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editorial

Health psychology in Europe and Beyond

Anthony Montgomery
editor

This issue provides us with a snapshot of health psychology practice in Europe, health psychology partnerships in Africa and a review of the 2016 Aberdeen conference.

In the first paper, Byrne et al present an important review of where health psychology practice is in Europe. Using the EHPS national delegates at respondents, the authors profile the state of play of health psychology with regard to education, training, practice and careers for Health Psychology Practitioners in twenty four countries. Overall, the authors conclude that a formal career pathway does not exist for Health Psychology in most EHPS member countries, and there is much variation in how teaching and training in Health Psychology is delivered. However, they behoove the EHPS to take a lead in promoting a more coordinated approach at a European and International level to training and careers in Health Psychology Practice.

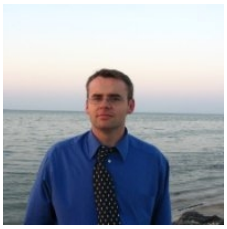
Following this Byrne-Davis et al report on their experiences of working in 'health partnerships', which are collaborative partnerships between UK organizations and organizations in low and middle income countries (LMIC) with an aim of strengthening health systems mainly through supporting education and training of healthcare professionals. The article covers diverse projects in Uganda, Mozambique, Malawi and Rwanda. It's obvious that their efforts had an impact, but the authors don't shy away from questioning the suitability of their approach to the different contexts they found. The authors' final reflection is that they have given their collaborators the desire to 'think behaviourally' about education. Not a bad outcome.

Finally, Robbert Sanderman dissects the participants' evaluation of the 2016 Aberdeen conference. Overall, the majority of respondents rated the scientific elements as either very good or excellent. Participants were very enthusiastic about the location, social program and catering. The conferences go from strength to strength.

The three papers were independently submitted, but they present three complementary perspectives on the impact of health psychology. Starting with the last, the EHPS conference was enthusiastically regarded by the participants both scientifically and socially. Congruently, the survey by Byrne et al emerged from discussions at the 2014 (Austria), 2015 (Cyprus) and 2016 (Scotland) conferences. This is strong evidence of the power of EHPS conferences (and the authors) to evolve important ideas. In terms of assessing the impact of EHPS conferences longitudinally, the gestation of their idea is an important outcome. The paper by Byrne-Davis et al is a must read for health psychologists thinking about working in LMIC's.

The paper encourages and chastises in equal measure, by providing an example of what health psychology can actually do while also cautioning against putting square pegs in round holes. The take home message of the three papers is clear; attend the EHPS conferences annually, do meaningful research and make a difference in the

world.



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original article

Health Psychology Practice in Europe: Taking Stock and Moving Forward Together

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Introduction

According to the British Psychological Society Division of Health Psychology website "the goal of health psychology is to study scientifically the psychological processes of health, illness and health care. [and]… apply health psychology to the promotion and maintenance of health, the analysis and improvement of the health care system and health policy formation, the prevention of illness and disability and the enhancement of outcomes of those who are ill or disabled." Health Psychology as a discipline emerged over 30 years ago after Engel's (1977) seminal paper introducing the Biopsychosocial model of healthcare and illness. Within Europe, The European Health Psychology Society (EHPS) was established in 1986 to promote "empirical and theoretical research in and applications of health psychology within Europe as well as the interchange of information related to health psychology with other associations throughout the world (EHPS, 2016)". These statements emphasise the broad scope of health psychology from theory and evidence to implementation, and the 'scientist-practitioner' role for health psychologists.

The EHPS is now a thriving international organisation which organises an annual conference with a full four-day scientific programme, attracting around 1000 delegates. There are also preconference workshops including those organised by CREATE (tailored to early career stage delegates) and SYNERGY (tailored to more experienced delegates). During the EHPS members' discussion forum at the 28th Conference of the EHPS in Austria in 2014, a number of delegates raised the issue that the EHPS is currently heavily focused on the academic and research aspects of Health Psychology, with much less engagement in issues more relevant to applied Health Psychology Practice. Using health psychology in practice is important to test and promote its value in the 'real world', disseminate knowledge, and facilitate empirical testing of theories and evidence, to feed back and strengthen the science overall.

Following on from the 2014 conference, we (MB and VS) organised an informal meeting at the 29th Conference of the EHPS in Cyprus in 2015 to discuss the role of EHPS in promoting the development of applied Health Psychology practice and careers. This meeting was attended by over 100 delegates, many voicing the opinion that EHPS could provide an ideal forum to support attempts currently underway within a number of member countries to promote and develop Health Psychology practice infrastructure in different contexts and different healthcare systems. Realising that we had limited knowledge about the current status of Health Psychology training and practice in these member states, we committed to conduct a survey of EHPS member countries to get a snap shot of current practice.

These data were presented at a Roundtable session at the 30th EHPS Conference in Scotland in

2016 facilitated by VS and MB. Here we present the findings of this survey.

The survey

The online survey was created using Qualtrics Survey Software and was distributed to the list of 40 EHPS National Delegates in January 2016. Respondents were asked questions about education, training, practice and careers for Health Psychology Practitioners in their country.

Results

Twenty-four participants from twenty-four EHPS member countries completed the questionnaire, giving a response rate of 60%. The respondents worked in predominantly research and academic settings with 23 stating they were lecturer/professor or researchers and no participants identifying as exclusively either a Health Psychology Practitioner or Clinician.

When asked about terminology, the term "Health Psychology" is used by 23 of the countries with the exception of Lithuania, which uses the term "Medical Psychology."

Health Psychology Training

Health Psychology as a topic is taught in 20 (83%) of the 24 undergraduate courses in EHPS member countries. At a post-graduate level, 18 of the 24 respondents reported having Masters programmes in Health Psychology in their countries. When asked about the focus of their Masters Programmes, ten said their programme focused exclusively on academic content and eight said their programme contained a mix of academic content plus practitioner skills. Seventeen countries reported having Doctoral level qualifications in Health Psychology: 12 of these were PhD programmes in Health Psychology, three were Doctoral level Practitioner Training in Health Psychology and two were defined as "other." See table 1 for further information on education and training in each of the EHPS member countries.

Employment for Health Psychologists

Career prospects and sectors of employment for Health Psychologists varied greatly across EHPS countries. Only eight respondents (33%) said there were jobs advertised specifically for Health Psychologists in their country; 13 (54%) answered that there were no health psychology posts. Table 2 shows the common sectors where Health Psychologists are employed. Note that this item was completed for sectors in which people with Health Psychology qualifications are employed, even if jobs are not actually advertised for 'Health Psychologists'. Third level education is the most common setting for Health Psychologists' employment (n=21; 88%), but high percentages of respondents reported that Health Psychologists were employed in secondary care or hospital services (71%) and public health (62%). It is noteworthy that fewer Health Psychologists are employed in primary health care settings (50%). Table 3 shows the types of jobs done by Health Psychologists. The most commonly reported type of job is lecturing and research in an academic setting, although relatively high numbers report Health Psychologists providing psychological services for clients at group or individual levels.

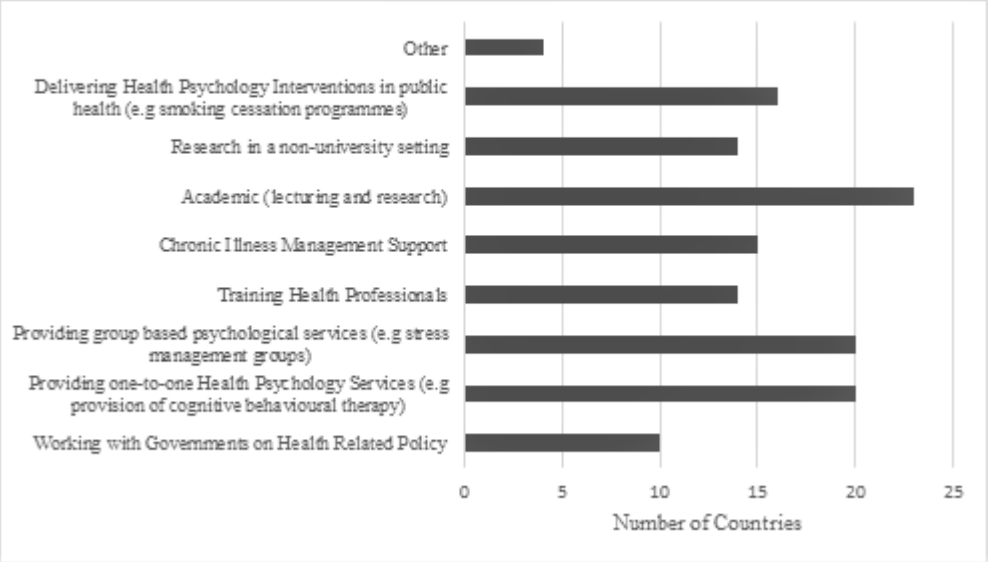
Table 1. Profile of Undergraduate and Postgraduate Health Psychology (HP) Programmes

Country	HP included in undergraduate Psychology course	MSc in HP: Academic only	MSc in HP: Combined Academic and Practitioner Training	PhD in HP	Doctoral Practitioner training in HP	Designated funding available to train as a practitioner in Health Psychology	Postgraduate programmes available which combine both 'Clinical Psychology' and 'HP' training.
Ireland	X	X		X	X		
United Kingdom	X	X		X	X	X	X
Israel							X
Luxembourg	X			X			X
Turkey	X	X	X				X
Greece	X		X				
Denmark							
Germany	X	X	X				X
Austria	X						X
Lithuania	X		X				
Bulgaria	X			X			
Croatia							X
France	X	X	X	X			X
Ukraine	X			X			
Slovenia	X	X				X	
Romania	X		X	X			X
Australia	X			X	X		
Latvia	X		X				
Poland	X	X		X			X
Brazil	X	X		X			X
Cyprus	X	X					
Finland						X	X
Japan	X	X		X			
Portugal	X		X	X			X
Total % of countries	83.33% (*n*=20)	41.66% (*n*=10)	33.33% (*n*=8)	50.00 % (*n*=12)	12.50% (*n*=3)	12.50% (*n*=3)	54.16% (*n*=13)

Table 2. Sectors of employment for Health Psychologists (or those with Health Psychology Qualifications)

Country	Public Health	Third level Education (research and education)	Health Services (Primary Care)	Health Services (Secondary Care or hospital services)	Community Settings	Other
Ireland	X	X	X	X	X	
UK	X	X	X	X	X	X
Israel				X		
Luxembourg	X	X	X	X	X	
Turkey	X	X		X		
Greece	X	X		X		
Denmark						
Germany		X	X	X		
Austria	X	X	X		X	X
Lithuania	X	X	X	X	X	X
Bulgaria	X	X		X		
Croatia	X	X	X	X		X
France	X	X	X	X	X	
Ukraine		X				
Slovenia	X	X				
Romania		X				
Australia	X	X				
Latvia		X	X	X		
Poland		X	X	X		X
Brazil				X		
Cyprus		X				
Finland	X	X	X	X	X	
Japan	X	X	X	X		X
Portugal	X	X		X	X	X
Total % of countries	62.50% (*n*=15)	87.50% (*n*=21)	50.00% (*n*=12)	70.83% (*n*=17)	33.33% (*n*=8)	29.16% (*n*=7)

Table 3. Types of Jobs done by Health Psychologists



Other Responses

One open-ended question allowed respondents to expand on their responses. Eight respondents (33%) added additional comments and four (17%) of these described current ambiguities in Health Psychology training and practice in their country.

"we do not have basic legal regulations which would formally recognize psychology as a profession (requirements for being a psychologist, available areas of professional activities and so on). Thus, any further specializations within psychology are not systematically regulated as well . . .(regulation) has been ongoing 'work in progress' for more than 25 years now. Sad but I cannot see any chance for a breakthrough in the nearest future."(Poland)

"(Jobs are) mainly in occupational health psychology, usually "health psychologists" apply for interdisciplinary job ads, even professorship positions are interdisciplinary (e.g. faculty position for behavioural prevention." (Germany)

"… jobs advertised in health psychology are very limited, so mostly psychologists work on a freelance basis ." (Greece)

"Although there are some examples of Health Psychologists working in clinical roles in Ireland, the vast majority are working in academic/research roles."(Ireland)

These responses highlighted some frustrations with the lack of standardised international regulation of Health Psychology Practice.

Conclusion

This survey aimed to document and describe the level of training and career opportunities for Health Psychology Practitioners within 24 EHPS member countries in 2016. The results highlight the variation in both training and practice internationally and the open-ended responses provided insight into the lack of progress and frustration experienced due to the issues with Health Psychology regulation in some countries. Even where regulation exists (e.g. in the UK) there is still a lot of interest in the potential role of Health Psychologists contributing to health and social care, but this has not been accompanied by

any sizeable increase in the number of practitioner health psychology posts. In the UK for example, there have been advances in the training of health psychologists in the health services and elsewhere, and there are some areas where health psychology practitioner services are continuing to develop but nevertheless remain small scale, and service provision is patchy.

Our study has some potential limitations. We did not receive responses from all EHPS member countries and we are therefore limited in our generalisability and representativeness. In addition, while National Delegates are likely to be well informed in relation to the questions they were asked, we did not verify their responses and it is possible some responses may have been inaccurate.

At this time a formal career pathway does not exist for Health Psychology in most EHPS member countries, and there is much variation in how teaching and training in Health Psychology is delivered. If we are to 'sell' health psychology to employers, it would be helpful to develop and benchmark consistent curricula, skills and competencies which characterise a health psychologist role across Europe. In most countries, jobs are not advertised for 'Health Psychologists', a less than ideal situation, which likely reflects this lack of coherent training structure and lack of post-qualification benchmarking of skills at a European level. There is a 'chicken and egg' situation here however, since the existence of practitioner posts is likely to showcase the 'added value' of health psychology practice to healthcare, and stimulate demand for more posts.

The 1990s has been dubbed the 'Decade of Behavior' https://en.wikipedia.org/wiki/Decade_of_Behavior with an increasing awareness of the centrality of behaviour change to any interventions seeking to promote health. Policy within many countries prioritises developing behavioural interventions to prevent and manage chronic illness. There is an excellent and timely opportunity for Health Psychologists to help to deliver this agenda. According to our survey, primary care is currently a setting with relatively little input from health psychology; as primary care provides an ideal health care setting for the delivery of chronic illness prevention and management programmes, it is likely to be an area of opportunity and for growth for Health Psychology input in future years.

The EHPS is ideally placed to take a lead in promoting a more coordinated approach at a European and International level to training and careers in Health Psychology Practice. There is energy and interest currently among members to do this. Now is the time to move forward together.

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commentary

Global Health Psychology: Research, Volunteering & Consultancy

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Since we started working in global health, we have lost count of the number of Health Psychologists who have told us of their attempts to volunteer internationally and the difficulties in finding a project in which they can use their specific skills and knowledge. Imagine then, our surprise, when we read the editorial in the launch of the journal 'Global Health Science and Practice' in 2013 entitled 'The 6 domains of behavior change: the missing health system building block'. This editorial described the global health priorities that would be addressed by an application of knowledge and skills in behaviour change. Not written by a psychologist, but by a public health specialist from the United States Agency for International Development, the editorial sets out a broad range of possible contributions that psychologists, with expertise in behaviour change, could make to improving and understanding health and healthcare (Shelton, 2013)[1].

Our own involvement began with a chance conversation with a colleague who worked in a 'health partnership'. These are collaborative partnerships between UK organisations and organisations in low and middle income countries (LMIC) with an aim of strengthening health systems mainly through supporting education and training of healthcare professionals. Typically, UK healthcare professionals will engage in education, training or mentoring of their counterparts in the LMIC, whilst learning skills themselves about teaching, tropical disease management, and managing with low resources to name but a few. The partnership in this case was between Gulu Regional Referral Hospital, a large government funded hospital in the north of Uganda, and University Hospital of South Manchester (UHSM). The partnership had been active for about 7 years at the time and there was good evidence that education was being conducted and was having an impact on the knowledge and skills of the workforce. With the partnership team, we reviewed their assessments of knowledge gain in two courses, maternal and adult acute illness management, which were 25 item multiple choice questions before and after training, based on the knowledge taught in the training and we found that learners were improving in their knowledge from pre to post course (Byrne-Davis et al, 2014; McCarthy et al, 2015). It was not clear, however, what impact the knowledge gain or the gain in skills, which was not robustly assessed, was having in practice. Nor was it clear what the UK workforce were learning. With grants from UHSM and the Global Health Exchange (the international arm of Health Education England: http://www.globalhealthexchange.co.uk), we began to explore ways of understanding the impact of learning on healthcare professional behaviour in Uganda (Byrne-Davis et al, 2016) and, with colleagues at the University of Salford, ways of

measuring the impact of volunteering on the UK workforce.[1] We created a collaboration of experts in behaviour change, Professors Marie Johnston and Chris Armitage and an expert in workforce and health professional education, Professor Ged Byrne. Working together, we found the health partnerships and volunteers to be willing and able collaborators and we learnt a great deal about working across countries and with a large multidisciplinary team.

Thinking about the personal growth this opportunity had afforded us, alongside the benefits to the health partnership and the contribution to the psychological literature, we decided to investigate possibilities to scale up our work. Our key priorities were to increase capacity for global health work for psychologists, make a difference to the health partnership projects and contribute to the science. Byrne-Davis and Hart, with co-applicants Johnston and Armitage, approached an organisation that, with funding from the Department for International Development, offered grants to health partnerships: The Tropical Health and Education Trust (THET: www.thet.org). After we had shared our vision and a proposed project plan, they offered to fund a pilot project for 12 months, beginning in January 2016. Our plan was simple (and complicated!): to recruit volunteers with expertise in behaviour change and to place them in existing health partnerships with a remit to: 1) support the partnership in reaching its aims and 2) conduct small scale action research based on certain basic frameworks, that could be pooled across the projects to ask and potentially answer crucial questions about the science of behaviour change in these applied settings. We had over 40 applicants and placed 11 psychologists in 5 partnerships. We worked on projects including:

1) Emergency obstetric training in Uganda with the UK Royal College of Obstetrics and Gynaecology to investigate practice change following training. We coded the training for behaviour change techniques (BCTs) (Michie et al, 2013), recommended enhancements to the course and trained Ugandan and UK Health professionals in behaviour change.

2) Twinning midwives in Uganda with the UK Royal College of Midwives; We interviewed midwives about barriers and enablers to mentoring and we trained UK and Ugandan colleagues in behaviour and research methods.

3) Medication safety in Beira, Mozambique with Ipswich Hospital, UK. We coded training for BCTs, audited a cardex system and multidisciplinary team working and we trained UK and Beira staff in behavioural theories and approaches.

Challenges and the future

Working as volunteers in projects geographically dispersed across continents is undoubtedly challenging. We found that some of the methods used in health psychology might not be possible to use with healthcare professionals in these countries. For example, there is no tradition of using Likert scales and we have multiple anecdotes that these did not make sense to our healthcare professional colleagues. So far, we have either reverted to qualitative methods to explore psychological determinants of practice or we have reduced the Likert responses to simple agree / disagree / don't know, with the resulting reduction in richness of information. The difficulty in using Likert scales is an issue that we are exploring in an ongoing study in the UK, Rwanda and Malawi. The balance between consultancy and research is a

[1]The MOVE project is a University of Salford and University of Manchester project to explore and assess the personal and professional development benefits of international placements for the UK NHS workforce.

difficult one. We are creating evidence quickly so that it can be used to improve each project and ultimately make crucial changes to help patients and the public. These data are necessarily, therefore, less robust than data collected for research purposes only: there are more compromises and there is less time to pilot and refine questions and methods. We are beginning to have ideas about methods that might be more appropriate and are investigating these. There are always ethical questions about researching and learning in low-resource settings: are we doing more harm than good? Are we prioritising our own development over the development of researchers from those countries? There is a lot of interest now in the mutual benefits of health partnerships (see THET, In Our Mutual Interest: http://www.thet.org/resource-library/in-our-mutual-interest). Volunteers gain personally and professionally from volunteering and it is crucial to set out the mutual benefits and costs in any memorandum of understanding between partners. The use of LMIC settings as a resource for research data is also a concern. We made a commitment to try to create a community of people working in LMIC in health and social care workforce research. We recently applied for funding and held a meeting in Rwanda of around 40 colleagues working in this field from nine countries and are hoping that this will be a start to the sharing of resource and expertise amongst HIC and LMIC researchers for our mutual benefit. We continue to apply our ethical standards, to adhere to principals of sustainable development and to work in partnership, ensuring that the relationship between ourselves and the health partnership is one of mutual benefit and ultimately benefitting our current and future clients, patients and the public.

As for the health partnerships, they were unanimously, enormously enthusiastic about the contribution of the psychologists to their projects. Their feedback (http://www.mcrimpsci.org/case-studies/emergency-obstetric-training-in-uganda/) to us included:

"I think from our perspective it was like a piece of the puzzle that had been missing that we hadn't realised and…I think every project is trying to make changes to behaviour and without understanding what that is and what that looks like then they are not really going to get anywhere so I think it is a really fundamental part to the work that we are trying to do."

"Without you we wouldn't have thought as much about importance of the barriers, behaviours and cultures, and how people behave in their clinical practice. People seemed to get the importance of this when we went on the wards because you communicated this in your presentations and activities. With you we were able to hear about 'the unspoken things' in the partnership, as you are neutral and don't mind asking about difficulties and why things don't happen. With you guys we were able to focus more on the key areas we wanted to change… Really, you guys made us see things that are right in front of us but we didn't see them until you were here."

It is clear from the comments that, as Shelton says in his editorial, that having expertise in behaviour change is a game changer when it comes to addressing issues in global health.

The future is, as always, uncertain. The experiences have given us all a clearer vision about the impact of our research, a greater desire to engage in activities in which we can advise as well as study and access to a global health movement that we did not know existed. In terms of research, there are grants to apply for, studies to conduct, students to supervise and collaborations to be developed across international borders. In terms of advice and consultancy, we remain at the disposal of the global health community and have been developing open access e-learning on behaviour change (see www.mcrimpsci.org), writing open access publications about our work and leaving an

open door for educators and health system managers who wish to discuss the psychological determinants of healthcare professional practice.

Final Reflections

Reflecting on the potential impact of our collaboration, we had the following thoughts. In our work we are trying to help educators to move from knowledge to practice change rather than ourselves change anyone's practice. The way the projects were set up (without us – they were already established when we started working with them) meant that the data on practice change were not being collected before we started work with them, so we can't tell if our working with them did help them achieve increased practice change. What we have given partners is a) the desire to 'think behaviourally' about education and training b) a framework to think about what their interventions are trying to change – C, O, M (Michie et al, 2011)– and a theory-based way of thinking about how change might happen. For some of them, we helped them tweak their education and training (e.g., adding implementation intentions), which previous evidence would suggest would make practice change more likely but we don't have those data – that would require further research.

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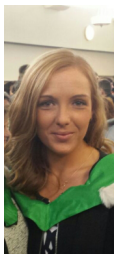

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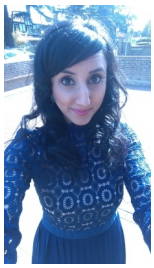

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conference report

Behaviour Change: Making an Impact on Health and Health Services

European Health Psychology Society & British Psychological Society Division of Health Psychology Conference 2016

Aberdeen, 23-27 August 2016.

Robbert Sanderman

It was a memorable event in Aberdeen last summer. It was the 30th conference of the EHPS as well as of the Health Psychology Division of the BPS. A great joint event of the two organizations in lovely Aberdeen. A special year and therefore a surprise for 'our' Marie Johnston, who has been around since the start of EHPS, and got a very nice and personal gift as a "big thank you Marie"; no doubt well-deserved. Well-deserved because we owe her a lot; for all her input, guidance, mentoring, inspiration and so much more.

Below you will find a couple of facts and evaluations on the basis of – among others - answers of around 200 delegates on a questionnaire which was distributed in the week after the conference.

We had excellent keynotes:

•Prof John Cacioppo, University of Chicago, who gave a keynote entitled "The Social Brain, Health, and Well-Being",

•Prof Marie Johnston, University of Aberdeen, who talked about "Making Behavioural Science Fit for Behaviour Change Interventions".

•Prof Kevin Patrick, US San Diego School of Medicine with a keynote entitled "From Personal Health Data to Population Health Improvement: New Data, New Insights and New Challenges", and

•Prof Aleksandra Luszczynska, University of Social Sciences and Humanities, Wroclaw on: "Ways to Increase the Impact of Behaviour Change Interventions in a Real-World Setting".

They were very well evaluated (around 50% said 'excellent' and around 40% good/very good). However, it is obvious that we can't satisfy everyone with all we have to offer at our conferences. This can be seen from individual remarks delegates gave, for example about the Keynotes as well as the State of the Art Lectures (also well-received; although slightly less than the keynotes). I would say it will be hard to get any better in the future because, what some people clearly like, others don't like and will rate therefore as less good. However, I found it particularly remarkable that the ratings (of the 200 respondents) rarely resulted in a rating of 'poor', i.e.: keynotes (1), state of the art (1). The same holds for the other categories: pre-conference workshops (0), symposia (0), roundtables (0), oral paper presentations (0) posters (2). So, overall the ratings were very skewed (which is good for such an event), towards above the average score: indicating (very) good to excellent. Hence, we can thank all the presenters for their well-received presentations, and of course the scientific committee for putting this all together so nicely and handling the enormous task. In particular, we would like to thank Wendy Hardeman (Chair of the Scientific Committee) for doing such a great job, supported by Kevin McKee (Co-Chair) and their SC-team. Wendy did a lot to further improve EHPS procedures and I am sure her work will be of great help for the EHPS conferences to come. This also

holds for the terrific work of Easy Conferences. The EHPS started to work with this company for the Cyprus conference and we are glad with the continuing partnership, it improves our services and surely helps to professionalize our conferences even further.

Following the ratings, we could simply conclude with– all good to excellent so no need for reflection. However, if we have a look into the individual remarks there is still a lot to learn from. So, for example some people would like to have more opportunities to talk one-to-one with poster presenters, find sessions with so many talks too much to digest, suggested excluding the chairs of a session having a time-slot in the same session, would like to have e-mail details of delegates in order to get into contact more easily, topics or themes they miss out, and many many more comments. We would like to thank the delegates who gave all the valuable comments and for being so positive in a lot of the written comments. The EHPS and future organizers will surely make use of it. However, we must be realistic in that, certain suggestions to change may lead in the future requests to change it back. We have already seen this in the past. Nevertheless, we are committed to make use of the comments and keep improving our conferences. By and large the comments do support the very positive evaluation of the Aberdeen event.

Now, if we have a look at the organizational part (conference site, social program, catering and the like) we can conclude that the delegates were very enthusiastic about the conference. Many explicit very positive remarks about the practicalities of the conference were made; like "What to change? Nothing!"). Also comments to improve or to change things (most people made positive comments about the conference building, but reported a desire to have the conference more centrally located in the city). The local organizers did a fantastic job and big thanks goes out to Marijn de Bruin (Chair) and Clare Cooper (Co-Chair) and Nikki Pearce (local conference bureau) for their fantastic work and for giving us an unforgettable event.

Robbert Sanderman
Past-President EHPS

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