, and therefore are considered pre-malignant. The screening programs aim to detect cancer in its initial phase but also to identify and remove these precursor lesions.

Due to the increasing number of cases, the screening for colorectal cancer is now considered a Public Health priority in Europe, and Portugal makes no exception.

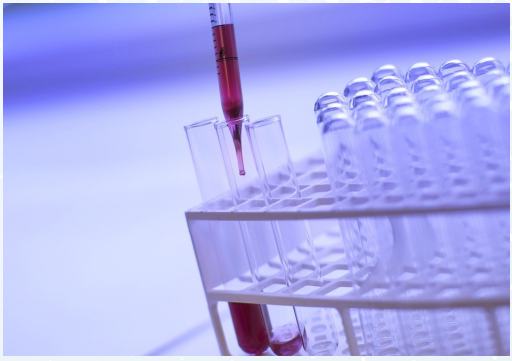
Although the significance of the colorectal cancer screening program is unanimously proven (it has the potential do reduce mortality rates by at least 20%)[3], there is no international consensus on the methodology that should be used. The strategies vary according to the human and financial resources available and the characteristics of each country. The most validated diagnostic exams currently in use are fecal occult blood tests (FOBT),

rectosigmoidoscopy and complete colonoscopy. The fecal immunochemical test (FIT) is currently the most commonly used primary screening test worldwide and has been shown to contribute to increased participation rates, with appropriate sensitivity and cost-effectiveness[10].

Portugal follows the European guidelines and has been developing the foundations for the implementation of a comprehensive population screening program. Thus, in Portugal, screening should be offered to the asymptomatic population aged between 50 and 74 years. As in most European countries, the primary screening test is the FIT, performed every 2 years. The convocation of patients for screening is ensured through their General Practitioners[11].

In case of a positive result in the FIT (cut off of 100 ng/mL), the patient should be referred for colonoscopy, under informed consent and within the scope of the Portugal National Health Service, in an average period of no more than 30 days.

The referral algorithm after colonoscopy varies depending on the result of the exam and is performed according to the recommendations of the European Society of Gastrointestinal Endoscopy (ESGE)[11].



Population-based screening programs for cancer have evolved significantly in Portugal during the last few years, with expansion of the geographic coverage, increased numbers of patients screened, and significant improvement in adherence rates. However, screening for colorectal cancer continues to present low countrywide coverage (about 19%)[1], with significant regional asymmetry.

Portugal is currently making efforts to extend colorectal cancer screening throughout the country and to create the channels to adequately screen all the eligible individuals. As a result of the acknowledgement as a Public Health priority and the ongoing efforts, it is expected that in a few years, Portugal will be able to effectively reduce this problem.

References

1. *Portugal. Ministério da Saúde. Direção-Geral da Saúde. Programa Nacional para as Doenças Oncológicas 2017. Lisboa: Direção-Geral da Saúde; 2017.*
2. *Portugal. Ministério da Saúde. Direção-Geral da Saúde. Direção de Serviços de Informação e Análise. A Saúde dos Portugueses 2016. Lisboa: Direção-Geral da Saúde; 2016.*
3. *Portugal. Ministério da Saúde. Direção-Geral da Saúde. Relatório de Monitorização e Avaliação dos Rastreios Oncológicos 2016. Lisboa: Direção-Geral da Saúde; 2017.*
4. *Organisation for Economic Co-operation and Development. OECD Health Division. Health at a Glance: Europe 2018. Paris: OECD Publishing; 2018.*
5. *Portugal. Instituto Nacional de Estatística. Causas de morte 2016. Lisboa: Instituto Nacional de Estatística; 2018.*

6. *Portugal. Instituto Nacional de Estatística. Estatísticas da Saúde 2016. Lisboa: Instituto Nacional de Estatística; 2018.*

7. *Portugal. Ministério da Saúde. Direção-Geral da Saúde. Programa Nacional para as Doenças Oncológicas – Orientações Programáticas PNDO 2012-2016. Lisboa: Direção-Geral da Saúde; 2012.*

8. *Globocan 2018 [Internet]. Lyon: Global Cancer Observatory. World Health Organization. International Agency for Research on Cancer; 2018 [uptated 2019; cited 2019 Feb 20]. Available from: https://gco.iarc.fr/*

9. *Portugal. Ministério da Saúde. Direção-Geral da Saúde. Direção de Serviços de Informação e Análise. Portugal – Doenças Oncológicas em números – 2015. Lisboa: Direção-Geral da Saúde; 2016.*

10. *Navarro M, Nicolas A, Ferrandez A, Lanas A. Colorectal cancer population screening programs worldwide in 2016: An update. World J Gastroenterol. 2017 May; 23(20): 3632-3642.*

11. *Portugal. Ministério da Saúde. Despacho n.º 8254/2017. Diário da República. 21 de setembro de 2017; 2.ª série, n.º 183: 20788-20789.*

Paternalism or Public Health

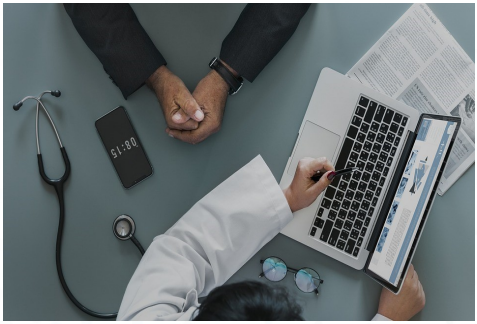
Nuno Simões
PH resident, Portugal

In the fast evolving technological world we live today, the discussion of ethical and moral matters is sometimes left lagging behind. I look to motivate debate and critical thinking about such issues that I believe are very important, especially in our field of medicine.

Paternalist legislation, libertarians argue, is and has always been a concerning flaw of democracy, when legislative bodies decide they should have a say about very personal aspects of human life. Paternalist laws are produced with the aim of protecting people from themselves, deeming the adult citizens unfit to make their own decisions by those who think themselves in the know, also known as the "Big Brother" or "nanny state".

The very word "paternalism" suggests the actions of a parent looking after a child. For some people, this may be comforting and consistent with the generally accepted role of government, but for others that is the exact problem, as critics argue against this infantilization of the individual at work.

A law becomes paternalist when it leaves insufficient room to respect the individual autonomy. While some authors make the distinction between "shallow" and "deep" autonomy, arguing that shallow autonomy can justifiably be limited to serve "deep" autonomy or self-rule, libertarians complain about every type of state intrusion in private life.



Other authors also make the distinction between hard and soft paternalism: when a government places laws between the citizen and his poor choices, protecting competent adults against their will, from the harmful consequences even of their fully voluntary choices and undertakings, there is hard paternalism;

Soft paternalism takes place when government views the ignorance of the individual as a kind of coercion, forcing him to do something he never intended to do. In this regards, government interference actually increases the individual's autonomy, as he now knows what he's getting into and can act accordingly.

Laws like the dry Law, passed in 1920 and lasting till 1933 in the US, are clear examples of legislative failures of hard paternalism.

From the libertarian perspective, trading freedom for security is a major mistake that has always resulted throughout history in power grabs and in the rise of authoritarian regimes and ruthless dictators. Such critics argue that in the last decades it has been particularly concerning the increasing tendency for western democracies, to somehow abandon the sphere of public morality to justify passing their paternalist laws, now resorting to Public Health claims to justify encircling governmental control of the people's choices.

Public health measures aim to protect, restore or promote people's health, and they are very important, especially nowadays, as migratory movements are on the rise and endemic infectious diseases spread to countries and regions where healthcare practitioners had hardly ever dealt with them before.

Nonetheless, while some measures can be justified on grounds of justice and don't need to be defended as cases of "justified" paternalism, other are still vulnerable to charges of paternalism with some critics arguing that, since medical paternalism is we wrong in the clinical context, it should also be rejected in public policy as well, with no place for permissible paternalistic public health policies.

Frequently charged as paternalistic are some pharmaceutical regulations, that despite providing a valuable public good by overseeing testing for new drugs and by certifying drugs that they deem generally safe and effective, can also undermine health, making patients more deferential to physicians and tolerant to medical risks if the regulations are too prohibitive. Similarly, paternalistic are the premarket requirements that take a long time while people suffer and die waiting for new drugs to get approved, which also discourages new drug development.

The benefits of regulation do not seem to come

from prohibition, as prohibitive regulations not only violate patients' rights, but they may also cost lives.

In some cases, public health has been its worst enemy due to communication problems with the public, as broad advices that are intended to inform are sometimes misunderstood as unnecessarily paternalistic or coercive, giving reason to critics.

While some public health policies seem to have conquered the major public, like the indoor smoking and trans-fat bans, society seems divided about other measures taken in the last decade. When these measures meet the resistance of a particular industrial interest and also face the resistance of the broad public, they will most likely take a long time to come into effect, if ever.

Examples of measures still facing hard resistance are the limitation of the availability of sugary drinks in some places, the taxes applied on them and the limits on the size of the containers used to sell them.

As you can see, paternalism comes in different shapes and sizes, and can be hard or soft, obtrusive or carefully dispensed. Some people defend that paternalist public health measures, far from an assault on liberty, can lead to more freedom, protecting against commercial interests, which potentially pose a much greater threat to free and informed choice, and arguing that healthy people, generally, have more options than sick people.

In my opinion, it is preferable to use soft paternalism than hard paternalism, as the push back to soft measures is much smaller, for example, instead of forbidding cigarettes which would stimulate the black market and cause uproar among smokers, cigarette warning labels are a successful public health soft paternalistic measure currently at work. This introduction of warning labels allowed the consumer to decide with open eyes.

Besides, the uproar provoked by public health efforts loses all its strength when put this issue into perspective: we already are regulated at all times and on all fronts, with coercion all around us. People just tend not to think about it, as society is full of measures designed to promote the general welfare through "benign" paternalist commonsense regulations.

In the end, communication of public health measures must be carefully done and such measures have to be balanced taking into consideration both the respect for individual autonomy and the effectiveness to achieve the collective good.

References

Thomas M, Buckmaster L. Paternalism in social policy when is it justifiable? Parliament of Australia research Paper no. 8 2010-11.

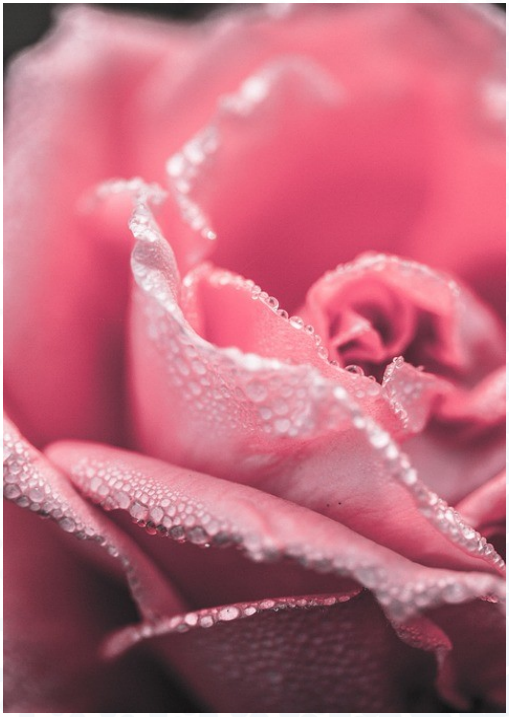
Galea S. Paternalism and Public Health. Boston University School of Public Health. 2016.

Buchanan DR. Autonomy, Paternalism, and Justice: Ethical Priorities in Public Health. Am J Public Health. 2008 January; 98(1): 15-21.

Greenacre M. Defending public health policies from objections of paternalism. UWOMJ 2016; 85:2

4th Regional Conference for the End of Female Genital Mutilation in Lisbon, Portugal

Margarida Paixão, António Carlos da Silva
Public Health Department of Amadora, Lisbon and Tagus Valley Regional Health Administration, Portugal



To signal the International Day of Zero Tolerance towards Female Genital Mutilation (FGM), the city hall of Lisbon welcomed professionals and activists involved in this cause in an effort to trade expertise and keep the conversation alive.

In the morning, during a mix of panels devoted to activism, law and health aspects of FGM, a multidisciplinary angle was given to this problem.

A recurring topic was the need to involve boys/men in this fight: as future partners and fathers, they need to speak out, join the fight and make it clear that they do not want their women and daughters to undergo this practice and that they do not see FGM as a prerequisite for marriage. We could not help but notice that issue in the first panel, which was devoted to youth activism, when sitting at that front table were only girls. For us, young boys, especially from communities known to practise FGM, were missing.

A message that came through was how difficult it was to put in practice what is already in the national law: despite several cases being presented to the justice system, there was never a prison sentence. The cases discussed were of young girls taken abroad during school holidays to African countries and returning already cut. The lack of convictions in some high-profile cases led to the President of the National Committee against harmful traditional practices for the health of women and children from Guinea-Bissau (Comité Nacional para oAbandono de Práticas Tradicionais Nefastas à Saúde da Mulher e da Criança), Fatumata Djau Baldé, to say *"Portugal lost a big opportunity to end the practice of taking girls to Africa to get cut"*.

Similarly, the fact that only recently has there been a prison sentence for someone charged with committing this crime to a minor in the England shows that there is a big gap between legislation and what ends up being practised. However, it also shows a will to change and to protect these girls.

In the afternoon specific examples of activities developed were explored. The example of communication networks in a suburban area of Lisbon, Amadora, was depicted: the local public health department, social services, the city hall, Guinea-Bissau's Committee and local non-governmental organisations regularly communicate and keep track of suspected cases, even when they travel to Guinea-Bissau.

As one panel speaker mentioned, Child Protection services see a spike of notifications of possible cases when FGM is mentioned more and has more media attention. As such, one of our take-home messages was the confirmation that partly our role is to keep on talking about it.

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Syphilis and HIV co-infection: my internship experience in a Sexually Transmitted Disease Clinic

Mário Rui Salvador
PH resident, Public Health Unit of ACeS Dão Lafões, Viseu, Portugal

One of the essential functions of public health services is epidemiological surveillance. In Portugal, epidemiological surveillance is assured by Public Health Authorities. Since June 1, 2014 Directorate-General of Health provides an electronic platform that allow physicians to electronically report cases of reportable diseases, including some sexually transmitted infections (STIs), the SINAVE - National System of Epidemiological Surveillance.[1]

Syphilis is a sexually transmitted disease caused by the bacterium Treponema pallidum. Since the beginning of the century there has been a resurgence of the pathology, reflecting greater access to the sex industry, an increase in promiscuous and risky sexual behaviours, less use of barrier contraceptive methods, and poor knowledge of STIs.[2,3]

This increased incidence of syphilis cases in the last decade has been attributed mainly to males and especially to homosexual and bisexual men and other men who have sex with men (MSM).[2,3]

According to ECDC data, Portugal is one of the countries with the lowest number of cases of syphilis per 100,000 inhabitants (less than 3 cases), being, however, one of the countries where the number of disease reports increased more between 2008 and 2013 (more than 50%).4

In Portugal, of the total number of HIV positive patients followed in a hospital in 2014, 4.4% had syphilis as co-infection and, in cases diagnosed in 2014, the co-infection was verified in 6.3%.[5]

In Portugal, there was a 33% increase in syphilis hospitalization rate between 2000 and 2014 in Portugal. The percentage of syphilis cases presenting co-infection with HIV and requiring hospitalization decreased by 69%.[6]

STD Clinic of Lapa Health Centre

In Portugal, there are specialized centres for counselling, diagnosis, therapy of patients with sexually transmitted infections.

In the first year of my public health residency I had the opportunity to undertake an internship in one of these centres: the Sexually Transmitted Disease (STD) Clinic of Lapa Health Centre, in Lisbon.

In the STD Clinic, health counselling/education is carried out, with information on the transmission and prevention of STIs. The clinical history is complemented by the collection of epidemiological elements. Biological products are collected for additional diagnostic or screening tests of STIs and, when necessary, therapeutics are available. The samples of biological products are conditioned, stored and transported daily to be processed in the

laboratories of the institutions with which the STD Consultation has collaboration. [7]

My internship in STD Clinic

During the internship, I participated in the STD consultations under the guidance of Dr. Jacinta Azevedo, dermatovenerologist, head of the STD Clinic. In addition to participation in consultations, I had the opportunity to develop a study whose objective was to estimate the proportion of syphilis diagnoses in users of the STD Clinic of Lapa Health Centre, living in the Central Lisbon area in 2015, as well as to estimate the proportion of HIV co-infection in the same users and the prevalence of previous HIV infection in those with co-infection.

Information of probable or confirmed cases of syphilis was collected from the STD Consultation database and from disease reports on the SINAVE platform during the year 2015.

During 2015, 34 cases of syphilis were diagnosed in users of the STD Consultation of Lapa Health Centre, residents in Central Lisbon area. 70,6% of cases were probable, based on serologic test for Treponema pallidum and 29,4% of cases were confirmed, according to diagnosis criteria, based on the confirmation of presence of Treponema pallidum in tissue.

Most of the new syphilis diagnoses occurred in men (91.2%), in the young adult age group (44.1% between 25 and 34 years of age) and in the men who have sex with men (82.4%), what is similar to the tendencies observed worldwide.[2,3]

HIV coinfection was observed in 26.5% of the population . Among those with coinfection, it

was observed that 44.4% already had a previous diagnosis of HIV infection on this STD Clinic and that 55.6% was HIV positive without knowing so.

Conclusions

Although STD Clinic of Lapa Health Centre is not the only diagnostic point of new sexually transmitted infections in Central Lisbon area, we can conclude that syphilis persists as a public health problem in Lisbon. The occurrence of syphilis in individuals with previous HIV infection demonstrates the need to reinforce strategies for counselling and prevention of sexual risk behaviours as well as early diagnosis.

Considering the re-emergence of pathologies such as syphilis, the increased prevalence of co-occurrence with another STIs, and the role of a public health service in epidemiological surveillance, health promotion and education, I believe to be pertinent the inclusion of an internship in infectious disease or STI services during the public health medical residency.

References

1. Portugal. Ministério da Saúde. Direção-Geral da Saúde. Despacho n.o 5855/2014. 2014;11660.

2. European Centre for Disease C and P. Annual Epidemiological Report for 2016 Syphilis. 2018;(July).

3. Centre for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2017 - Syphilis. 2018; Available from: https://www.cdc.gov/std/stats17/syphilis.htm

4. European Centre for Disease C and P. Surveillance Report: Sexually transmitted infections in Europe 2013. 2013.

5. Portugal. Ministério da Saúde. Direção-Geral da Saúde. Infeção por VIH, SIDA e tuberculos em números - 2015. 2015;

6. Sousa-pinto B, Freitas A, Lisboa C. Syphilis hospitalisations in Portugal over the last decade. 2016;(February).

7. Santo I, Azevedo J, Cardoso J. A Consulta de Doenças Sexualmente Transmissíveis do Centro de Saúde da Lapa. Caracterização da população utente e padrão epidemiológico das IST. Trab da Soc Port Dermatovenereologia. 2007;65:383-94.

What causes meningitis today?

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The control of communicable diseases is a Public Health priority worldwide. Even nowadays, meningitis remains an important communicable disease, sometimes associated with outbreaks. It causes significant mortality and morbidity, especially in children.[1,2,3]

If not fatal, meningitis can result in serious sequelae including hearing and vision loss, amputations, epilepsy, neurological deficits and cognitive impairment.

Risk factors for this disease include preterm birth, low birth weight, newborn concomitant infections, recent otitis media, genetic polymorphisms, immunosuppression and recent antibiotic therapy.[4]

Meningitis has many potential causative agents. Nevertheless, the epidemiology of this disease is gradually changing, in part due to the commercialization and distribution of new vaccines that protect against the most frequent causative agents.[2,5] For example, it was demonstrated that the relative frequency of meningitis caused by Neisseria meningitidis increased after the vaccines against Haemophilus influenzae type b and Streptococcus pneumoniae were included in most immunization schedules.[6]

Bacterial meningitis

Bacterial meningitis remains an important cause of mortality and morbidity, especially in children. The main bacterial causative agents of meningitis, accountable for 75% of the total number of cases worldwide, are Neisseria meningitidis, Haemophilus influenzae and Streptococcus pneumoniae. These are commensal microorganisms of the oropharynx and may be transmitted from person to person through respiratory droplets of an asymptomatic carrier or sick individual.[1]

1.1 Neisseria meningitidis

Neisseria meningitidis is a Gram-negative, aerobic diplococcus. The most relevant serogroups are A, B, C, W135, X, Y and Z1, with variable geographic distribution worldwide. The incidence of invasive meningococcal disease is higher in nursling infants in comparison to adolescents and adults.7 It is estimated that 5 to 10% of the population is an asymptomatic carrier of Neisseria meningitidis.[4]

In Europe, the serogroups B and C have prevailed during the last decades, even though the incidence of the serogroup C decreased significantly after the introduction of the vaccine against the serogroup C in the immunization schedules of many European countries.

Since 2009, in England and Wales, there has been an increase in the number of cases of invasive meningococcal disease caused by the serogroup W, a phenomenon also observed later in other European countries.[3,7]

Since 2010, there has also been noticed an increase in the number of cases of invasive meningococcal disease caused by the serogroup Y in some European countries.[7]

In Africa, following the implementation of national immunization programmes against the serogroup A, the frequence of outbreaks caused by this serogroup has reduced.[8,9]

In 2016, the serogroup B was responsible for 34,9% of invasive meningococcal disease cases in the United States of America for all ages, followed by serogroups C (26,6%) and Y (14%).[10]

However, as the vaccines against the most frequent serogroups (C in Europe and A in Africa) keep being introduced, invasive meningococcal disease caused by the serogroup B has been increasing relatively.

1.2 Haemophilus influenza

The population at greater risk of developing invasive meningococcal disease caused by Haemophilus influenza are children under 5 years of age, adults over 65 years and people with comorbidities that induce severe immunosuppression states.[11]

The vaccine against Haemophilus influenza does not cover serogroups other than type b, responsible for most cases of invasive disease caused by Haemophilus influenza, nowadays.[12]

1.3 Streptococcus pneumoniae

The colonization by Streptococcus pneumonia decreases with age in children and the opposite occurs in adults.1 In the year 2000, after the worldwide distribution of the heptavalent vaccine, it was possible to significantly reduce the number of cases of invasive pneumococcal disease. Simultaneously, the number of cases caused by the serogroups included in the vaccine in non-vaccinated individuals also reduced, due to herd immunity. The colonization of the mucosae by the serogroups present in the vaccine also decreased.[13]

According to recent studies, the case fatality rate of pneumococcal meningitis worldwide is approximately 8% in children. This particular etiology is becoming progressively more difficult to treat due to the increasing antibiotics resistance.[14]

Other causes of meningitis

Viruses can also cause meningitis, even though the infection is usually less severe than the bacterial infection. In non-vaccinated populations, mumps virus is responsible for 25% of the viral meningitis cases. In high-income countries, enteroviruses are also relevant causative agents in this context.

Although much less frequent, fungus are also possible causative agents of meningitis, mostly in immunosuppressed individuals. The infection can sometimes result from the inhalation of fungal spores present in the environment.

Particularly in low-income countries, parasites

can be causative agent of meningitis, due to the lack of adequate sanitary conditions.

Lastly, another rare cause of meningitis is the trauma of the skull and brain caused by accident or surgery.[1]

Conclusion

The continuous efforts to identify the causative agent behind each case of meningitis is essential to maintain an effective epidemiologic surveillance system.

Through this information, it is possible to plan and implement adequate intervention strategies, such as appropriate and responsive immunization programs.[5,15]

The European Centre for Disease Prevention and Control (ECDC) coordinates the European Invasive Bacterial Diseases Surveillance Network and all European countries report their data annually through their respective surveillance systems.[16]

It is crucial to establish a dynamic surveillance system at a local, regional, national and international level. The continuous monitoring and report of meningitis allows Public Health professionals to intermediate and prevent outbreaks.

References

1. Heymann, David L. Control of Communicable Diseases Manual. 20th ed. Washington: American Public Health Association; 2015.

2. Patel M, Lee CK. Polysaccharide vaccines for preventing serogroup A meningococcal meningitis. Cochrane Database of Systematic Reviews. 2005.

3. Mustapha Mustapha M, Marsha Jane W, Krauland Mary G, Fernandez Jorge O, Lemos Ana Paula S, Dunning Julie C, XinWang Hotopp, Mayer Leonard W, Lawrence Jeffrey G, Hiller Luisa N, Harrison Lee H. Genomic Epidemiology of Hypervirulent SerogroupW, ST-11 Neisseria meningitidis. Elsevier. 2015:2352-3964.

4. Sudarsanam TD, Rupali P, Tharyan P, Abraham OC, Thomas K. Pre-admission antibiotics for suspected cases ofmeningococcal disease. Cochrane Database of Systematic Reviews. 2017.

5. European Centre for Disease Prevention and Control (ECDC). Invasive meningococcal disease. Epidemiological report for 2015. Stockholm: ECDC; 2017.

6. Zalmanovici T A, Fraser A, Gafter-Gvili A, Paul M, Leibovici L. Antibiotics for preventing meningococcal infections. Cochrane Database of Systematic Reviews. 2013.

7. Comissão de Vacinas da Sociedade de Infeciologia Pediátrica e da Sociedade Portuguesa de Pediatria. Recomendações sobre vacinas extra programa nacional de vacinação. 2018.

8.World Health Organization (WHO) [edição online] disponivel em http://www.who.int/csr/disease/meningococcal/BulletinMeningiteS40432017October.pdf?ua= 1. [citado em 2019].

9. O'Ryan M, Stoddard J, Toneatto D, Wassil J, Dull Peter M. A Multi-Component Meningococcal Serogroup B Vaccine (4CMenB): The Clinical Development Program. Drugs. 2014; 74:15-30.

10. Centers for Disease Control and Prevention (CDC) [edição online] disponivel em https://www.cdc.gov/meningococcal/downloads/NCIRD-EMS-Report.pdf. [citado em 2018].

11. Centers for Disease Control and Prevention (CDC). [edição online] disponivel em https://www.cdc.gov/hi-disease/about/causes-transmission.html. [citado em 2019].

12. Instituto Nacional de Saúde Doutor Ricardo Jorge (INSA). Monitorização da infeção por Haemophilus influenzae em crianças após a introdução da vacina após a introdução da vacina para o Haemophilus influenzae tipo b no PNV. Doenças evitáveis por vacinação. Artigo breve nº2. Lisboa: INSA; 2013.

13. Tendais-Almeida M, Ferreira-Magalhães M, Alves I, Tavares M, Azevedo I. Vacinação Contra Infeções por Streptococcus pneumoniae em Crianças e Adolescentes de Alto Risco para Doença Invasiva Pneumocócica. Acta Médica Portuguesa 2015; 28:583-589.

14. Centers for Disease Control and Prevention (CDC) [edição online] https://www.cdc.gov/pneumococcal/clinicians/clinical-features.html. [citado em 2019].

15. Vasconcelos M, Lemos S, Gonçalves P, Rocha G, Grupo de Estudo sobre Meningite Bacteriana na região Centro. Meningite bacteriana na região Centro - Casuistica de 1994 a 2002. Revista de Saúde Infantil. 2004:0874-2820.

16. Simões M, Fernandes T. Rede de Laboratórios VigLab-Doença Meningocócica. Doença invasiva meningocócica em Portugal. Vigilância epidemiológica integrada, 2003-2014. Lisboa: INSA; 2016.

Why the Diet Culture is wrong and how Public Health must fix it

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We all know global prevalence of overweight and obesity has increased substantially over the last few decades. The data tells us obesity grew from less than 1% in 1975 to 6-8% in 2016 among children, from 3% to 11% among men and from 6% to 15% among women. The overweight population had an even bigger growth, reaching a total of 39% of adults in 2016 (1).

We also know that overweight and obesity are associated with increased risk of chronic disease morbidity and mortality. A high Body-Mass Index (BMI), the most widely used criteria to classify weight, has been extensively associated with overall and cause-specific mortality, particularly with cardiovascular diseases, cancer and respiratory diseases (2). The Global Burden of Disease Study 2015 estimated that high BMI alone accounted for 4.0 million deaths globally, nearly 40% of which occurred in overweight people and more than two thirds were due to cardiovascular disease (3). Nevertheless, another thing we all know is that BMI is an inaccurate measure of health, as it doesn't consider the wide range of healthy body weights.

Because of these pandemic proportions, negative health consequences and economic burden, obesity has become a major Public Health issue around the globe. However, and while it is usually acknowledged as "largely preventable", the bigger truth is… we don't have a clear strategy to prevent it nor an efficient treatment to cure it.

Intervention studies report short-term (max. 1 year) weight loss with almost all lifestyle strategies created (either through dieting, exercising or a combination of both), but not only does obesity relapse in more than 80% of patients in the long-term, as after the intervention patients reach a new plateau phase with an actual weight gain in comparison to their pre-intervention weight (4). This appears to have a strong physiological, neural and attentional basis, with hormones liberated and metabolic pathways for hunger and fat accumulation being turned on by the nutrient and calorie starvation the body feels while dieting (5) – making this post-dieting weight gain outside of the person's control.

Besides, we live in an obesogenic environment, where processed calorie dense foods are cheaper than high-quality wholefoods, with technologies and environmental structures that reduce or replace the need for physical activity, and with open access to inexpensive nonphysical entertainment, making it harder every day to maintain a healthy weight.

So… what do we do? How do we stop obesity when, for example, the evidence tells us that dieting could be worse than non-dieting? I'm not sure we have an answer yet.

In my opinion, promoting lifestyle changes without addressing psychosocial factors and the environment we live in is utterly pointless. The biggest differences in health outcomes aren't due to lifestyle or biological factors (those only account for less than a quarter of differences; Figure 1), but due to social, ecological and health-access factors: the stress of being poor, oppressed and discriminated leads to worse health outcomes than any genetics or health behaviors combined ever could – I'm not saying that obesity doesn't lead to diseases, but maybe we have bigger problems…

We also need to start acknowledging the negative health effects of stigmatizing an already obese population (barely half of the world's population!): creating an anti-fat climate where heavier children or adults are constantly told they should be thinner, and that there's something wrong with them, is unlikely to reverse the problem and will probably only contribute to even more negative outcomes. When we emphasize the "diet culture" in our public health measures with the general public, we put the responsibility only on the individual level, and we punish people that can't lose weight, we aggravate the discrimination and we increase mental health issues, without ever recognizing

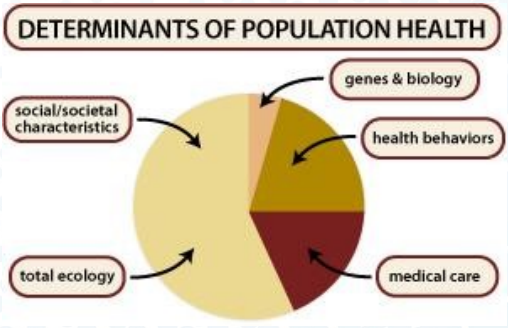

Figure 1. Estimates of how each of the five major determinants influence population health.

the societal blame that we know for a fact is there.

Ultimately, I'd say the most efficient way of solving the problem is to simply avoid its beginning. And how do we do that? We do it by focusing our public health efforts in transforming the health policies that created the current obesogenic environments into ones that will prevent children from becoming obese; by challenging the notion that weight gain is always negative and to be blamed and that it leads to the most health discrepancies, and creating a new evidence-based notion that takes into account the influence of healthy foods and exercise but that actually holds social differences accountable for most of society's stark health differences; and finally, maybe we should start to accept that there really is beauty and health at every size.

If people are to live healthier, longer and happier, what we need is social change, and that goes way beyond their weight.

References

1 - NCD Risk Factor Collaboration (NCD-RisC). Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128·9 million children, adolescents, and adults. Lancet 2017; 390: 2627–42.

2 - Association of BMI with overall and cause-specific mortality: a population-based cohort study of 3·6 million adults in the UK

3 - Health Effects of Overweight and Obesity in 195 Countries over 25 Years.

4 - Obesity: a chronic relapsing progressive disease process. A position statement of the World Obesity Federation

5 - https://www.apa.org/science/about/psa/2018/05/calorie-deprivation.aspx

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