European Network of Homeless Health Workers (ENHW)

Issue N°10 – summer 2009

Editorial

Stefania Del Zotto, *Policy Officer, FEANTSA*

Dear Readers,

In the current issue of the ENHW newsletter you will find a number of articles covering a variety of topics relevant to homelessness and health. These include: a word from Angela Jones and Igor van Laere, co-initiators of the network; an overview of the daily activities of street nurses in Brussels; a reflection by a young physician calling for more awareness of homelessness; an article on social relief policies in the Netherlands, as well as an account of a patient's experience written by a doctor from the Netherlands.

In the resources section, you will find information on a FEANTSA-MHE joint statement on homelessness and mental health; the link to a report on access to health care for undocumented migrants in 11 European countries published by Médecins du Monde; information on the CHIPS programme aimed at undergraduate medical students of Liverpool University as well as a link to recent research on emergency service use by homeless people in the US.

In the forum section, readers are invited to send relevant information to the French National Health Insurance Fund, which is currently carrying out research on how marginalised populations are integrated in prevention programmes at national level in the different European countries.

We hope that this reading will stimulate further reflection and interaction. Please do not hesitate to send us articles, links to relevant research and information about future events you organise for the next issue of the newsletter (deadline for reception: 20 November 2009). Should you wish to contribute in a different language, please send us an accompanying paragraph summing up the content of the article in English.

I would like to extend my warmest thanks to everyone who has contributed to the current issue. Please do not hesitate to send your responses, comments, questions and contributions for the next issue of the newsletter to stefania.delzotto@feantsa.org.

News from the ENHW

Congratulations on the tenth ENHW newsletter on homelessness and health

Angela Jones and **Igor van Laere** *
Doctors for homeless people in Oxford, UK, and Amsterdam, the Netherlands

As initiators of the European Network of Homeless Health Workers, in cooperation with FEANTSA, we applaud to all those who have contributed to ten editions of the ENHW newsletter. What a wonderful achievement.

The seeds for the initiative to share knowledge and experience in homelessness healthcare were planted in 2006. In this year we met at the inaugural Oxford Health and Homelessness Conference, and in Amsterdam, at the Doctors for Homeless Workshop, hosted at the International Conference on Urban Health (1). During these events and by meeting international experts on homelessness and health it became clear that there was a need to develop tools for mutual learning. Besides online teaching programs and professional meetings at Oxford University, a newsletter for professionals in the field was postulated.

Early in 2007, we both went to Brussels to meet with FEANTSA's director Freek Spinnewijn and policy officer Dearbhal Murphy. We agreed on a creating a newsletter for the European Network of Homeless Health Workers, with editing and practical support of FEANTSA. After contacting people in our networks, who happily contributed their experiences, the first edition appeared in spring 2007. During the preconference dinner, at the Second Homeless and Health Conference in Oxford, fall 2007, the ENHW was launched and introduced to many professionals skilled in homeless health work. From than on many have written and shared

their reports from the fields. We applaud both our friends in the network and the initial professional editing and support provided by FEANTSA's Dearbhal Murphy and currently Stefania Del Zotto.

Today we read the tenth edition. We are proud of this wonderful accomplishment. Through the ENHW newsletters a broad variety of programs, initiatives, knowledge sources, and meetings, that all focus on homelessness and health, have been shared across Europe and other continents. These efforts clearly demonstrate the contributors' passion for their profession and aim to provide and improve services to those unsheltered and in high need of social and medical support.

It is the hope that many editions will follow to continuously learn from each other to better help those in highest need.

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Sharing Experiences

Street nurses in Brussels

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Access to hygiene and health care are a major problem for people living in the street. The Belgian organisation "Infirmiers de rue " (street nurses) believes that this can and should be changed. The organisation was founded four years ago and focuses on homeless people and people living in a precarious situation. It aims at acting as an intermediary between them and specialized care services. The organisation's objectives are: to give people the motivation (back) to take care of their health and hygiene; to train health personnel, social workers and security personnel; to improve the environment of the homeless people

Below you will find an analysis of the situation in Brussels as well an overview of the responses brought by Infirmiers de rue in this context.

What is the problem?

We studied the link between health and precariousness in Brussels. We found 3 main problems:

1) The people who live in the street are not always motivated to care about themselves. They don't know where they can go, they are ashamed to speak about their hygiene and their health, they don't understand the information from the medical personnel, and sometimes they are totally cut from their body, so they don't feel the pain, they don't perceive their smell. This explains why some of them are in very bad physical condition.

2) The medical personnel at the hospital or in other health structures doesn't succeed to speak about hygiene with this group and they don't always adapt the treatment to the street environment (strong and more resistant dressings, simple treatments, etc.). Sometimes they are also discouraged when they see a homeless person who is coming with a lot of problems.
The personnel of social services and homeless organisations, even if they are more accustomed to this specific public than the medical personnel, doesn't succeed either to speak about hygiene with the homeless persons.

3) Facilities and environment are not always adapted to the needs of this public.

How do we work?

To address these problems, Infirmiers de rue has developed the following actions:

1) We motivate people and give them the trust back in the medical services.
We are a team of nurses only, so that the person, when meeting the team, is "forced" to think about his/her health and hygiene. We go in the patient's environment during the day, when other medical services are open: when necessary we can go with the person to a medical consultation or hygiene centre. We walk by team of two nurses in the street, and we meet the person where he/she is. By doing this, we inspire confidence, and little by little the person will accept to speak and then to take care of him/herself. Sometimes we give the first aid and care in the street, but generally we tend to encourage and support the patients when going to the doctor and to the dispensary where they can take a shower or receive medical care. Slowly, we

create a new dynamic and the person becomes responsible for his/her body again.

2) Training: we have set up two kinds of training: "hygiene and precariousness" and "first aid".

- Hygiene and precariousness

There are three different trainings: for the health personnel, for the social workers, and for the security personnel (railway and underground stations, parks). The aim is to train people to adapt their way of working to the homeless people, to allow these professionals to have appropriate reactions and to be more effective in their work.
For example: health professionals are told to put more energy into the relation with the patient, and to streamline the treatment. Social workers are sensitized to the importance of hygiene, how to use it as a tool in their daily work, how to speak about it. Security personnel are told about how to approach homeless people and maintain good relations with them, about the importance of hygiene and how to adapt the environment for better hygiene and cleanliness.

- First aid

The aim is to train the personnel of institutions or organisations to use a very basic first aid kit, in order to be able to face little medical events of daily life. For any other problem they can call us to do the first medical intervention at their organisation.

We also go in different nursing schools and we raise awareness among students so that they adapt their reception and medical treatment for the people who live in the street.
We work with emergency services at the hospital and with the health services to ensure good cooperation.

3) We change the environment or the way people can make use of it.
We issued some tools, like a map, which mentions all drinking water fountains available in Brussels, or a poster with what to do during a heat wave (drink more water, stay in a cool place, …). The map of the fountains was given in the street to the homeless persons, but also to the homeless organisations, and it was also posted in the railway and in the underground stations. The poster was distributed to all interested organisations.
The aim is to improve the use of the existing infrastructure, but also to stimulate the authorities to improve and broaden the offer. These services are also used by everybody, not only homeless people: e.g. fountains or public toilets (see below) are also used by tourists and passers-by.

Expected impact

So far, we could really see an improvement of the self-esteem of the persons we have been following. They speak more easily about their health and their hygiene, they ask about risks and they act in a more responsible way towards their health. For example some of them bought and continued to use the cream that we used with them; others went back to the doctor. Since the setting up of our organisation four years ago we have seen a decline in people faced with very heavy conditions on the street. However, more work will be necessary to have a real impact on mortality or morbidity.

Further development

Infirmiers de rue hopes to further develop a number of activities in the near future, including:

- to have a stronger presence in Brussels to give an answer to all the demands and to reach all the persons who live in the street;
- to develop training sessions for more people and organisations, in order to create a different approach in the sector as a whole, which could generate a change in practices in general.
- to produce more tools, like a map with the public toilets.
- Finally, we will consider the opportunity of starting activities in other towns.

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Perceptions of homelessness amongst youth and health practitioners: a young doctor's view

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I am a young physician working as a registrar in family medicine and community health in Reus, Catalonia. When I was a student, I have been active in the International Federation of Medical Students Association (IFMSA) working with youth and public health.

Do European youth care about homeless people? Do young health practitioners know enough about them?

Last July I was participated in a conference organised by the European Youth Forum and the European Commission on health of young people (1). In this context I was asked to facilitate a working group on youth and health inequalities, which included a part was focused on homeless. Many topics were raised, but participants have to work on the following sentences:

1) Unemployment: free health care for all young people, who are not in formal education structures, as prevention to unemployment.
2) Homelessness: educate at risk young people living in care on their rights regarding access and coach them on practical survival methods. Example: how/where to find job/housing, etc...
3) Cross-border health care: the new directive should take regional health inequalities into consideration, so as to create incentives for Member States to improve their own health infrastructure.
4) Patients' rights: the existing patients' rights charter should be enforced to introduce a realistic (basic) set of rights that apply to all European citizens.
5) Human rights: everyone should have access to basic healthcare and have the same rights as the citizens of the country.
6) When studying, health professionals should receive a training relating to different cultural backgrounds and cultural sensitivity.
7) Health care should not discriminate on the basis of sexuality.

As it appears from the sentences that were drafted by a group of young people from all around Europe, there is a lack of information about homeless people and about the ones who meet them during their daly routines. As almost everybody has his/her own house, there is not a special interest among the society to think about housing exclusion. Usually it is only when you meet homeless people or have someone near you having problems that you start thinking about them.

In this context, I would like to mention my daily work and the main problem I faced when I started my residence. After 6 years of medical studies, I have never found a subject that taught me about how I should treat patients in a personal way, only the biological way as if every patient was a concrete disease. But now that I spend 24 hours a day in the emergency department I feel I miss these kind of lessons. There is no book that explains you what you should do with people who come to the hospital and are living in the street. Physicians only treat the disease, which is the reason why they came to the hospital, without helping them to find a place where to stay. Contacting the social workers is not enough. Sometimes homeless people are illiterate and can't fill out all the papers they need to provide before contacting the social worker, and no doctor will lose his/her time to help them. I'm used to hear in the emergency department, "Oh, here comes J.A. again...he needs a place to sleep!" Yes J.A. is a well-known homeless person in my city, who knows that when he is ill he can go to the emergency and stay a few days to recover but then once he better, he will go back to the street. Nobody is going to call the social workers or to ask him about where is he lives. Why should they do that? Why would they, if no doctor at the university showed them to do it?

What I would like to highlight with this example is that there should be a specific part of the medical curriculum where sutdents can learn about patients as a whole and not only as a disease. Medicine should be a bio-psycho-social science and should not only focus on biology. There should be a protocol on how to support homeless people or people with social problems as there are protocols to follow when someone comes to the hospital suffering from a headache or an acute coronary syndrom.

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(1) Information available at: http://ec.europa.eu/health-eu/youth/index_en.htm.

Social Relief Policies to Reduce Homelessness in the Netherlands

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Over the recent years, in the Netherlands, major efforts have been made to reduce homelessness and to improve the living conditions of those who are homeless. The target groups, ambitions and performance indicators are usually reported in Dutch language. In this article the recent Dutch social relief policies, and the eviction prevention practice in Amsterdam in particular, are presented to be shared internationally.

In the Netherlands, the Social Support Act was introduced in 2007 (1). This Act specifically includes a 'performance field' to serve those threatened with homelessness, the residential and factual homeless people. This performance field is named Public Mental Healthcare; in Dutch: Openbare Geestelijke Gezondheidszorg = OGGZ (1-9). The OGGZ can be described as a harm reduction 'patchwork-system' for vulnerable people with multiple problems, who, stepwise and increasingly, harm themselves, their social networks, if any, and society. In response, specific social and medical services appeared, stepwise and increasingly, in a fragmented way.

Social relief plan

In 2006, as a preamble to the Social Support Act, the Dutch Government and the four big cities (Amsterdam, The Hague, Rotterdam and Utrecht) introduced a Social Relief Plan to reduce homelessness and to improve the condition of those who are homeless (6). In this plan it was estimated that the four big cities harboured 11,800 people threatened with homelessness, and 10,000 rough sleepers and homeless people living in temporary accommodation. Furthermore, others reported around 6,000 street youth in the Netherlands in 2007, of whom 50% would stay in the four big cities (10). In addition, to include those vulnerable to homelessness in other settings, around 35,000 people stay in Dutch Penitentiary Institutions per year (11), and around 59,000 people were admitted in a residential Mental Health clinic in 2007 (12) .

City compass

As a guideline to translate the Social Relief Plan to the local situation in the four big cities and in other Dutch cities, the objectives and methods were presented in the so called City Compass (6). The Compass aims at an individual and problem oriented assistance approach, for which interagency agreements are made to meet up to a multitude of problems among the most vulnerable in our communities. Hereto, target groups and ambitions are defined, and five performance indicators serve as a landmark for data to be shared periodically with a central monitor (13).

The target groups, ambitions and the performance indicators are based on a so called five step OGGZ ladder [7]. Along this ladder, each step down represents a growing burden of multiple and interacting problems, and a growing need of multiple services and professionals to reduce harm. The last step reflects the situation of a person sleeping rough. In table 1, the objectives, target groups, ambitions, and performance indicators, are shown. The performance indicators 1-3 are based on the sources of homelessness, related to settings and signals that include a potential for service providers to be or become in contact with the most vulnerable people. In the Netherlands, evictions, as well as relationship problems in combination with specific social and medical problems, are found to be the major triggering sources of homelessness (14-16). As regards the reduction of homelessness, the eviction prevention practice in Amsterdam is outlined below.

Prevention of evictions

Preventing evictions will most likely contribute to the reduction of homelessness. Hereto, Early Reach Out services have been introduced. According to this method, landlords can report households with two months in rent arrears to these services. In response, a home visit is conducted by a social worker, in cooperation with a financial worker, to explore the social and financial condition and act accordingly (17). In 2007, in Amsterdam, most commonly social landlords reported 1,353 households (0.5% of all rent dwellings) to the Early Reach Out services (of these 30% had two months rent arrears and 70% had 'serious' rent arrears), 599 home visits were conducted, 61 evictions were

reported, and for 162 households the outcomes were unknown. For 2008, the Early Reach Out figures were 1,502, 1,042, 57 and 115, respectively (18). In order to comprehend these figures the Early Reach Out data have to be related to the total eviction picture. In 2007, in the total Amsterdam rent sector, 5,491 households were served with an eviction court verdict (1.9% of all rent dwellings), of these 4,167 were presented to the housing effects management (1.5%), and 1,303 households were actually evicted (0.5%) (14).

Although the Early Reach Out support is most likely beneficial for the households visited, at least temporarily, knowledge is needed in order to be able to judge if the households that receive a home visit belong to those with a high eviction risk. In other words, who among the households do the Early Reach Out services need to visit in order to prevent an eviction that would be executed if no assistance would be provided? For example, in Amsterdam, with around 300,000 rent homes and let's say ten percent in rent arrears, who among these 30,000 households should be visited when staff, time and budget among the Early Reach Out services is limited? Moreover, since 1.9% of all rent dwellings were served with an eviction court verdict, 0.5% of households with two months rent arrears or longer were reported by the landlords (of which 44% were visited by the outreach services in 2007 and 69% in 2008), and 0.5% of all tenants were actually evicted (with an unknown overlap with those reported by landlords to the Early Reach Out services), the need for targeted outreach support seems evident. Furthermore, to integrate the Early Reach Out figures in the total eviction picture, Early Reach Out services should collect additional and eviction process related data to be shared with a central point.

As regards the eviction prevention practice, the criteria to be applied by social and private landlords to report households to the Early Reach Out services should not be based on two months rent arrears alone. Moreover, policies should also aim to prevent community budget unnecessarily spent on rent court applications to evict tenants that will not be evicted in the end, and not on those households who can mend their own way. That is to say, the aim should be to narrow the gap between the number of eviction court verdicts and the number of households reported by landlords to the Early Reach Out services. Consequently, only the most vulnerable households should be reported by landlords to the Early Reach Out services, whereas others should be referred to mainstream services. To learn to know the most vulnerable households and their problems, both landlords and the Early Reach Out services should collect defined data that give insight in the household characteristics, underlying social and medical problems encountered, eviction process steps, problem oriented interventions and referrals, and the outcomes and results of the interventions applied. For this, landlords and the Early Reach Out services are in need of additional academic support (15, 17).

Conclusion

Although much remains to be learned about how to prevent people from experiencing homelessness and how to improve the condition of those who are homeless (14-16, 19-21), the Dutch social relief policies to reduce homelessness are a good first step. As a next step, for the eviction prevention practice, it is up to policy makers, service providers and the academic world to collect those data that contribute to the knowledge needed to reach and assist those households in highest need in our communities. Targeted support should reduce the number of people experiencing homelessness whereto community budgets should be spent cautiously. Furthermore, the support introduced should be based on integrated knowledge and experience. Only together we can keep more people at home.

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(12) See: www.ggznederland.nl.
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Table 1: the Dutch Government's Public Mental Healthcare (OGGZ) Objectives, Target Groups and Ambitions to reduce homelessness

General Objectives
increase life expectancy
prevent avoidable deaths
improve the quality of life
Objectives performance field OGGZ
reduce homelessness
improve the condition of people threatened with homelessness
improve the condition of homeless people
reduce the related public nuisance
Target Groups
households at risk of eviction
ex-prisoners
ex-residential clinic users
residential homeless
factual homeless / street youth
Ambitions (performance indicators)
30% eviction rate reduction in the social housing sector between 2005 and 2008 (1)
monitor the number of evictions in the social housing sector (1a)
monitor persons who become homeless and use shelters within 30 days after an eviction (1b)
minimise homelessness after release from prison (2)
monitor persons who become homeless and use shelters within 30 days after prison

minimise homelessness after residential clinic discharge (3)
monitor persons who become homeless and use shelters within 30 days after clinic discharge
provide housing for 60% of the homeless by 2010, and assign a case worker to all homeless
people in the four big cities by 2010 (4)
monitor persons with an intake an individual care plan (4a)
monitor persons for whom housing, income and care is realised; stable mix (4b)
75% public nuisance reduction between 2006 and 2013 (5)
monitor persons with an individual care plan and 5 or more police contacts within a year

Source: (5, 6).

* Igor van Laere, MD, Founder and Director of the Doctors for Homeless Foundation Amsterdam. This foundation aims to share international social medical knowledge and experience in practice, education, research and policy making, to better assist poor and underserved people in our communities. welcome@doctorsforhomeless.org

The story of Jim

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Jim was a craftsman. He was a metalworker and made beautiful things. Illegal labour subcontractors usually had work for Jim. Jim was an Irishman who had lived in Rotterdam for a long time. He knew Rotterdam and Rotterdam knew him. Jim knew where to get his cocaine. He did not feel he was a homeless person. He wasn't. He had a job and he had a room. He just needed his cocaine. Often he was too short of breath to be able to work. Then he did not have money to pay his rent and became homeless and ill at the same time.

Jim smoked his cocaine as "crack". That means he smoked the cocaine in a pipe and the cocaine vapour would go directly into his airways. Crack can be made with sodium bicarbonate which takes a little longer. Crack, however, can also be made with cheap ammonia. Unfortunately, Jim's dealer chose the easy way and the good money. Bad luck for Jim. And bad for Jim's lungs. When smoking cocaine, your lungs get worse very quickly. But if the cocaine is made with ammonia, you will be even worse.

Jim was not the only one. Practically all cocaine users have lung problems. This is not only because of infections in the lungs and airways but also because of the cocaine and ammonia. Twenty five years ago, I once climbed on a table in a shelter for homeless people. Everybody had to know. Then the message was: "Don't shoot up heroin, there is a new disease: AIDS!" Now, history repeats itself. "Don't use coke. Coke is trash."

Jim was in the infirmary again. He was in a very bad condition. Jim was 47 and practically dead. His lungs were fully stretched, not just because of cigarettes but particularly because of the coke and the ammonia effect. The doctor in charge was wise and honest. "Jim, maybe the hospital will be able to help you but you yourself will have to fight for your health." When I, as a lung specialist, have someone admitted to hospital and artificial respiration needs to be applied, there is no point if he will start taking cocaine again. When someone uses coke again after admission to the hospital and artificial respiration, there will be no further treatment. There is a capacity problem in hospitals with ventilation machines and in cases like this it leads to nothing at all.

Jim had artificial respiration because the lung specialist, the general practitioner and Jim had an agreement. He would have one more chance. He was told honestly that this would not happen again if he started using again. Everybody fought. Jim recovered. After hospitalization he regained his strength in the infirmary. Thanks to extra nutrition his condition improved. His muscles became stronger and his breathing got better. One year later, Jim still died because of his lung condition. Jim teaches us: Don't use coke. When you are sick, your condition is often bad. Eat well. Coke also breaks down your muscles! Talk to nurses and doctors. Even if you are sick, you will still get a chance. Don't blow that chance. Nurses and doctors can't do it all…

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Resources

FEANTSA-MHE joint statement on homelessness and mental health

FEANTSA and Mental Health Europe (MHE) have recently issued a joint statement on homelessness and mental health.

The two organisations joined forces and called on newly elected Members of the European Parliament to support previous commitments and make a difference in the fight against homelessness and the promotion of the mental well-being of the population.

The paper, which is available in English and French, can be downloaded from FEANTSA's web site, health and social protection section.

Médecins du Monde's report on access to health care for undocumented migrants

Médecins du Monde has published its second report on access to health care for undocumented migrants. It is the result of two surveys carried out in 2008 in 11 European countries.

The report gives an overview of who these vulnerable migrants are. It shows how their living condition affects their health and which obstacles prevent them from accessing health care and further increase their vulnerability.

The report, as well as a press kit, is available online in English, French and other languages.

For more details, see Médecins du Monde's Observatory web site.

The CHIPS Programme for undergraduate medical students

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"CHIPS" stands for Cheshire and Merseyside Health Inequalities Program for Students.

Aim: Experiential training program on health inequalities

Participants: Undergraduate medical students (but also applicable to nurses and social workers)

Learning outcomes:
1. To understand the causes and consequences of health inequality, and to be up to date with current literature in this area.
2. To learn about the main clinical problems of the socially excluded, focusing on four key groups: asylum seekers, homeless people, Travellers and prisoners.
3. To explore the best ways to provide health and other services for hard to reach groups, in a sustainable fashion.
4. To reflect upon these issues and relate them to their future role as qualified professionals, and to consider ways to manage stress and avoid burnout.

Program Structure: Core learning activities. This is a 4 week elective program.The first 2 weeks are an experiential 'immersion' program, with numerous service learning visits. The last 2 weeks are to write up a 3000 word interpretive essay, to include case histories, and a personal reflection.

Course evaluation and student feedback: students typically say that their 'eyes have been opened' in their personal reflection. Many offer to volunteer with the NGO's they have visited. Over 50% receive a 'Merit' or 'Distinction' for their University evaluation for this course.

Service user involvement: this is crucial to the success of this course. Service users are involved from day one. Students typically say that this aspect

of the course is the most useful, and it helps to bring public health issues to life.

Academic links: this course is funded through the School of Medical Education at Liverpool University, UK.

Conclusion: this is a very effective course in changing student's attitudes to socially excluded groups. It is also a rewarding and enjoyable course to teach on.

* For further details contact Dr Joseph O' Neill, Chair Global Inclusion, Administrator Gina Phillips at global.inclusion@yahoo.co.uk.

A Comparison of National Emergency Department Use by Homeless versus Non-Homeless People in the United States, by Gary Oates, MD, Allison Tadros, MD, Stephen M. Davis, MPA, MSW, Project MUSE, Journal of Health Care for the Poor and Underserved 20 (2009): 840–845.

The study, which has been published in August 2009 by the Journal of Health Care for the Poor and Underserved, shows that homeless patients who visited Emergency departments in the United States in 2005 were more likely to arrive by ambulance and were less likely to be insured compared to non-homeless patients.

An abstract of the article is available on the Project MUSE web site.

Forum

The French National Health Insurance Fund is looking for information

Christian Foury*
French National Health Insurance Fund

The French National Health Insurance Fund is the main actor of the French healthcare system as it finances both the ambulatory and hospital care sectors under the supervision of the French Ministry of Health. We also play an important role in the prevention sector. We are currently carrying out a research on the integration of marginalised populations into the prevention programmes in different European countries.

We would be pleased if readers could answer the questionnaire we have been circulating to help us gathering relevant information in this context.

The goal of the research is to identify how the different European Member States are targeting marginalised populations (our definition of marginalized populations is included in the note) to help them participating in prevention programmes (primary prevention as a first step and then secondary and tertiary prevention if necessary).

The questionnaire is available in French and English.

Deadline for receipt of responses: end of September 2009.

Responses should be sent to Christian Foury at christian.foury@cpam-lemans.cnamts.fr.

Further details can be found on www.ameli.fr.

* Christian Foury is the Official Representative of the International Research of the Mission for European and International Relations and Cooperation of the French National Health Insurance Fund.

Events

Conference on Health Care and EU law
Nijmegen, The Netherlands
Date: 1 and 2 October 2009
The relevant information is available online.

Health Impact Assessment conference
Rotterdam, The Netherlands
Date: 14 - 16 October 2009
The relevant information is available here.

Conference on support after discharge/ release from treatment institutions or prison
Gothenburg, Sweden
Date: 24 November 2009

The conference is organised by the National Board of Health and Welfare and will be in Swedish. Relevant information is available here.

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The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries.
To that effect, PROGRESS purports at:

- providing analysis and policy advice on employment, social solidarity and gender equality policy areas;
- monitoring and reporting on the implementation of EU legislation and policies in employment, social solidarity and gender equality policy areas;
- promoting policy transfer, learning and support among Member States on EU objectives and priorities; and
- relaying the views of the stakeholders and society at large.

For more information see: http://ec.europa.eu/employment_social/progress/index_en.html