

**10th SYMPOSIUM
ON PUBLIC HEALTH**

10
**Networks in Public Health:
at the Crossing of Practice and
Research**

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Observatoire de la Santé du Hainaut

Université de Mons Hainaut

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Programme / Programma

9:15 – 11:00 Plenary session 1

Welcome address on behalf of the BAPH:

Prof. Dr Guido Van Hal (UA), president BAPH

Welcome address on behalf of the Province du Hainaut

Dr Luc Berghmans, Director Observatoire de la Santé du Hainaut

Welcome address on behalf of the Université de Mons (UMons)

Prof Sven Saussez, Vice-dean UMons

Keynote lecture 1

“Networks in Public Health”

Prof Dr Mathieu Ouimet, Université Laval, Québec, Canada

Keynote lecture 2

“Thirty years Registration Network of Sentinel General Practitioners”

Dr Viviane Van Casteren, Scientific Institute of Public Health, Brussels

11:00 - 11:25 Break

11:25 - 13:00 Parallel sessions - part 1

Parallel session 1: Health Information and Health Policy

Parallel session 2: Health Promotion and Lifestyle

Parallel session 3: Mental Health and Environment

Workshop 1: Mise en place d'itinéraires cliniques

13:00 - 14:00 Break and poster session

14:00 - 15:30 Parallel sessions – part 2

Parallel session 4: Health Programmes

Parallel session 5: Child Health

Workshop 2: Developing a health information system (HIS) and a health information dissemination system (HIDS): the necessary channels from a European Point of view

15:30 -16:15 Plenary session 2: Round table and conclusions

Networks in Public Health

by

Ouimet M¹

This talk aims at improving our understanding of networks by mobilizing research knowledge from four disciplinary fields:

- 1) physical sciences,
- 2) sociology,
- 3) management sciences, and
- 4) political science.

Key messages for network creation and maintenance in public health will be derived.

More precisely, this talk will address the followings:

- i) basic conceptual definitions of networks,
- ii) variety of networks,
- iii) key findings from complex network research in physical sciences,
- iv) key findings from sociological network research,
- v) key findings from inter-organizational research in management sciences,
- vi) key findings from network research in political science, and
- vii) key messages for network promoters in public health.

¹ Université Laval, Québec

Thirty years Registration Network of Sentinel General Practitioners

by

Van Casteren V¹

Abstract

Aims

In 1979 a Registration Network of Sentinel General Practitioners was set up in Belgium as a new tool for public health surveillance. The aim was to estimate the importance of health problems within the general population, expressed in terms of incidence, and to study the management and follow-up of health problems encountered in general practice.

Methods

A group of GPs, spread over the country, participates on a voluntary basis in a weekly paper-based recording of a list of health problems. The recording programmes comprise 8 to 9 different health problems, which can vary from year to year, according to the selection by the Steering Committee of the network. The denominator population is estimated on the basis of the number of consultations in the participating practices.

Findings

The recording of a wide variety of health problems led to a considerable list of reports and publications at the disposal of the scientific community and the public health authorities. Several themes were explicitly registered at the request of the latter for the purpose of policy development and evaluation. The network grew to about 170 practices well spread over the country with little turnover of GPs.

Conclusions

The past 30 years were very successful for the Registration Network of Sentinel General Practitioners. The future however is challenging. The network's place among the wide variety of current health information sources should be consolidated and a progressive orientation towards EPR-based recording should be adopted.

¹ Scientific Institute of Public Health, Public Health & Surveillance, Brussels, Belgium

Keywords

Sentinel surveillance, general practice

Introduction

In 1978, a group of enthusiastic general practitioners (GPs) and researchers from respectively the Scientific Association of Dutch speaking General Practitioners (WVVH, presently Domus Medica) and the Institute of Hygiene and Epidemiology (IHE, presently the Scientific Institute of Public Health, WIV/ISP) started up a pilot study on the surveillance of infectious diseases encountered in general practice. The initial purpose of this new surveillance tool was to get more reliable data than those originating from the system of compulsory notification of infectious diseases. Inspiration was sought in similar registration networks abroad (UK, Weekly Returns Service; the Netherlands, the Sentinel Stations) (1). After a few months, GPs from the Scientific Association of French speaking General Practitioners (SSMG) joined the pilot network.

The GP was chosen as health information source as in many countries he is the point of entry to the health care system and a wide variety of health problems are (exclusively) seen in general practice. Even in Belgium, where the GP does not have a gatekeeper function, 95% of the general population always visits the same GP and 79% of the general population has at least 1 encounter/year with a GP (2).

The network described in this article is a sentinel surveillance network; surveillance meaning the ongoing systematic collection, analysis and interpretation of public health data for use in planning, implementing and evaluating public health programmes (3). Sentinel (surveillance) means that a group of GPs (not all GPs) provides information on health problems, therefore not covering the entire population, but providing sufficient information for public health decisions and for studying time trends.

This kind of sentinel surveillance network was, in the course of the first European collaborative study with similar networks all over Europe, commonly defined as “a system that keeps a watchful eye on a sample of the population by supplying regular and standardised reports on the incidence and main epidemiological characteristics of specific diseases and of procedures in primary health care” (4).

Although the initial purpose of this new surveillance tool was to get more reliable data than those originating from the system of compulsory notification of infectious diseases, expressed in terms of incidence, very soon after the start non-infectious diseases were also included in the registration list and the recording was enlarged to a set of epidemiological

characteristics of the health problems under surveillance. The goal of continuous observation of certain health problems over time, such as measles, mumps, chickenpox and flu, enables to study the impact of prevention and vaccination campaigns or to function as an early warning system. In the course of its existence, an additional goal of the network became the study of the management and follow-up of health problems in general practice.

This article deals with various aspects of the network: the partners in the network, the denominator population, the registered health problems and registration forms, the reporting activities and the collaborative studies with similar networks at European level.

Method

Partners and Steering Committee of the network

From the start, the participating GPs, the Scientific Associations of GPs and the central coordinating team at the IPH are partners in the network. Interaction between these partners has long been on an informal basis. As of 1987, a Steering Committee, with delegates of the mentioned partners, meets twice or three times a year. Since 1991, this Steering Committee is enlarged with delegates of the Dutch and French speaking Community, who since that year financially support the network. Interaction with the mentioned partners in the network goes through this Committee. The latter is involved in the choice of the health problems to be recorded, the follow-up of the analyses and of the reporting activities.

Central coordinating team

The central coordinating team at the IPH is involved in methodological issues, in quality control of the participation and of the recorded data and in the analyses and reporting of the data.

Interaction between the coordinating team and the participating GPs goes through e-mail, regular mail and telephone exchange.

Participating GPs

At the start, an opportunity sample of GPs was taken to set up the network, resulting in a non-representative group of highly motivated GPs. In the course of its 30 years of existence, continuous efforts were made to get, by contacting random samples of GPs, a more and more representative group of participating GPs in order to enable extrapolation of the data to the whole country. Representativeness of the GPs remains an important methodological issue as participation has always been on a voluntary basis.

The geographical spread of the GPs was, in the course of the 30 years, presented in various ways, but the ultimate goal has always been to have participating GPs in all 43 administrative districts ('arrondissement') of the country and to cover at least 1% of the global population in each one of them (5).

Denominator population

Belgian GPs have no gatekeeper function and medical specialists are freely accessible. A fixed patient list per GP is not available, hampering the exact calculation of the denominator population. The latter is up to now estimated on the basis of the annual number of encounters in the participating practices divided by the mean annual number of encounters in general practice per inhabitant, according to the following formula (5):

$$P = \sum_{i=1}^{43} P_i = \sum_{i=1}^{43} \frac{CSGP_i}{CGP_i / Ni}$$

P = sentinel population

P_i = estimated population of a district

CSGP_i = total annual number of contacts with sentinel GPs in the district

CGP_i/N_i = mean annual number of contacts with GPs per inhabitant in the same district

Age and sex distribution of this denominator population is assumed to be close to the Belgian population as far as the participating GPs are representative according to age and sex distribution of the Belgian GPs and are homogeneously spread over the country. This denominator approach provides a crude estimate of the denominator population.

The yearly contact group denominator (=number of patients seen at least once a year in a practice), corrected for the non-attenders, can be considered the best estimate of the practice population in countries where patient lists are not available (6). However, this kind of denominator approach is not feasible in a paper-based recording system. An EPR (electronic patient record)-based data collection could offer perspectives in this matter.

Registered health problems and registration forms

Health problems can be included in the recording list as far as they concern problems for which the responsibility of diagnosis, treatment and follow-up rest with the general practitioner; as far as they can have a clear and standard definition; as far as they are important health problems not subject to surveillance of another system (unless the network of sentinel general practitioners provides complementary information); as far as they encounter a frequency which on the one hand allows statistical analysis,

but on the other hand does not represent too heavy a burden on the participating physicians.

So far, recording is paper-based using weekly registration forms comprising 8 to 9 health problems included in the annual registration programme. Besides these weekly registration forms, specific follow-up forms per health problem are used in order to capture missing information and information on e.g. the presence of complications, confirmation of diagnosis and follow-up of the patient after the event.

Reporting activities

Retro-information is regularly distributed to participating GPs, concerned authorities, medical press, scientific associations and interested individuals in the form of reports, newsletters, scientific publications and presentations. The participating GPs receive an annual feedback on their own results as compared to those of their participating colleagues.

Collaborative studies at European level

A number of European countries have organised comparable surveillance networks and in the framework of several projects financed by the European Commission, international surveillance concerning e.g. measles, mumps, HIV tests, chickenpox, diabetes, stroke and influenza-like illnesses has been undertaken in the last 20 years (4;7-9).

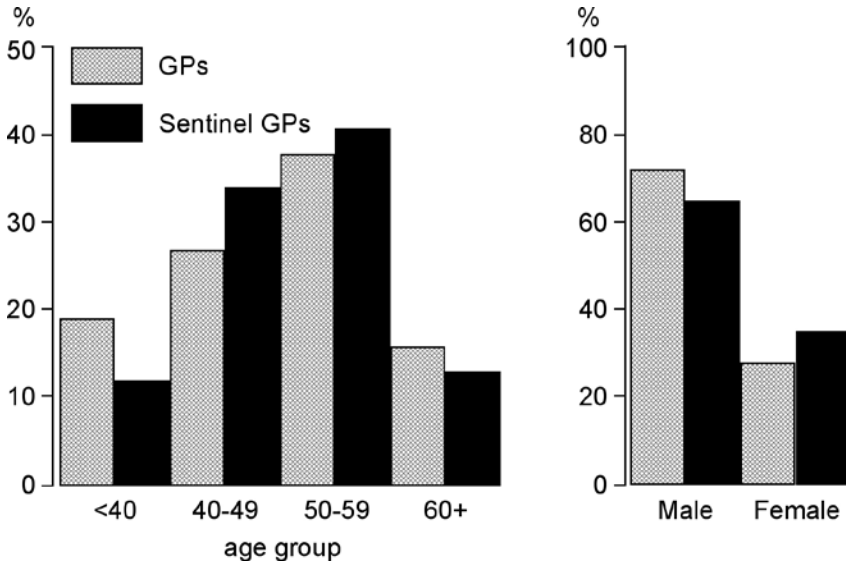
Results

Participating GPs

Between 1982 (first year of well-documented lists of participating GPs) and 2008, 616 GPs participated in the network on a regular basis during one or several years. Only GPs registering at least 26 weeks a year are included for final data analyses. In recent years, the turnover of the GPs, from year to year, is low (<10%). Among the present 160 regularly participating practices, 95 have been participating for at least 10 years.

Annually, the age and sex distribution of the participating GPs is compared with the same characteristics of the non-participating GPs at national level as well as at regional level. In 2007 (most recent comparison available), the age and sex distribution of the participating GPs at national level was different ($p=0.03$) from the one of the non-participating Belgian GPs, due to an underrepresentation of female GPs younger than 40 years of age (10;11).

Figure 1. Age and sex distribution, the Registration Network of Sentinel General Practitioners, 2007

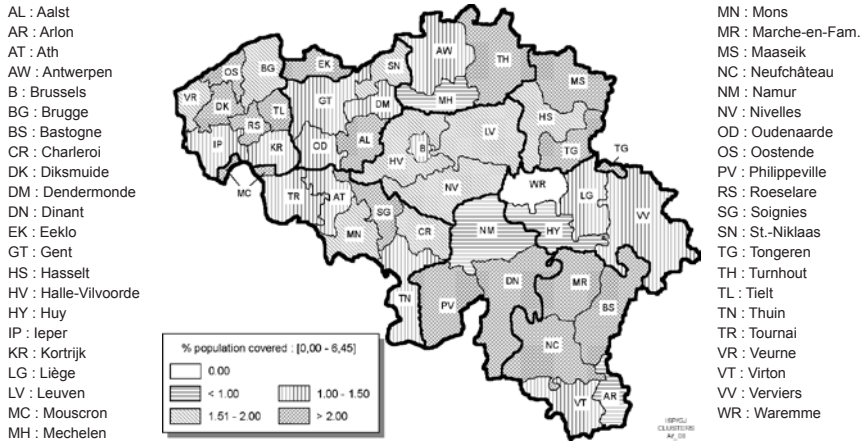


GPs mention various reasons why they want to participate in this network. Some are proud to be able to provide meticulously and continuously recorded morbidity data for public health monitoring and commissioning. Some realise that data instead of extrapolation of theoretical considerations and intuition are needed to support medical practice. Others see their participation as a unique opportunity to reinforce the recognition of the profession of general practitioner and to improve the quality of general practice as well as the health of the general population.

Geographical spread and denominator population

In 2008, the 172 participating practices were well spread over the country. In 38 of the 43 districts, at least 1% of the population was covered by participating GPs, in 4 districts the coverage of 1% of the population was not obtained and in 1 district there were no participating GPs. The estimated population coverage in Flanders was 1.9% of the total population, 1.7% in Wallonia, 1.2% in Brussels and 1.8% for the whole country.

Figure 2. Geographical coverage, the Registration Network of Sentinel General Practitioners, 2008



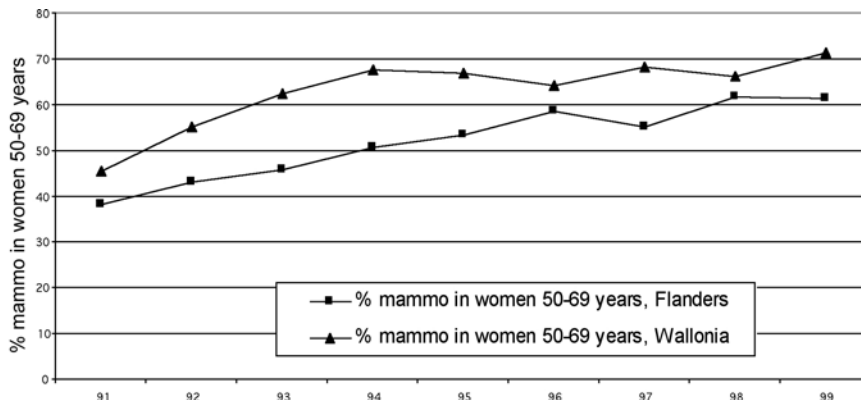
Registered health problems

The recording of a wide variety of health problems led to a long list of reports and publications at the disposal of public health authorities and the scientific community (12). Several results caught the attention of the authorities or were explicitly registered at their request for the purpose of policy development and evaluation. Some examples are illustrated below.

The most typical example is the surveillance of measles and mumps which ran in the period 1982-2000 (13-17). The network was the only source of information on both infectious diseases and highlighted in the beginning of the eighties their importance in terms of incidence and complications in the non-vaccinated community. Since the start of the recording in 1982 till 2000 the annual incidence rates and most important epidemiological characteristics were used by the public health authorities to develop and evaluate the vaccination policy.

The percentage of breast cancer screening mammograms among women aged 50-69 years old was followed up in the nineties and used by the Flemish Community to develop its public health targets regarding this issue (= 80% of the screening mammograms should be carried out among women of the target group) (18).

Figure 3. Evolution of the percentage of screening mammograms among women aged 50-69, the Registration Network of Sentinel General Practitioners, 1991-1999

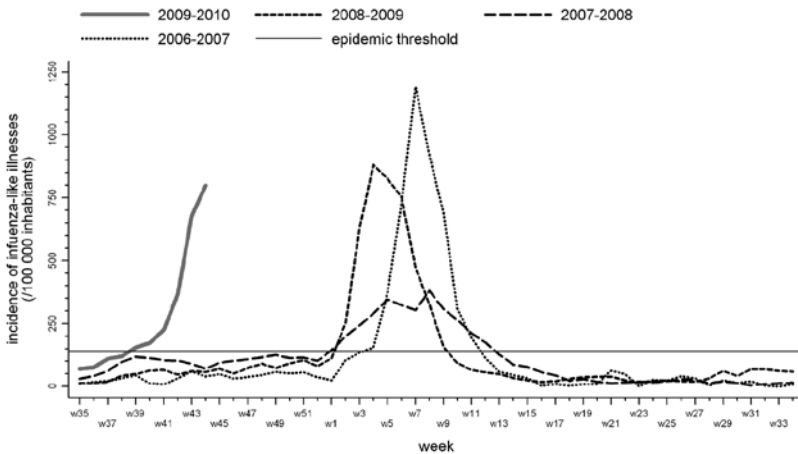


Placement of adults in an institution (e.g. nursing home, home for the elderly, psychiatric institution) has been recorded in 1994 and in 2003-2004. Public health authorities were interested in the existence of waiting lists and time spent on such a list. Data from the network highlighted the importance of waiting lists and the increase of time spent on these lists in recent years (19-21).

The network revealed that GP consultations for domestic violence are frequent and involve considerable between-physician variability in care (22).

As of autumn 2007, the network is continuously involved in the surveillance of influenza and took part, as many other surveillance networks, in the European Influenza Surveillance Scheme activities (EISS) (9). In the present A(H1N1)2009 pandemic, the network is the most important pillar to follow up the situation by providing weekly incidence rates on influenza-like illness consultations in general practice and information on circulating influenza viruses via swabs among patients presenting with influenza-like illness.

Figure 4. Syndromic and virologic Influenza surveillance, the Registration Network of Sentinel General Practitioners, week XX 2009



An important theme on the registration list since several years is the monitoring of end-of-life care, a study in collaboration with the Free University of Brussels (VUB). This recording tries to complete the lack of population-based and nationwide data that evaluate and monitor the circumstances of death, the care received and the caregivers involved in the final months of life (23-29).

Discussion

In its 30 years of existence, the sentinel network has proven to be capable of recording a wide variety of health problems, delivering information for public health monitoring and commissioning by public health authorities.

Strengths

The Belgian Registration Network of Sentinel General Practitioners has a long tradition in public health registration. The highly motivated participating GPs are a guarantee for the quality of the participation and of the recorded data. A good acceptability of the recording by the GPs is reflected in the annual low dropout of GPs (<10%). All GPs have to participate in the recording of all themes, thus avoiding a selection of GPs interested in one particular item. It is a flexible network capable of including new topics every year. The possibility of health monitoring over long periods of time enables us to study the impact of prevention campaigns. The inclusion of follow-up studies on the recorded patients (e.g. stroke) allows the gathering of unique information on these patients.

Weaknesses

The Belgian Registration Network of Sentinel General Practitioners also has several weaknesses. One weakness is the denominator problem caused by the absence of patient lists per GP in Belgium. Only a crude estimation of the denominator population can be made. The possible selection bias of highly motivated GPs and the impact on the representativeness of the data is another concern. Various exercises of external validation indicated however that the population of patients covered by the network is representative of the general population (25;30-33). Still, caution is needed when studying preventive procedures or management of health problems by the network. Sensitivity or completeness of recording can be hampered by the fact that other health care professionals are also dealing with a condition under study (e.g. gynaecological problems, problems in children). Specificity can be hampered by the lack of very strict inclusion criteria. Indeed, we do not want to disturb the daily routine of care given by the GP and do not always include very strict criteria to in- or exclude a case. Not all health problems can be studied by the network. They have to occur in general practice with a certain frequency. As the recording is continuous, a constant effort is required from the GPs contrary to ad hoc studies during a certain period of time.

Also, the registration form has to be kept simple. Consequently, in-depth study of some aspects of the recorded health problems is generally not possible with this type of registration network.

Opportunities

Emerging important health problems can, if responding to the basic conditions for recording by the network, be included in the recording list. Very recently the RIZIV/INAMI asked the network to play a reference role in the framework of the care trajectories of diabetes and chronic renal failure.

Collaborative studies with similar networks in Belgium and in Europe are also considered an important opportunity. The most recent example is a collaborative study on the monitoring of care at the end of life with the participation of the Netherlands, Italy and Belgium.

The progress in the use of the electronic patient record by the GPs in the network will progressively allow an EPR-based data collection, decreasing the workload for the GPs and the central coordinating team. This EPR-based recording will also enable the use of the above-discussed denominator approach (yearly contact group corrected for non-attenders). The EPR-based registration network of Intego in Flanders is already using this kind of denominator (34).

Threats

Thirty years ago, very few other health information sources were available, whereas nowadays the network has to find its place among sources like surveys, registers, administrative data and other registration networks. It has to focus on its particular strengths and try to remedy its weaknesses. The existence or development of other GP-based registration networks in Belgium can be seen as an opportunity but also as a threat, as in that case these networks have to compete for the often limited financial support.

Conclusion

The past 30 years were very successful for the Registration Network of Sentinel General Practitioners. The future however is challenging; there is not only the progressive orientation towards EPR-based recording, but also the consolidation of the network's place among the wide variety of current health information sources.

Acknowledgments

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The author would like to thank all GPs that have contributed or still contribute to this network.

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Creation of a Walloon Health Observatory

by

Billiet A¹, Nick L², Léonard P², Tellier V¹

The Walloon Government created the Walloon Health Observatory (OWS) on October 2, 2008. This observatory is charged to contribute to the improvement of the Walloon's health conditions by developing knowledge on health by providing scientific tools for the setting up, follow-up and evaluation of public health policies; by highlighting the social inequalities and by rationalising gathering of information produce at regional level.

The OWS currently counts three agents. An agreement between the regional health authorities and the Walloon Institute of Prospective and Statistics (IWEPS) rules the work of the OWS.

The regional level constitutes an interesting scale to integrate health information with other information concerning the population, the economy and the regional policies. The centralisation of tasks and the analyses at a regional level also makes economies of scale possible by structuring and analyzing national databases so that they become directly usable to the regional or infra-regional level.

The objective is also to contribute to the building of a coherent medical information system. In such a perspective, the OWS will work in an integrated way with the main actors in the field of the public health: French Community, "INAMI", "SPF", other health observatories, academics, etc.

The OWS was created; it starts to be effective and aims at enrich knowledge regarding health in Walloon region as soon as possible.

Keywords

Observatory, HIS (health information system), regional

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Case-management by the GP of domestic violence: an example of the results from a sentinel network of general practitioners

by

Bossuyt N¹, Van Casteren V¹

Objective

To demonstrate how a sentinel surveillance network of general practitioners can provide data on interpersonal violence. This example aims to describe the medical interventions and referrals carried out by the general practitioner (GP) when taking care of victims and to quantify the between-physician variability in management of domestic violence.

Methods

A nationwide sentinel network of 150 general practitioners, covering 1.5 % of the Belgian population, registered in 2002-2004 all episodes of domestic violence for which they were consulted, via paper registration forms. A multilevel analysis was carried out by fitting a random effects logistic regression model for every intervention/referral.

Results

The most frequent interventions of the GP were providing a certificate of injury (54 %), and making an appointment for a next visit (33 %). Half of the patients were referred or hospitalised upon the first consultation, most frequently they were advised to go to the police (17 %) or referred to a psychologist or psychiatrist (11 %). The intra cluster correlation coefficient (ICC) of the interventions varied between 11 % and 39 % and the median odds ratios between 1.82 and 3.96.

Conclusions

The sentinel network of GPs can provide useful data on domestic violence, i.e. that GP consultations for domestic violence are frequent and involve considerable between-physician variability in care.

Keywords

Domestic violence, GP, case management

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Establishing a longitudinal health information system based on a network of health data providers and users

by

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Objective

The Federal Public Service-Social Security hopes to create a dynamic vision of health in order to better understand the Belgian population's health status. This vision, generated through the participation of data providers and users to an organised network, should enhance the capacity of the national health information system to support relevant evaluation and decision-making processes. Our research proposes the outline of an operational model, aimed to catalyze discussion and cooperation among public health professionals in Belgium.

Methodology

An international comparative review was used to identify multidimensional criteria that are fundamental for the efficacy of such a system; this has led to the design of a conceptual model. Different strategies to obtain life-course perspectives are analysed through thematic case-studies. In this manner, the project acquires a deep understanding of constraints and possible outcomes linked to the elaboration of appropriate indicators.

Results

The proposed conceptual model relies on two complementary strategies: the coordination of cohort studies and the establishment of data linkages, which is a technically feasible and affordable opportunity. However, few cohorts are implemented in Belgium. Furthermore, linkages require a high degree of cooperation between professionals, decision-makers and researchers of the health sector. Since a longitudinal information system requires that personal data are stored and handled according to strict privacy regulations, the model has been adjusted to fit with the Belgian legal

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framework applied to health information. A comparison of different societal approaches regarding the ethical implications of the person-centred data collection has also been carried out.

Conclusions

A prospective and dynamic vision of health is an asset to the information system. In a setup able to integrate as many sources as possible, institutional and private structures participate to define the prerequisites, adopt common technical standards and coordinate operations as well as outcomes.

Keywords

Health information system, longitudinal health approach, data sharing

Reinforcement of National Reference Centers for Human Microbiology in Belgium

by

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Currently, multiple laboratories fulfill reference tasks for human pathogens that could cause a threat to public health. These laboratories support improved patient care by providing enhanced diagnostic tools and contribute to the public health by early detection of outbreaks, identification of emerging threats and monitoring trends in genetic markers of infectious diseases. However, given the lack of a mechanism to support these laboratory activities substantially and in a coordinated way, there was a risk that these labs would reduce or even discontinue these activities. This could have become a major issue for the patient care as well as for the public health. Therefore, it was decided to develop a system for selection and support of official reference centers.

A total of 40 pathogens was selected for which the establishment of a reference center was essential. For each of these pathogens, a list of missions and terms of references were developed. These represent the framework for the activities undertaken by the laboratories and for any evaluation of their experiences and performances.

In the future, the sustained services of these reference laboratories, each with identified tasks and responsibilities, will be the keystone of a network that is centrally coordinated by the Scientific Institute of Public Health (WIV/ISP).

This network will stimulate national collaboration for the collection and transmission of epidemiological data to European, national and regional authorities or public agencies. Similarly, the network will stimulate the collaboration between university hospital laboratories, peripheral laboratories, national laboratory institutes and national and regional authorities for the realization of the aim and mission of the project.

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In this presentation we would like to present our first experiences with the establishment of a financially supported network of reference centers for human microbiology in Belgium.

Keywords

Microbiology, laboratory, network

Superior Health Council: bridge between science and public health policy

by

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The Superior Health Council (SHC) is the official Advisory Body on public health issues of the Belgian Federal Ministers of Health and Environment. The SHC consists of a network of 200 nominated experts and a network of over 300 invited experts in different domains of public health. Furthermore, any expert can be invited whenever his specific expertise is required. The public health domains covered by the SHC are “mental health”, “physical environmental factors”, “chemical agents”, “diet, nutrition and health including food safety”, “blood and blood products and cells, tissues and organs of human and animal origin” and “vaccination, infectiologie and control over infectious diseases”.

The ultimate goal of the SHC is to improve Belgian Public Health. Therefore, scientific, independent advices, based on literature reviews and expert opinion are delivered to the Minister on his/her demand or on demand of his/her administration or on proper initiative of the SHC. No political or commercial considerations are taken into account. Independency of the SHC is safeguarded by several procedures (e.g. conflict of interest).

In order to control the quality of the delivered work and its impact on public health, a Balance Score Card (BSC) was put into place at the SHC after a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis. In the BSC, different key success factors with their key performance indicators were determined.

One of the important key success factors is the network of experts as it is the all-important basis of the activities of the SHC. However, several difficulties are encountered in maintaining and developing the network, such as finding the right expert for very specific topics, avoiding conflict of interest, availability of experts etc. To counter these problems, special procedures and actions were developed such as an extensive database of experts, a procedure on conflict of interest, etc.

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European Science Advisory Network for Health

by

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National science advisory bodies are the gateway between science and health politics and aim to support policy makers with recommendations based on scientific knowledge. Many of the issues these national advisory bodies are confronted with are border-crossing, such as infectious diseases and environmental threats, or similar in most European countries, such as obesity and an ageing population. In order to improve the quality, effectiveness and efficiency of science advice for health across Europe, a network between national science advisory bodies in public health was established: the European Science Advisory Network for Health (EuSANH). Currently, advisory bodies of 12 European countries are involved in EuSANH, among which the Belgian SHC.

Over the next three years, the EuSANH-ISA (Improving Science Advice for Health) project, funded by the European Commission, aims to explore the nature and role of existing national science advisory bodies in the different European countries. A common best practice methodology for preparing science advisory reports will be established and tested in a pilot study case. And finally, a task performed by the Belgian SHC, the EuSANH network is expanded and a communication and cooperation structure is developed. Difficulties and opportunities encountered in this task will be discussed in the presentation.

Key objectives are to improve the quality, effectiveness and efficiency of science advice on health at both national and European level and to convene the best experts from Europe to make science-based policy recommendations on major health issues. In connection to this, important knowledge gaps can be identified as a priority for new health research programs. In addition, working together, the participants can combine their limited resources to cover many more important health issues.

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The general practitioner: a potential partner in a collaboration's network to build with the associations working in health promotion?

by

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Objectives

- to analyze the different collaborations with general practitioners and the associations or organizations working in health promotion;
- to emphasize in the starting up of projects and the operation what worked and what difficulties were encountered;
- to study the motivations and the role of the general practitioners in these collaborations;
- to know the established place of prevention and health promotion in their daily practices.

Methods

A qualitative investigation realized in 2008-2009 in Wallonie with 26 non directing interviews face to face, except 2 in Brussel. Interviews as a whole have been realized close to the general practitioner and to the associations he is working with.

Results

- The collaborations are not right away obvious.
- They are first favoured by the knowledge of the actors.
- They depend on the time the actors wish to give to these actions.
- The general practitioners appear to be a "target person" or as partners to promote health.
- As partners, they have particular characteristics (deputy mayor, working in medical home...) that often permit them to impulse the projects in a more practical way.

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- Unlike prevention, health promotion is generally implemented without being mentioned as “health promotion”.
- On the whole, the collaborations unroll more as a necessity than an increase or an advisability.

Conclusions

Depending on the nature of projects, the knowledge of general practitioner confers him a register of local expert who will evolve according to partners, spreading of project and its fixing across the difficulties encountered.

In their actions to improve global health, these collaborations develop practices which appeal to actors of different fields and throughout elements of mode of functioning take form in informal network.

Keywords

General practitioner, health promotion, prevention

Energising an exchange network between trainers in health promotion in the long term

by

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Ongoing training initiatives relating to health promotion sometimes struggle to adapt to the realities faced by professionals in the field. Based on this claim, a group of trainers came together using two modalities: (a) a wide network of around 25 people (18 organisations), existing over the long-term and incorporating a smaller network which is more limited in time (12-18 months); (b) intensive, inductive work by this restricted group, drawing out questions, followed by avenues for exchange with the wider network at the end of the 12 to 18 months.

According to Lemieux's typology (Lemieux Vincent, *Les réseaux d'acteurs sociaux*, collection sociologie, PUF, 1999), the restricted network appears to be a support network and the enlarged network appears to be a mobilisation network. The involvement of participants in the network's activities can be encouraged by exchanges, but above all by drawing out the questions and, ultimately, formalisation of common denominators.

Within the restricted group, drawing out questioning is supported by the use of reading grids to exchange experiences: 13 circumstantial and structural variables, reading grids specific to the evaluation questions (Goudet Bernard, *Pôle Formation DIREPS GSO, Paradoxes de la formation et convictions d'un formateur, 1989-1999: Itinéraires pluriels de formation dans le champ de l'éducation pour la santé et la promotion de la santé*). Meetings thus enable specific concerns to be developed and analysis of them to be refined, as well as encouraging the emergence of shared problems and exchanging practices and resources.

The formalisation of reports, questions and recommendations with a view to communication, however, remains a difficult step to accomplish: use of internet forums with this aim has not, to date, been particularly in-depth.

In addition, work with a two-level investment network requires the accumulation of contributions from one year to the next as well as

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maintaining motivation of the various participants. This requires not only acknowledgement of others' views but also investing time in following them up.

How can progress be retained, how can links and effects be made permanent, and how can the various challenges encountered by the network be achieved? The competitive context for financing training initiatives, as well as the existence of different and often divergent practices also represent two pitfalls which constantly need to be addressed.

Evaluating a Local and Regional Community of Practise on Healthy Living, Weight and Health

by

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Objectives

Identifying the factors favourable and adverse to the establishment of a local and regional community of practise around healthy living, weight and health.

Methods

Interviews were conducted with the 21 partners of this community of practise. A qualitative analysis of the interviews and written documents (reports and accompanying power points, assessments, planning documents and action plans) was realized. The documents covered the period of December 2004 to October 2007.

Results

The results reported a gap between the scheduled activities and those carried out. A second gap appeared between the activities carried out according to the written data sources and the sources of verbal data. The analysis of the results showed that to succeed in achieving their goal the community of practise must:

- clarify their vision;
- review their action plan and stabilize their funding;
- promote the permanence of partners and recognize the nature of their organization and their role in the community;
- review the structure and the modes of operation of the community of practise.

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Conclusion

The challenges identified in this assessment are linked to conditions of success, which, if not integrated, may affect the sustainability of the community of practise.

Keywords

Community health, integrated programs, health promotion, preventive programs, wellness programs

Building a network for services of health promotion at school of Hainaut- Belgium

When the evaluation gives a new boost to the network!

by

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Introduction

In 2005, at the request of around thirty SPSE (services of health promotion at school) and further to the obtaining of a grant (2005-2008), the Health Observatory of Hainaut (OSH) proposed the implementation of a network on the Province.

It has been working since October 2008 thanks to the partnership between two local centres of health promotion (Mons-Soignies and western Hainaut) and OSH. One of the objectives of the network is to facilitate the sharing of experiences and the exchange of tools.

Two committees of orientation (institutional and operational) have allowed releasing of resources for the functioning and for the organization of activities. Coordination centralizes the information. Various working subgroups are organized, an annual meeting and also some various specific days.

Methodology

After two years of functioning, an evaluation was realized (in 2009). The objectives were to investigate the contributions of the network, the sense of belonging to the network, the use of the tools, the expectations for 2009-2010 and the motivations to intervene actively.

The evaluation was realised thanks to a named specific questionnaire. The results were presented and discussed in a public meeting.

Results

In priority, the motivations to participate in the network remain the sharing of practices. Most of the participants feel they belong to the network. They use the tools created. Everybody wants the network to continue. Suggestions on the organization have been put forward. The evaluation has permitted to redefine the orientations but it also allowed a diversification of activities for 2010. New opportunities are open.

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Discussion

The realities of the SPSE are very different depending on institutional networks, territories and the kind of public. One of the difficulties is to interest everybody. It is though necessary to alternate activities in common but also specific activities.

The lack of resources appears at every level (Provincial, SPSE, schools, etc.). One of the limitations is the difficulty to involve actively the SPSE and to strengthen the relationship with the field. The network adds to the actions on the field. It also encourages links between the different territorial levels.

Keywords

Network, school, evaluation

A multilevel framework to support long-term breastfeeding

by

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Introduction and objectives

The World Health Organization (WHO) recommends exclusive breastfeeding for the first 6 months. Nowadays there are important disparities in breastfeeding prevalence among European countries, with Belgium far behind others. To develop effective interventions, it is important to know all the determinants involved. We review the literature on factors associated to breastfeeding duration of more than 3 months.

Methods

The review is based on Pubmed and Sciencedirect research combining “breastfeeding” and “duration”. Articles were limited to recent studies (2001-2007) held in high socioeconomic level countries.

Factors significantly associated to breastfeeding duration of more than 3 months were categorized in four interdependant levels in an ecosystemic framework: the mother and her baby (microsystem), the social support and relationships (mesosystem), the health system (exosystem) and the health policies (macrosystem).

Results

Factors that influence the outcomes of breastfeeding duration are numerous and varied, both positive and negative. The microsystem included sociodemographic variables (age, race, education, marital status, socioeconomics, parity), breastfeeding experiences, intentions and knowledge, infant and mother health problems (delivery, breastfeeding difficulties, maternal obesity and smoking), psychosocial factors (confidence, depression) and work situation. The mesosystem included family, partners and social support. The health system factors consisted in maternities practices and professional support. The macrosystem included paid work and commercial legislations, and the “Baby-Friendly Hospital” initiative.

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Conclusion

In order to reach the WHO recommendations, one must act at each level. Work can be done to increase mother's information, to get the father more involved, or to improve the formation of health care providers on breastfeeding. After discharge from the hospital, mothers with risk factors must get support in order to improve breastfeeding duration.

Keywords

Breastfeeding, duration

Indicators on children's health and the environment for Europe

An update for Belgium

by

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on Environment & Health Indicators

Introduction

At the 4th Ministerial Conference on Environment and Health in Budapest (2004), member states of WHO-Europe adopted a Children's Environment and Health Action Plan for Europe (CEHAPE) aiming to reduce the health risks for children. In this framework, Belgium contributes to the Environment and Health Information System (ENHIS).

Objectives

1. To supply data from Belgium for the indicator-based assessment for the 5th Ministerial Conference on Environment and Health in Parma, 2010.
2. To establish networking with governments and institutions in Belgium within the field of Health and Environment and with WHO.

Methods

Twenty-two indicators have been defined by WHO. The indicators cluster in four Regional Priority Goals: (I) safe water and adequate sanitation, (II) protection from injuries and adequate physical activity, (III) clean indoor and outdoor air and (IV) chemical-free environments. For every indicator, WHO has developed fact sheets with a short description of the exposure and health risks as well as with the methodology used to assess the indicator. A first baseline assessment was reported at the Midterm review "Children's Health and the Environment in Europe: a baseline assessment" (Vienna, 2007). To enable comparison among countries, WHO requires submission of data through harmonized methods: existing data collection systems and databases, and standardized questionnaires and formats.

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Results

A Working Group on Environment and Health Indicators, with delegates from several governments and institutions in Belgium, was set up within the National Environment and Health Action Plan (NEHAP). Networking with WHO-Europe was established to follow-up the update of indicators and to submit data from projects. Furthermore, data submission to international databases by responsible departments was verified and coordinated by IPH. This extensive networking resulted in the update of data and in the elimination of gaps for all non-policy indicators of the four Regional Priority Goals.

Conclusion

Networking by IPH with delegates from governments and institutions and with WHO enabled the complete update of all non-policy indicators for Belgium in the forthcoming WHO indicator-based assessment.

Keywords

Indicator, health, environment, CEHAPE

A network on mental health and ageing Practice of networking and health promotion

by

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A network constituted with the « Observatoire de la Santé du Hainaut », the « Espace Seniors des mutualités socialistes », « Mouvement social des aînés de l'Union Chrétienne des Pensionnés », the « Agence wallonne de Lutte contre la maltraitance des personnes âgées », the « Haute Ecole Libre du Hainaut Occidental » and the « Direction Générale des Affaires Sociales de la Province de Hainaut ». It was initiated by the «Plate forme picarde de concertation en santé mentale »and the « Centre local de promotion de la santé du Hainaut occidental »

These partners drew up a common statement: the ageing of the population affects more and more the mental health sector. Old people who land up in psychiatric institution do not suffer from mental pathology but from social isolation and precariousness. The network developers decided to propose a comment intended to actors on the field on the themes of needs and professional practices related to this growing phenomenon.

They agreed to organize three meetings, which objectives were: to increase the knowledge of the network, to identify the principal needs, to provoke the debate and to bring up tools to improve accompaniment of ageing persons and their family.

The first morning was devoted to a global approach of the health of the seniors thanks to the Walloon dashboard of health. The second meeting focused on two networks based on specific missions “elderly people” of two centre of mental health. On the basis of the themes identified during the gathering, the third meeting selected priorities and drafted a planning of the activities parallel to the consolidation and the enlargement of the network. Each of the sessions gathered around fifty participants from various sectors: hospitals, ambulatory, home help, social help, accompaniment, hosting and seniors' associations.

The communication strives to present the evaluation of the meetings (needs, expectations and satisfaction of the participants), the activities

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fulfilled and also levers and barriers that stood up in the development of the network. Difficulties encountered will also be discussed.

Keywords

Mental health, ageing, networking, health promotion

Is Brussels' mental health care delivery integrated? A study of the interorganisational network and focus on the 'Plate-forme de concertation'

by

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Introduction

The mental health care policy is going through an important reform phase in western European countries. The deinstitutionalisation of patients with chronic mental illness has generated many new types of services and collaboration modalities. Notably the development of home treatment delivery enlarged and complicated the management of the continuity of care. Thus, partnership working is one of the core issues of current mental health public policies.

In Belgium, coordination in mental health has been assigned to the 'Plate-Forme de Concertation pour la Santé Mentale' (PFCSM/OPGG). No study has evaluated its role, so far.

Aim

The aim of this study is to assess the actual co-ordination of mental health care delivery for the adult population in Brussels, through an analysis of services network structure. On this purpose, we investigated four main concepts: network's fragmentation, subgroups stratification within the network, the 'hospitalo-centrism' (centrality of hospitals within the network), and finally the role of the PFCSM/OPGG as co-ordinator.

Method

The study included all the adult services for mental health care in Brussels (N=91). These services were asked to fill a questionnaire to assess 5 types of relations: referrals received, referrals sent, case coordination, joint programs, service contracts. Data were processed by *Social Network Analysis* (SNA). This method enables to visualise the structure of links as well as to measure network's structural characteristics, such as: centrality, density, and multiplexity.

Semi-structured interviews of members of the PFCSM/OPGG were added to ensure a qualitative interpretation analysis of its role.

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Results

There is a lack of integration in Brussels' mental health care delivery. Hospitals still benefits of huge power and centrality in clinical terms. Many services remain isolated in the network. There are numerous subgroups of services densely interconnected but poorly linked with the rest of the network (cliques). The PFCSM/OPGG is not involved in clinical matters. However it has a great deal at other levels.

These results point out barriers in the implementation of projects of integrated mental healthcare based on an equal participation of all the services.

Mental health and social services collaboration for socially marginalised people: a social network analysis of inter-organisational partnerships in Brussels

by

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Background

In western countries, socially marginalised groups are twice more likely to have common mental disorders than better-off groups. A challenge the marginalised groups face is the fragmentation of mental health and social care; that is, the way mental health and social services collaborate to provide users with comprehensive, integrated and streamlined solutions to complex and chronic problems.

Most of the research on health and social care inequalities has been carried out at the individual level. In spite of a growing literature on social network analysis, the study of inter-organisational networks at the network level remains underexplored.

Objectives

This social network analysis of the relationship between mental health and social services aims to draw patterns of networks in Brussels deprived areas on two dimensions: referrals and service meetings. We test two hypotheses: 1. Inter-organisational networks tend to pursue either breadth – large networks of weakly connected services from different sectors – or depth – small networks of strongly connected similar services; 2. The connectivity between social and mental health services is dependant of brokers, that is specific services bridging the two sectors, these brokers possibly have a great influence on network management.

Method

This study is part of a broad European research project on best practice in promoting mental health in socially marginalised people (PROMO). Data on referrals and service meetings were collected in 60 mental health and social services of two deprived areas in Brussels through face-to-face interviews between September 2008 and June 2009. Data were processed through social network methods, including density, centrality and connectivity measures and graph representation.

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Results

The patterns of networks included many services situated outside the investigated areas; meanwhile some services inside the areas remained isolate. Whole networks had low densities, including denser sub-networks of similar services. Services with the highest centrality were some psychiatric hospitals, general health services and CPAS. They are situated in broker positions within networks, although they were not commissioned to create linkage. Possibly these services play a major role in network development and functioning.

A case of institutionalization of local mental health networks: the Belgian therapeutic projects

by

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Since the end of the 1980s, a new vision of mental health has been developed under the influence of the Belgian “Psychiatry” permanent work group of the National Council of Hospital Facilities. This new vision adopts a holistic perspective which takes into account the diversity of factors at stake and aims to give a central place to the patient and his or her needs. The principles on which this innovative vision lies fall within an international trend (among other developed in the WHO declaration of Helsinki) which aims to put the patient at the centre of the system but also in field actor practices.

This vision is made concrete in a restructuring of mental health care sector in terms of care circuits and networks, which necessitates an “interinstitutional” and interdisciplinary cooperation. With this approach the old bureaucratic model of organising a sector would be replaced by a post-bureaucratic one marked by notions such as networking or negotiation. The “Therapeutic projects”, organised by a Royal Decree in 2006 after a long term decision making process, constitute the experimental phase of this new mental health care concept. It is a wide ranging pilot project which aims to achieve, by the end of the three-year experimental phase, the definition of guidelines and the implementation of norms as regards mental health care circuits and networks.

The purpose of this contribution is (1) to give a presentation of the mechanisms which have lead to the creation and implementation of the therapeutic project. Using a case study method, we will also (2) to analyse the functioning of a therapeutic project, showing at the one hand the tensions between the philosophy of the project (network functioning and flexibility) and the technocratic temptation developed by the administration which funds them, and, at the other hand, we will also examine how the “traditional” psychiatric rationality is able to maintain its central position in a context where other fields and actors should emerge.

Keywords

Mental health, care circuits, therapeutic projects

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Human biomonitoring of heavy metals in the vicinity of non-ferrous metals industries in Ath, Wallonia

by

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Objectives

To estimate human exposure to lead, cadmium, nickel, chromium and cobalt in the population of Ath living in the surroundings of the non-ferrous metals industries.

Methods

Cross-sectional study. Two study areas were defined: a “central” area with 1 km radius around the industries and a “peripheral” area more than three kilometers away. We studied three age groups: (a) children aged 2.5 till 6 years (n=98), (b) children aged 7 till 11 years (n=74), and (c) adults from 40 to 60 years without occupational exposure (n=106). A random sampling in the general population was done. Metal concentrations were measured in blood and/or urine and information on factors that may influence metal levels was obtained by questionnaire.

Results

Blood lead levels (geometric mean) were significantly higher in children aged 2.5 till 6 years living in the central area (18.20 µg/L) compared to the peripheral area (14.79 µg/L, p=0.05). Lead levels, however, did not differ significantly between the two areas in children aged 7 till 11 years (central: 15.49 µg/L and peripheral: 14.13 µg/L) or in adults (central: 31.20 µg/L, 22.52 µg/L and peripheral: 32.33 µg/L, 20.31 µg/L, for men and women, respectively). Urine cadmium levels were not significantly different between the two areas in any of the three age groups (central: 0.07, 0.23, 0.29 µg/g creatinine and peripheral: 0.06, 0.20, 0.25 µg/g creatinine, for children, men and women, respectively). For nickel, chromium and cobalt, no significant differences were observed.

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Conclusions

With exception of lead in children aged 2.5 till 6 years, human exposure to heavy metals did not differ significantly between the zone around the industries and the peripheral zone. The concentrations found in our study are comparable to those found in other biomonitoring studies in the general population.

Keywords

Heavy metals, human biomonitoring, environmental exposure

D'un programme de formation à un Réseau ? Le cas du Réseau Itinéraires Cliniques

by

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Objectifs – attendus

Après quatre années de fonctionnement du RIC, le comité de pilotage du réseau a décidé de faire un bilan, avec essentiellement des objectifs managériaux. En effet, afin d'assurer sa viabilité et sa pérennité, une meilleure connaissance et compréhension de la dynamique de développement et de fonctionnement du Réseau IC apparaissent comme essentielles, et ce dans une optique de transparence pour adapter au mieux les services aux attentes des membres de ce Réseau.

Question de recherche

D'un programme de formation à un Réseau ? Par vocation, ce réseau est essentiellement axé sur la formation. Par intention et au fur et à mesure de son expansion, sa plus-value ne résiderait-elle pas davantage dans la création, la circulation, la gestion et le partage de connaissances ?

Méthodologie

Nous nous appuyons sur des données recueillies pendant plus de deux mois auprès d'une quinzaine de gestionnaires de projets intra-hospitaliers. Des entretiens semi-directifs ont été menés sur base d'un guide d'entretien. Les informations recueillies ont été traitées de manière qualitative. L'objectif de cette communication est de décrire ce que les gestionnaires de projets intra-hospitaliers entendent par "Réseau", en essayant de comprendre l'aspect dynamique des jeux d'acteurs, la manière dont ils prennent naissance et s'organisent dans des situations d'action commune.

Résultats

En partant de ces données, nous avons pu constater que les membres du Réseau sont des personnes qui se rassemblent afin de partager et d'apprendre les uns des autres. Ils sont tenus ensemble par un intérêt commun dans un champ de savoir (les Itinéraires Cliniques) et sont conduits par un désir et un besoin de partager leurs problèmes, leurs expériences,... Entre ces individus partageant les mêmes pratiques, des

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relations d'interdépendances et de dynamiques identitaires se créent. Les individus entretiennent une multitude de liens, mais tous ne sont pas de même nature et n'apportent pas les mêmes bénéfices. Le Réseau devient un instrument social et ouvre à un autre espace de projets.

Limites

Cette analyse ne contient aucune référence au contexte institutionnel qui permettrait de conceptualiser la manière dont les acteurs construisent leur univers en intra-hospitalier.

Clinical pathway's methodology Concrete use of the 30 activities' plan

by

Dierckx de Casterlé R¹, Sermeus W², D'hoore W¹

Introduction – context

Resulting from the methods of planning developed in industry during the 50's, the Clinical Pathways (CP) started to be spread in the health care towards end of the 80's. Their development bases itself on the description of an optimal and efficient care process based upon recommendations of best practices, on the various professional's expertise and on the patient's expectations. One of the key objectives of the CP is the performance of the multidisciplinary care of patients presenting the same pathology or having similar needs (Chaidron, Calass 2008).

The Network Klinische Paden (NKP), clinical pathway's network animated in Flanders by the Centrum voor Ziekenhuis in Verplegingswetenschap (CZV) of Katholieke Universiteit Leuven (KUL) has acquired for more than ten years an experience and a big expertise in this field. In order to facilitate this initiative, the French-speaking institutions of care joined this network five years ago with the support of the Université catholique de Louvain (UCL). In 2009, the Réseau Itinéraires Cliniques - Network Klinische Paden (RIC-NKP) holds now Flemish (63), Dutch (20) and French-speaking (25) institutions of care. The RIC-NKP recommends a methodology in 30 activities to help those institutions of care in the development, the implementation and the evaluation of the CP.

The experience gathered from the institutions since a few years has shown that the methodology recommended by the RIC-NKP works on an efficient way. However, even if methodology IC (plan in 30 activities) is a red line to follow, its use can appear long and tiresome for the CP coordinators that have to implement in the field. The 30 activities' plan is based on the cycle of Deming which recommends the continuous improvement of quality through its Plan-Do-Check-Act. This methodology can be regarded as a management tool to initiate and manage a project within the organisations.

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Expected Objectives

Based upon the results from the implementation of the CP within organizations and on the experience of the CP coordinators, we observe that the effectiveness of the CP methodology has become a reality.

However, even if CP methodology (30 activities' plan) seems to be time consuming and tiresome, a continuous update of it is needed in order to reach a quicker implementation and a rationalisation of the required efforts.

Question of research

The 30 activities' plan is considered as a methodological support by the affiliated institutions of care. Nevertheless, we realized progressively, after the development and the evolution of several CP within institutions of care, that the CP coordinator adapts by himself the 30 activities' plan. We thus wondered about the way in which the process of Clinical Pathways development was really followed.

Methodology

The theoretical part of this work initially bases on a detailed description of the 30 activities. We then took the assumption that this CP methodology belonged to the methods known as project management. In order to do so, we based ourselves on the standards ISO 10006:1997 / ISO 9001:2008, on foreign methodologies such as the CP in France and also on the techniques of CP development described by Harkleroad et al (2000). Based on these various concepts, we established our research methodology.

We chose on the one hand a quantitative research in order to analyze the data collected via questionnaire filled by French- and Dutch-speaking coordinators. In this case, we made use of RIDIT analyzes method because this one takes into account the ordinal scales: the questions aimed to identify the degree of importance attached to each activity according to the two groups evaluated.

On the other hand, we carried out a qualitative research to analyze the sowing-directing talks realized together with the CP coordinators belonging to the RIC. These interviews made it possible to be focused on the CP realization process itself; the finality of these interviews being to better understand the real use of the methodology within the institutions of care and to justify the degree of importance of the activities that were pointed out in the quantitative part.

Results

From the first approach and based upon the reality of the coordinators, we will be able to identify key, relevant, non prior and useless activities within this 30 activities' plan. We will then realize a global view in function of the importance and the weights allocated to each activity.

The second approach will allow us to go more in details on the way the process of CP development is really followed in the field. So we will be able to better determine its coherence and to justify the global view that we established before.

The network and its evolution: the perspective of a coordinator of clinical pathways

by
Stevens M¹

Introduction – context

Composed of 6 clinics, rest homes and ten polyclinics in the province of Liège, the CHC is a network of care where advanced technology and quality service provide to patients a advanced medicine with human face.

In March 2004, CHC shows its interest for the clinical pathways by registering in the network of Clinical pathways (RIC) and names a clinical pathways coordinator for the 6 hospital sites.

As part of the first cohort of French healthcare institutions have joined the RIC, I had the opportunity to see the network evolve. It is this change that I propose to develop through this personal experience.

The network and its evolution

The primary mission of the RIC is to support health care institutions in the development, implementation and evaluation of clinical pathways, so I, initially benefited from the training.

This training provided by a team of experts was initially very theoretical, because the trainers had little or no practical experience of implementation of IC. The adaptation of theory to practice has therefore proved necessary and far from obvious to everyone. Very quickly, the collaboration between institutional coordinators, supported actively by the team of trainers, was installed and exchanges of good practice, mistakes not to commit and tips were developed. The training phase ended, a new cohort of institutions joined the RIC.

The trainers, led by coordinators involved in these “training” of the following coordinators in providing practical experience of development, implementation and monitoring of clinical pathways.

As to various encounters and exchanges, the network has grown. The training program develops. In fact, the confrontation with the practice has highlighted that the IC methodology (30 activities plan) is an excellent guide but its use is long and tedious. A re-actualization becomes necessary to

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make it operational soon. This update will be possible through the support of trainers but also and especially through the collaboration of institutional coordinators who wish to develop the network to a real tool for learning and exchange.

But this development did not come easily. Some brakes (accessibility and enrichment of the INTRANET, positioning and different institutional means granted to IC,...) and some levers (expertise, experience coordinators, development of quality committees, quality coordinators and various initiatives,...) will be discussed.

Currently, the network is composed of 4 successive cohorts, a fifth is under appeal.

The institutional coordinators are therefore different levels of learning and experimentation. Some have developed special areas of expertise, be guided by specific skills or by acquired through experience. These areas of expertise are widely available to the network by the active participation of coordinators in training but also through the Intranet, and the transmission of knowledge outside the network.

Personally, in my institution, 5 clinical pathways are effective and one IC transverse is under development. The future is building a new hospital consisting of 3 sites for CHC and therefore an opportunity to experience methodology of IC differently, however, having the desire to provide patients the central role in the care process.

Aanpak van patiënten met coronair lijden vanaf de hartkatheterisatie tot de revalidatie na een hartoperatie

by

Vandamme A¹, Michotte S¹, Ilunga J¹

Doelstellingen

Bij professionals een gedragsverandering en veranderingen in de praktijk tot stand brengen tegenover hun patiënten en andere betrokken partijen.

Het gevoel creëren bij een multidisciplinair team te horen (bereid zijn om te luisteren naar belangrijke aspecten die anderen aanbrengen).

Methodologie

De adjunct medisch directeur en de coördinatrice hebben een audit uitgevoerd van de huidige weg van de patiënten in het ziekenhuis. Disfuncties en aanbevelingen voor veranderingen werden geïnventariseerd en in vier polen geklasseerd: patiënt, personeel, productiviteit (gebruik van de middelen), performantie (indicatoren van morbiditeit en mortaliteit).

Er werd een multidisciplinair team opgericht met alle beroepscategorieën die zich bezighouden met de patiënten. Dat team werd in 7 subgroepen verdeeld in overeenstemming met de zeven grote fasen die binnen het zorgpad geïdentificeerd werden. Op basis van de audit moesten deze subgroepen een inventaris opmaken van de middelen, oplossingen bedenken en doelstellingen voor verandering uitwerken. Het onderzoek van de verschillende groepen werd samengebracht tijdens plenaire bijeenkomsten. Alle protocollen, brochures, documenten over de aanpak werden in een subgroep opgesteld en vervolgens besproken en goedgekeurd door het multidisciplinaire team. Er werd een stuurcomité opgericht om de toepassing van goede praktijken op te volgen en de afwijkingen ten opzichte van de protocollen en documenten voor de aanpak die binnen het KP werden uitgewerkt, te analyseren.

Resultaten

De indicatoren werden gekozen om de aanpak van de patiënt te verifiëren en te evalueren: de invulling van de documenten over de aanpak, de naleving van de verschillende protocollen (fysieke voorbereiding, overdracht van informatie tussen de teams en opvolging van de patiënt). Er loopt een onderzoek naar

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de patiëntentevredenheid. Tijdens driemaandelijksse bijeenkomsten zal het stuurcomité de tevredenheid van de professionals, hun instemming met de veranderingen en de algemene werking van het KP evalueren. Het comité zal bevoegd zijn om indien nodig, aanpassingen aan te brengen.

Conclusies

Het project had aanvankelijk in twee delen gesplitst kunnen worden, een eerste deel met betrekking tot de hartkatheterisatie, het andere tot de hartchirurgie. Dezelfde professionals van het KP zijn echter bij de twee fasen betrokken en deze opsplitsing riskeerde gebrek aan eenvormigheid in de kwaliteit van de behandeling te creëren. Dit had door de patiënt ervaren kunnen worden als een aanpak met twee snelheden volgens de fase van het KP of de ernst van zijn aandoening. De adjunct medisch directeur en de coördinatrice hebben bewust gekozen om de verschillende betrokken partijen samen te laten werken om de volledige filosofie over de aanpak van patiënten met een coronaire aandoening te veranderen. Dat is een onmisbare dimensie bij het klinisch pad gebleken om het project te laten volgroeien en de auteurs ook, en het gevoel te creëren om bij het multidisciplinaire team te behoren.

Theorieën voor andere NKP-RIC organisaties

De identiteit van de Opdrachtgever van het klinisch pad en de motieven achter de studie zijn bepalende factoren om lid te worden van het project.

Bij de keuze van de betrokken populatie en de afbakening van het bestudeerde klinisch pad moeten we aandacht blijven hebben voor de algemene beleving van de patiënt en indelingen vermijden die zeker zin hebben voor de gezondheidswerkers, maar die door de patiënt zouden kunnen worden ervaren als incoherent en een gebrek aan eenheid in de kwaliteit van de aanpak.

Belang van rekening te houden met de dynamiek van de instelling en plaats van diplomatie in de samenstelling van de werkgroepen.

Noodzaak om voortdurend informatie uit te wisselen, zelfs tussen coördinatoren om bronnen van spanning te vermijden.

Participatieve benadering bij het vastleggen van de doelstellingen van het klinisch pad.

De nodige tijd nemen om een vertrouwensklimaat te creëren en de problemen op te lossen (en dikwijls niet uitgesproken kwesties uit het verleden).

Verandering is alleen mogelijk als een akkoord tussen alle betrokken partijen nagestreefd wordt door te luisteren, te onderhandelen en een consensus te zoeken.

Deprived population in Hainaut: a network of health education for care professionals

by

Bizel P¹, Lens B¹, Berghmans L¹

The dashboard (Tableau de bord) of health in Hainaut 2006 reveals a ratio of unemployment (20,4 %) overtaking the national ratio rate (12,3 %) by 66 %.

People in deprived areas are more at risk (often additional) than others categories. socio-medical workers are often helpless, facing massive and multiple health problems.

Goals

OSH had taken on a supporting program for professionals leading to:

- Ensuring collection of regular information linking population health to level of education and environmental conditions.
- Creating a professional network developing actions of public health for deprived population.
- Supporting teams in a effort to make progression the practice of health education.
- Providing documents to professionals on methods.
- Establishing a “news” activity on the theme “Health and deprivation” in order to present regularly specific teaching tools and available resources.

Method

These options turn around three axes :

- Creation of a meeting point for professionals.
- Adaptation and linking the most important message of health and prevention of cardiovascular illnesses and cancers.
- To create specifics tools and methods of practice.

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Results

Progress in the program allowed to:

- develop a come and go movement between the help offered on the ground to professionals and moments of training and analysis.
- participate actively in health education tool (film on breast cancer).
- to point out the most efficient method.

Discussion

This program open on varied fields of intervention (transport, housing, culture,...). Interest to health education messages is largely increased by community work and in continuation.

Keywords

Deprivation, empowerment, health message

Participating in the Walloon network of sustainable food Opportunities and stakes for Health Observatory of Hainaut

by

Demarteau M¹, Thibaut A², Rixen J³, Versailles A⁴

Introduction

In 2008, inspired by the 'Réseau des acteurs bruxellois de l'alimentation durable' (RABAD), the Federation 'inter-environnement Wallonie' (IEW) invited actors to create a network and to organise a symposium (Bioforum, CLPS Mons Soignies, Collectif souveraineté alimentaire, Co-intelligence Europa, CRIOC, Etopia, OSH, Réseau éco-consommation, Union des agricultrices wallonnes).

Objectives

IEW's original objective was to promote dietary choices which preserve both health and environment particularly using the levers of the collective food.

Methodology

Steps of the initial project (example of the RABAD):

- A symposium to exchange knowledge
- One or more round tables to define a charter and principles of actions
- Putting on a sustainable food network
- A communication campaign for the general public

Results

The general meeting gathered 85 persons coming by a majority from three sectors: environment, agriculture and public administrations.

Health district was poorly represented such as the distribution district.

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Participants stuck to the idea of participating in a network but they only wanted to go for a flexible, specific, action and innovation oriented structure.

The network's second year was centred on "thematic visits" intended to encourage exchanges and to define better the concepts and the approaches.

Three themes were reached: precariousness, health and agriculture.

Discussion

The methodology of constitution of the network favours the widening of the exchanges instead of experts' presentations: exchange of knowledge, appropriation of stakes, and enlargement of the basis of the global network from networks

Sustainable development in general and sustainable food in particular offers a new and essential field for Public Health to reassert the specific stakes of nutritional health but also to take into account the environmental, economic and social stakes.

Participating in an inter-sector-based network from the associative sector is an opportunity that needs to be caught. It could be a strategic approach for a local administration of public health centred on prevention and health promotion.

Networking health care practitioners and occupational prevention services for early rehabilitation of low back pain workers

by

Mairiaux P¹, Creytens G², Delaruelle D², Poot O², Strauss P²

Context and aims

The Belgian government has launched, starting March 1st 2005, an evidence-based program to prevent chronic low back pain (LBP). This program is since June 2007 open to all economic sectors. Target workers are workers occupationally exposed either to manual handling or to whole-body vibrations, and being off work due to LBP for at least 4 weeks and maximum 3 months. The program involves two main components: a medical one and an ergonomics one. On the medical side a multidisciplinary back rehabilitation program is provided by more than 50 rehabilitation centres across Belgium, whereas an ergonomics intervention may be carried out in the enterprise of the worker by the OH prevention service.

Evaluation methods

The program implementation is monitored by a task force created within the Fund for Occupational Diseases and among the various process and impact evaluations carried out since the program inception, a phone survey has been conducted among the first 83 participants, and more recently a questionnaire survey has been conducted among the OH physicians (188 responses).

Results

In 2008, 619 workers have been included in the program out of 852 requests for participation. Data analysis shows that the program has been consistently applied in its medical component, but much less in its ergonomics component.

This presentation will thus specifically address the challenge in stimulating a good balance between these two components and in networking the curative and the preventive sector. For more than 40 years, caring physicians have been encouraged not to come into contact with OH physicians and such behaviours cannot be changed in a few months.

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Several other barriers to an efficient collaboration between curative and prevention services have been identified: concurrence between health professionals has had a negative influence in some areas; entering the program implies a visit by the OH physician during the sick leave, a new procedure still largely unknown from the treating physician; arising from wrong beliefs about back pain, some treating physicians are not keen to see their patients participating to such an active program.

Keywords

Low back pain, occupational health, rehabilitation, prevention

Evaluation of the implementation of the 10,000 steps whole-community project in Flanders

by

Van Acker R¹, De Bourdeaudhuij I¹, Cardon G¹

Purpose

To evaluate the effects of '10,000 steps Ghent', a network-based and whole-community intervention to promote physical activity in adults. To subsequently evaluate the implementation of the 10,000 steps project in the whole region of Flanders.

Methods

In order to make the intervention possible, sustainable partnerships between intervention agents of different sectors were created. In a pilot study baseline and follow-up physical activity measures of a randomly selected intervention group (n=872) and control group (n=872) were compared to determine the effects of the '10,000 steps Ghent' intervention. The RE-AIM framework will be applied to report on the dissemination and implementation of projects based on the 10.000 steps project. Consequently, a random sample of Flemish municipalities (n=25), all Flemish health insurance organizations (n=28), and local health promotions services (n=19) were surveyed by questionnaire. Furthermore, a random sample of Flemish subjects (n=1000) was interviewed.

Results

At follow-up there was a significant increase of 8% in the number of people reaching the health-related '10,000 steps per day' standard in Ghent (t=3.2, p=0.001) while no increase was found in the comparison community. Results of the dissemination and implementation evaluation will be reported, including the proportion of subjects that knows the concept of 10.000 steps (Reach), the awareness of intermediates concerning the 10.000 steps project and the impact of the project on subjects (Effectiveness), the proportion of intermediates that is willing to adopt the project (Adoption), the proportion of intervention agents that have implemented the '10,000 steps project' according to the guidelines (Implementation), and the proportion of intermediates that are planning to continue the project (Maintenance).

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Discussion

The '10,000 steps Ghent' intervention showed to be effective in reaching the Ghent population and in increasing physical activity levels in Ghent. The coordination of the intervention by a steering committee of different partners, and the availability of each partner's network was important for the realization of the project. The RE-AIM analyses will provide important information about the projects' wider implementation into the Flanders region.

Conclusion

The whole-community project of 10.000 steps Ghent, initiated by and implemented through sustainable partnerships, was effective in increasing PA levels in the Ghent population. Implementation studies will provide more information on translatability and on needs for successful implementation on a large-scale basis.

Keywords

RE-AIM, physical activity, community

The Consortium of Flemish breast cancer screening centres: networks can work

by

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Background

Since 2001, a breast cancer screening programme in Flanders is implemented. A lot of different bodies are involved in the implementation of this programme: municipalities, GPs, gynaecologists, radiologists, the Centres for Breast Cancer Screening and the Flemish government.

Aims

The main objective of the Flemish Breast Cancer Screening programme is to reduce the cause specific mortality rate by offering a high qualitative programme to all Flemish women aged 50 to 69.

Results

To optimize the performance of the breast cancer screening programme in the complex Belgian/Flemish health care system, a consortium, consisting of the five existing Centres for Breast Cancer Screening in Flanders, was founded. By closely working together, a uniform programme for Flanders was established. This means that parameters such as quality, participation, cancer detection rates and so on, are measured in a standardized and uniform way, at the level of the whole Flemish community. This resulted in a first comprehensive year report for the year 2007.

The Consortium is not only responsible for the processing of the data, but also for standardizing the manner of working within the different Centres for Breast Cancer Screening. For example, the Consortium reports to the GPs, gynaecologists, radiologists and the public in a standardized way; all women receive an invitation letter with the same logo and heading and a uniform leaflet and the reports and the feedback letters concerning the quality control of the mammographic units are also standardized.

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The Consortium tries to further improve the networking and the communication between the different partners by organising the 'yearly day on breast cancer screening', a scientific workshop.

Evaluation

As a result of the network of the five Flemish Centres for Breast Cancer Screening (the Consortium) the Flemish programme for breast cancer screening is performing in a uniform and optimal way. Different results, such as the standardization of the materials used (uniform leaflets and letters), the uniform reports towards the 'field workers' (e.g. the mammographic units, local health care centres) and the possibility to present uniform data for the entire Flemish programme are achieved by the close collaboration within the Consortium.

Keywords

Breast cancer screening, Flanders, consortium

Network organisation: the impact of dominant paradigms?

by

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Context

This report presents the influence of the challenges and paradigms structuring the two networks which aim to prevent language difficulties in children from vulnerable backgrounds. The two networks exist within the dynamics of the *Plan Régional de la Santé des Enfants et des Jeunes (PRSJ)* (Regional Health Plan for Children and Young People) in the Provence-Alpes-Cotes d'Azur (PACA) region in France. This assessment was sought in 2006 to define the conditions for making these networks permanent.

Method

The researchers carried out their analysis using semi-structured interviews with the key actors in these networks (n=32). The actors who were interviewed assume different roles within the networks: funders, coordinators, field workers and beneficiaries. Comparisons between the two networks focussed on several criteria: depiction of work in the network, geographical spread, synchronies, network objectives, structure, effects, the role of beneficiaries, long-term conditions and overlap with existing networks.

Results

Comparison between the two networks using these criteria highlighted a fundamental difference in the choices which took place prior to the network being established. The leadership of certain actors, sometimes initiating action, had an influence on the networks' rationale for action; one was established as a test network and the other as a support network. The challenges facing these actors influenced the work of the networks: detecting children, relations between institutions, organisation of care, professional training.

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Discussion

These challenges and reference paradigms are rarely addressed as objects of evaluation. While they touch upon the social context (risk of stigmatisation, restrictions on the offer of services, lack of centre of reference,...), by their very nature they reduce the occurrence of these phenomena.

Computerization of medical data of school-aged children in the French Speaking Community: results of an exploratory research

by

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Objectives

The implementation of the computerization of socio-medical data is a new mission assigned to the school services of health promotion. This new assignment has caused difficulties for the field workers. The evaluation of the quality of the data reflects also some shortcomings. The purpose of our research is to take part of a better comprehension of the situation and to help with decision making, necessary to improve the device planned for the data collection.

Methods

To understand in-depth the difficulties linked to the installation of the data computerization, the qualitative approach (exploitation of existing documents and interviews) seemed to be the most appropriate one. The analysis was carried out in two phases: the description of the data collection process (phases, stakeholders,...), of the institutional context and of the realities at the fieldwork level, followed by the description of the differences concerning the appropriation of the mission.

Results

We could notice an important diversity of the situations of the health promotion school services. This heterogeneity touches all phases of the process of the data collection and causes inequalities between services in the implementation of the data collection. Behind this heterogeneity, there are some elements that play a key function in the appropriation of the mission: the perception of the utility of the collection, the possibilities of having been prepared themselves for the data collection, to be proactive in the process and, having the material resources allowing the implementation.

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Conclusions

The results of this qualitative research contribute to better understand the difficulties encountered by the field workers and the problems of quality of the data collected. They put forward the need for setting up adaptations to the process of data collection. That means, mainly, to accompany the services towards an appropriation of the data collection by taking into account their perceptions regarding the project and capacities to implement it.

Keywords

Health system information, qualitative research, evaluation

School 21 network

by

Lorenzo P¹

School 21 is an intervention program in schools, combining health promotion and sustainable development fields. Generally, interested schools get involved either in health promotion actions – for example in the Healthy schools network – or on sustainable development, by setting up an Agenda 21. Actually, these programs are separated. In fact, schools follow only one of these two actions. School 21 suggests that health promotion and sustainable development could be part of the same program and be jointly implemented within the same school.

Funded and implemented under the European Interreg IV program, School 21 is part of a 4-year scheme (“Génération en santé”, “Healthy generations”, 2008-2012), involving 3 French regions of the North of France (Champagne – Ardenne, Nord – Pas-de-Calais, Picardie) and three provinces in the South of Belgium (Luxembourg, Hainaut, Namur).

The communication describes the main principles of School 21. It shows how from the first steps of this program, from 2007 to mid 2009, a network of partners has been built with the aim to share objectives and challenges with all the stakeholders.

Then, taking the example of Picardie, the communication shows the construction of a network involving schools and local authorities. We will focus here on the difficulties and the facilitating points of this program.

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Health promotion as a guideline for the 'GO!' school network of the Flemish Community

by

Moens O¹, Dethier E²

In 2005 the Flemish Institute for Health Promotion finalised a renewed national strategy for health promotion. It contains a facilitating methodology to work out an integrated health policy in schools.

Early 2005 the management board of the GO! - a national school network with 17% of the primary and secondary schools in Flanders – decided to support the health policy in their schools as a strategical priority. They chose for an evidence based policy based on the national strategy of health promotion. In the implementation there is a focus on:

- whole school approach with attention for a wide view on health (physical, social and mental health);
- a policy making in function of the specificity of the school and his pupils;
- supportive structures at the different levels of the school network (at the national services, at the regional school groups and health centers for pupils, at the schools);
- competence building and empowerment of policy makers, pedagogical advisors, school managers, headmasters by training, consultancy and partnerships;
- structures and procedures for (project) funding of health policy in schools.

We evaluated the process of change management and interventions by using the concept of the new health promotion of the Netherlands Institute for Health Promotion and Disease Prevention (Saan & De Haes, 2005). We also worked with the triennial research on health policy in schools for tobacco prevention, food policy and physical activities (Moens & Tambuyzer, 2008). Both evaluations give us a clear view on determinants of success and failure for the national implementation of health promotion in education.

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Evaluating the impacts of a network on the practices relating to promoting good quality nutrition in schools

by

Vandoorne C¹, Van Hoye A¹

Context

This evaluation focuses on the creation of a network of actors involved in offering healthy food in schools, through a series of seven visits to projects in the French-speaking community. This initiative was launched and financed by the Fondation Roi Baudouin in 2007 and was evaluated between December 2007 and March 2008.

Objectives and methods

The impact of this network on the spread of good practice and encouragement of exchanges between actors were explored through analysis of the documents inviting and encouraging participation in the visits, analysis of the coverage of network participants and other initiatives for promoting healthy eating in schools, and a questionnaire to 18% of participants.

Results

Analysis of attendance at the visits and the professional profiles of the participants clarified the various audiences in terms of their involvement in one or more visits, their proximity to the place where the visit took place; their role in the school on one hand or school partner organisation on the other, their experience of health promotion projects.

Discussion

This “network” appears to have operated on two levels relating to different audiences and different impacts. The study on the impacts of the network in terms of the spread of new practices only affected one of these audiences.

According to the school-based actors, the network mainly served as a means of awareness-raising and of supporting fledgling activities. For this type of actor and this type of function, the proximity of the activity remains a crucial motivating factor.

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Exchange of good practice particularly involved people with particular motivation, belonging to organisations already with experience in promoting healthy eating in schools. These people gladly participated in a greater number of visits, even when these took place far away.

The North East Public health observatory (NEPHO) and its place in the English health information system

by

Wilkinson J¹

Public Health Observatories were created in each of the nine regions of England in 2000 with seven main responsibilities:

- Monitoring health and disease trends and highlighting areas for action
- Identifying gaps in health information
- Advising on methods for health and inequality impact assessment
- Drawing together information from different sources to improve health
- Carrying out projects to highlight particular health issues
- Evaluating progress by local agencies in improving health and cutting inequality
- Looking ahead to give early warning of public health problems

They were created because there was felt to be an absence of public health intelligence available to decision makers.

Public Health Observatories (PHOs) in England receive core funding from the Department of Health, and by taking on other projects bringing in new resources (for NEPHO, the core funding represents 25% of income).

PHOs have also been established in Scotland, Wales and Ireland and an Association of Public Health Observatories (APHO) has been created. Each Observatory in England has 'lead areas'. For the north east, these are mental health, offender health, Europe and International. Therefore the NE will take the national lead for these areas and for example is leading a national piece of work on mental health in prisons. Similarly NEPHO runs the National Library for Public Health, on behalf of all Observatories. The South East Public Health Observatory runs the national health profiles project. All PHOs contribute money to run the APHO and its staff. APHO bids for resources on behalf of all PHOs. The APHO is also currently setting up a separate 'business arm' to respond to commercial tenders.

¹ North East Public health observatory (NEPHO), Stockton on Tees, United Kingdom

One of the main difficulties which the APHO has is that not all PHOs can proceed at the same pace. Some PHOs do not value the benefit of cooperation and collaboration to the same extent. This means for example that some joint projects can proceed very slowly. However, there is much sharing of work. Every year a staff conference is held. The last one was held in September when over 300 staff from Observatories attended.

In this presentation the work of the English Public Health Observatories will be outlined using the NE as an example. The issues likely to be facing public health observatories in 2010 will be discussed.

Keywords

Health information system, health observatory

The French Regional Health Observatories (ORS) and their Federation

by

Trugeon A¹, Imbert F, Ochoa A.

Introduction

Forty years ago in France, the analysis of the health condition became a main component of health policy.

Wiser for this experience of more than 25 years, Regional Health Observatories understood this from the beginning. They have become recognized actors in the public health sector as can be seen with their inscription in the law of July 21st 2009 about the reform of the hospitalization and concerning Health, patients and territories (the 'réforme de l'hospitalisation et relative à la santé, aux patients et aux territoires' – HPST).

Thanks to the competences of their staffs and their administrators the Regional Health Observatories have gained a recognized expertise from the local and national actors (State, medical insurance, territorial authorities, professionals and health's institutions, community life sector,...)

The need to work together and to offer a single interlocutor is at the origin of the creation of the national federation of regional health observatories (Fédération nationale des observatoires régionaux de la santé - Fnors).

Method

The action of this network is in four steps.

Mobilization and validation of the information:

- Valorisation of the information which is available but disorganized, to make it available for those who use it in their decision making.
- Production of homogenous protocols and methodologies.

Investigation

- Organisation of qualitative and quantitative surveys in several regions
- Matching with national surveys

¹ National Federation of Regional Health Observatories (Fédération nationale des observatoires régionaux de la santé-Fnors), Paris, France

Dissemination of information

- Multiplication of the channels of dissemination of their work (internet, various forms of publications, participations to meetings, etc.)
- Creation of a regional and sub-regional database (SCORE-Santé)
- Advice and help to the evaluation :
- Involvement in stages of elaboration of Health's priorities
- Collaboration to the evaluation of regional Health's policies.

Conclusion

Regional health observation which is harmonized because it is federated at national level has become essential for the establishing of an efficient Health policy in France.

The strengthening (through the HPST law) is reinforcing in a unique network the Regional Health Observatories and their Federation in terms of independence of observation towards the national as well as regional decision makers.

Health information system in Wallonia: a progressively structured network

by

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Observatoire de la santé du Hainaut

Introduction

In Belgium, most of health data collected come from health services and are used for financial purpose. Data collection through surveys for epidemiological use and/or for health promotion is more recent (network of sentinel doctors in 79, Birhn study and Monica in 83, birth of the first provincial health observatory at Namur in 86, HBSC in 94, first national HIS and school sentinel network in Hainaut in 97). Links between health services utilization data and population based health data are scarce. Up to now, there is no true and functional health information system (HIS) to support decisions despite several attempts.

Development and Discussion

Belgian health information system is impaired by the complicated Belgian institutional landscape: three levels of health ministries (federal, community and regional), with data collected at different levels, in different formats. Similar level structures (such as provinces) may even have different missions, objectives and means. Provincial health observatories (PHO) were among the first to gather a large range of data and disseminate them broadly in their 'Tableaux de bord de la Santé'. For them, existence of data is not enough; they must be used, to increase health knowledge, to support decision and to improve the HI system itself. The acronym of Health information and dissemination system is introduced (HIDS). Recently, a regional health observatory has been created for Wallonia, with a function of structuring the available information concerning this region; the necessary collaboration between regional and PHOs is progressively built on a voluntary basis, partly thanks to experiences coming from other foreign health observatories. The network is still very soft and asymmetric even if there is a true willingness to develop complementarities. The links between PHOs themselves are not facilitated by their differences in terms of size, missions and political dependence even if the willingness exists on behalf of the professionals working in those structures.

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² Observatoire de la santé du Hainaut, Havré, Belgium

Conclusions

Health observatories in Wallonia play an important role in health information dissemination. A broad health information dissemination will maybe contribute to bring up a necessary decision making cultural (r)evolution, but surely to increase the general knowledge about health and its determinants in the public opinion, and to improve the HIDS itself. Clarifying the structure of their network would probably facilitate their task.

Keywords

Health information system, health observatory

French-speaking Network for heart health and prevention of obesity

by

Bizel P¹, Beauchemin M², Lorenzo P³

The network consists of ten public health institutions at provincial or regional level who want to develop in one hand common datas and in the other hand, programs.

The members are faced with the same problems for their population: increase of chronic illnesses associated with life style. However, the factors of risk associated with these illnesses are evitable.

Goals

- ensure a better knowledge of cardio vascular illnesses and their risk factors;
- maintain the exchange of information about tools, methods and strategy and also on estimation of heart health;
- give preference to french speaking members of various cultures and skills by means of a transcultural and interregional network.

Method

- dissemination of information on cardio vascular illnesses and promotion of heart health in French-speaking zone: repertories, reports, as well as participation in major international events;
- research on specific themes: social marketing, modification of risk behaviour, children...

Members

- Belgium: Observatoire de la santé du Hainaut
- France: CRES Picardie, CODES Mayenne, OR2S Picardie
- Grand Duchy of Luxembourg: Ministère de la Santé - Direction de la santé

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² Agence de la santé et des services sociaux de la Capitale Nationale, Québec, Canada

³ Observatoire Régional de la Santé et du Social de Picardie, Amiens, France

- Switzerland: Hôpitaux universitaires de Genève
- Tunisia: Faculté de Médecine Communautaire et Santé Publique de Sousse
- Québec: Agence de la santé et services sociaux de la Capitale-Nationale
- Sardinia: Institut d'Hygiène et de Médecine préventive

Discussion

The different local competences and application fields involved in the network, represent an advantage, and a great interest. The effectiveness of each member is increased.

Keywords

French-speaking institution, regional or local level, exchanges

Steps prior to the RAI Instrument implementation in Belgium

by

Degey S¹, Tancredi A¹, Renard F¹, Londot A¹, Collard J¹, Declercq A²,
Gosset C¹

The Resident Assessment Instrument (RAI) is a comprehensive geriatric assessment (CGA) tool whose main objective is to improve the quality of life and the quality of care in elderly.

For this purpose, Federal Public Service in charge of Health, Food Chain Safety and Environment decided to implement this instrument in Belgium across different care settings (at home, in hospitals and in long-term care facilities). This would be the first time to use a web-based software application to share information across settings.

An action research was undertaken in order to set up the preliminary appropriate conditions to adequately implement the RAI. These conditions concern cultural adaptation, adaptations to care settings, translation in many languages, content validation, development of a web-based software application, survey on informatics, design of training content and training courses, etc.

These preliminary steps led to a web-based software application that incorporates a clinical decision support system. There are lots advantages to use this network practice: database access is secured and controlled by e-health; privacy is respected; and inter and multi-disciplinary communication and collaboration are stimulated.

Some difficulties (availability, accessibility and the ability to use informatics) have been taken into account and will be improved.

The implementation test in 2010 will investigate the information transfer and sharing across care settings and health care professionals which guide in the continuity of care, guide to monitor and finally improve the patient health status.

Keywords

Elderly, assessment tool, Internet

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Ontwikkelen van een project rond gezonde lucht in scholen, samen met het lokale netwerk waar scholen deel van uitmaken, o.a. resulterend in het project 'Lekker Fris' in basisscholen (België - Vlaanderen)

by

Deplancke D¹, Reekmans S¹, Van lent N¹, Vanhoutte S¹, Benoy S¹

Uit onderzoek blijkt dat de kwaliteit van binnenmilieu op school niet optimaal is. Dit kan leiden tot negatieve gezondheidseffecten bij leerlingen en leerkrachten. Ongezonde lucht in de klas is geen individueel probleem maar is van belang voor het volledige schoolnetwerk: in de klas en het schoolgebouw, Centra voor leerlingenbegeleiding, lokale besturen, oudercomités, etc.

In Vlaanderen werken veel scholen rond gezondheid en rond milieu. Vóór 2005 werd de link tussen beide weinig gelegd. Vanaf 2005 hebben de Medisch Milieukundigen samen met de Vlaamse Overheid een werking uitgebouwd met als doel leerlingen, leerkrachten en directies problemen in het binnenmilieu te leren herkennen en aan te tonen hoe ze dit kunnen verhelpen om zo het welzijn in de klas en op school te verbeteren.

De voorbereiding voor het project in het basisonderwijs (2005) bestond uit focusgesprekken met lokale netwerkpartners: leerkrachten, directies, preventieadviseurs en CLB's. Voor het secundair zijn lokale partners binnen het onderwijsnetwerk en leerlingen bevraagd via vragenlijsten (2008).

Sinds 2007 kan elke Vlaamse basisschool intekenen op het project Lekker Fris. In de klas wordt samen gewerkt aan een gezond binnenmilieu. Dit project betreft ook de school, CLB's en lokale besturen. De lokale besturen kunnen o.a. projectmaterialen aankopen en ontlenen aan scholen en hen zo steunen in hun milieugezondheidsbeleid op school.

De hoofddoelstelling is streven naar een gezonde omgeving om in te leren en te werken, een gevoel van comfort en een goede gezondheid en welzijn voor iedereen op school. Dit kan echter enkel bereikt als wordt samengewerkt met het netwerk van de school.

De methodiek voor het secundair onderwijs is voorzien voor 2010.

¹ Logo, in cooperation with Vlaams Agentschap Zorg & Gezondheid, Brussels, Belgium

Vanuit de Medisch Milieukundige werking wordt hiervoor de aanzet gegeven. Wanneer verschillende actoren in en rond de school zich inzetten voor hetzelfde doel, kan op een duurzame en beleidsmatige manier worden gewerkt aan een gezond binnenmilieu op school.

Keywords

Milieugezondheid, samenwerken, lokaal netwerk, onderwijs

Silly (Belgium): A partnership that keeps its ground!

by

Gérin S¹, De Jonghe K¹, Demarteau M¹

Introduction

Since 1999, a partnership was created between the directors of Silly's communal schools, the caterer (who provides warm meals to certain schools) and the OSH (Public Health Observatory of Hainaut). At the beginning, the goal was to better the lunch times, but in the middle of the project we added the arrangement of the toilets.

Methodology

Since the early beginning, a basic cell puts together the "invariable" partners and the occasional ones (according to the chosen activities). The school managements are the link between the educational teams of every school and the basic cell. An analysis of the situation has been made on every site. Regularly, the different partners made valuations about the action, the changes done or those to consider. The writing of synthesis gives the possibility to keep traces and to make a link with the (political) authorities.

Results

Since 10 years, the partners are still present and active. Real changes occurred in the schools on behalf of children wellness (bettered food supply, water available, improvement of the organizing and premises, quality of the staff, renovation of the toilets, etc) and they last! The project is part of the school's one. There is harmonization and not uniformity: every school chooses its own changes! Some other schools profit of more balanced meals (result of the work done with the caterer).

Debate

The long-term follow-up, the respect of everyone's rhythm, the trust between the partners allow working up and maintaining real changes. The necessity of every partner to spend time, to recall themselves in question. For the OSH, the difficulty to leave the project is real. And what about if one of the partners changes?

¹ Observatoire de la Santé du Hainaut, Havré, Belgium

The dynamics of a network of practitioners and researchers for supporting the work of teams promoting health in schools

by

Miermans MC¹, Melen G², Vandoorne C²

In the context of the systems and programmes relating to health promotion and preventative medicine planned by the Communauté Française de Belgique, university teams and practitioners have come together to create and distribute tools and practices regarding public health priorities and/or legal requirements for school health workers. This presentation aims to highlight the dynamics of this network, which links three categories of actors and the synergies which develop between their challenges and skills.

The three categories of actors are as follows:

- SCPS APES-ULg researchers (health promotion) and PROVAC (long-term vaccination promotion programme)
- HPS (health promotion in schools) professionals involved in temporary networks producing tools and materials and to support awareness raising days. Some of these professionals form a nucleus of specialist actors; they thus constitute a permanent informal network, fed and reactivated by temporary networks.
- All HPS professionals are regularly invited to awareness-raising days and information updates on specific themes.

The synergies between the skills and strategic positioning of these actors will be discussed,

- by linking the motivations and profiles of participants in these temporary networks to the way in which they can use new practices and how new recommendations can be integrated into practice (training, presentations and team-leading, establishing legal and administrative frameworks in terms of new public health requirements, lobbying at the political and administrative levels...)
- by highlighting the role of the research team at these different levels (definition of a frame of reference, proposition of content and working methods, formalisation of practitioner contributions, logistical and organisational support)

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² SCPS APES-ULg, École de Santé publique, Université de Liège, Liège, Belgium

Platform inter-sectors (South area of “Sambre et Meuse”): a device in the service of the quality of life

by
Mouyart P¹

Summary

This platform is defined as a privileged place of meetings and exchanges for institutions and structures coming from various sectors (economical, cultural, social and environmental) and which wish to work on the local development and on the improvement of the health and the well-being of the population of the South area of “Sambre et Meuse”.

Objectives

The objectives of the inter-sector-based platform are:

- to identify the local actors coming from different sectors
- to give a wider visibility and accessibility to the information and to the existing resources
- to federate the local actors whose actions have an impact on the health and on the quality of life of the citizens of their territory
- to develop an effect of “resonance chamber” for the activities organized by the various sectors
- to realize economies of scale by sharing of the resources and the skills

To reach the fixed objectives, the platform implements various initiatives:

- organization of information exchange and presentation of projects
- organization of local events having vocation to gather the actors coming from different sectors around common problematic

Elements of analysis and recommendations

This experience enlightens these following elements:

- management of schedule
- management of the results

¹ Centre Local de Promotion de la Santé de Charleroi-Thuin, Charleroi, Belgium

- definition of the identity of the group
- definition of a relevant field

Recommendations

Being able to manage the dangers of this particular partnership:

- time-eating meetings
- contradictory logics because of the intersector-based character of the platform
- different business ethics
- no concrete realizations

Being able to emphasize the assets of the partnership:

- win-win logic
- shared efficiency

Keywords

Inter-sectoriality, partnership, local network

Zoet Zwanger project: towards preventing diabetes in high risk women

by

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Wens J⁵, Mathieu C⁶

Objectives

The global burden of type 2 diabetes (T2DM) is rising, following the trend in overweight and obesity. Joint action of all stakeholders in diabetes prevention is key to curb this epidemic. Initiatives at the societal level are necessary but particular attention should be paid to targeting high risk populations. Women with a history of gestational diabetes (GDM) are at the highest risk to develop T2DM early in life. Scientific evidence shows that lifestyle advice can significantly reduce the incidence of T2DM. GDM women are currently not receiving appropriate postpartum diabetes screening and typically maintain risk behaviour. Opportunities for prevention are being missed as these women slip through the cracks of healthcare systems.

'Zoet Zwanger' is a new diabetes prevention project (2009 to 2012) in Flanders, aiming to bridge the described prevention gap.

Methods

The Flemish Diabetes Association (VDV) is both a patient and a professional organisation. Some of its key objectives include raising awareness and the promotion of early diagnosis and prevention, which are important public health issues. To translate these objectives into action, the association largely builds upon its strong network of volunteers and established collaborations with different health stakeholders.

'Zoet Zwanger' is coordinated by VDV and implemented in close collaboration with the region's professional associations of obstetricians-gynaecologists (VVOG) and general practitioners (Domus Medica). It is supported by the Flemish authorities. The first part of the project consists of an awareness campaign. Secondly, women diagnosed with GDM will

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have the opportunity to participate in a GDM recall register, with annual reminders asking them to see their general practitioner for a glucose screening. Compliance with this advice will be the main indicator used for evaluation.

Expected Results

The described multi-stakeholder project is an important opportunity to advance diabetes prevention and should improve long-term outcomes after GDM.

Keywords

gestational diabetes, long-term follow-up, risk awareness

Permanent sample of socially insured

by

Preal R¹

The permanent sample (PS) is a new instrument dedicated to the study and monitoring of health care utilisation and expenditure in Belgium.

The 7 sickness funds, by which the compulsory public health insurance is administered, routinely collect all claims for reimbursement of health care expenditures of their members.

A one in forty random sample of their members with all their claims data are assigned to the PS. Members over 65 years old are oversampled (1 in 20).

The management of the PS is attributed by law to the Intermutualistic Agency (IMA-AIM) created jointly by all sickness funds. The law also grants access to five other governmental bodies in the field of healthcare and planning. The PS managing committee is constituted of representatives of these partners and of the Privacy Protection Commission.

Information is organized at the person level, and includes every specific reimbursement code number, date, caregiver, place of care, cost,... for every single health related contact, procedure, test, admission, drug, ..., as well as a number of socio-demographic characteristics of this person.

The sample cohort is followed up longitudinally for a period of 10 years.

The main advantages of the PS are: permanent availability on line, representativeness, manageable size, high level of detail and longitudinal design, allowing 10 years follow up.

Patient IDs are double-coded by a third trusted party, and access to the PS is strictly regulated and limited to clearly identified persons in each of the partner organisations. Third parties, such as university researchers, regional authorities, the cancer registry,... can request access to specific views on the PS in order to answer specific research questions.

In the near future, the PS is likely to become an essential instrument helping public health authorities and stakeholders making better-informed decisions.

¹ IMA – AIM, BU-IT & Steekproef coördinatie, Brussels, Belgium

The Provincial Frame in Health Promotion: a network practice tool

by

Renard C¹, Bizel P¹, Loria R¹

'Le Plan Directeur Provincial en Promotion de la santé' (the Provincial Frame in Health Promotion) has been introduced by the Province of Hainaut to develop a pole of resources and skills to the provincial institutions which wish to develop projects in health promotion. For several years, this plan aims at creating a global frame allowing the provincial institutions who wish to benefit from resources to help them in the implementation of programs of health promotion. For some years, this plan has been centred on the prevention of the cardiovascular diseases by treating simultaneously the question of addiction to smoking, physical activity and well-balanced nutrition.

Applied to the provincial secondary schools, this plan allows:

- a more sensible exploitation of the available resources;
- an inventory of programming and evaluation diagnosis tools (situational diagnosis, questionnaire for the pupils);
- a data analysis between a comparison sites to identify better:
 - the specificities of contexts;
 - partnership process between the institutions which develop similar projects;
 - incentive between various directions of institutions during regional meetings;
 - bigger recognition and the institutional legitimacy on behalf of the provincial institution.

An analysis of obstacles met in the implementations will enclose the presentation.

Keywords

Health promotion, network, secondary schools

¹ Observatoire de la Santé du Hainaut, Service Education Santé, Havré, Belgium

Online assessment of the quality of care in elderly (Belgium)

by

Tancredi A¹, Renard F¹, Degey S¹, Collard J¹, Londot A¹, Declercq A², Gosset C¹

Within the framework of its health policy aiming at improving quality of care in elderly, Federal Public Service in charge of Health, Food Chain Safety and Environment seeks an instrument to evaluate the quality of care and the quality of life in older adults. The Resident Assessment Instrument (RAI), a comprehensive geriatric assessment (CGA) tool, was developed and validated by InterRAI, an international research group, for this purpose.

The RAI, relying on the 'Minimum Data Set' (MDS), has been adapted to the Belgian health-care system and can be applied to different care settings (Home care, Long Term Care and Acute Care). The MDS, requiring the commitment of multiple caregivers, is a group of items covering various fields of physical, mental and social health. Specific definitions, response categories and strategies are also provided for arriving at a correct response. A large number of assessment items are common to different health care settings which allow the information sharing and ensure the continuity of care across settings.

The RAI (MDS) allows a structured and standardized online data collection of high-quality level. On the basis of specific items on the MDS, other outputs are available: 'Clinical Assessment Protocols' (CAP) guide facilities in development of the care plans for patients, 'Quality Indicators' (QI) help identifying and monitoring potential quality problems in facilities and also allow the benchmarking at several levels. The 'Resource Utilization Groups' (RUG) which are indicative of the extent of care needed by individual patients determine the workload of caregivers.

Although the MDS is designed primarily to provide a holistic and comprehensive picture of each patient's health status and to provide 'evidence-based' care, it can be used in many other ways such as quality improvement, studies of the intervention outcomes, workload assessment, performance of international comparative research or decision making in public health.

Keywords

Aging, quality, assessment

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A framework for Physical Activity programs within the Community School (PACS): targeting the digital-age student through school-community partnerships

by

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Purpose

Community school principles are believed to be a sound foundation for integrated PE and physical activity programs, necessary to meet the challenges of today's digital age. Therefore the purpose was to document on the principles and organizational guidelines of an evidence-based socio-ecological framework for Physical Activity Programs within Community Schools (PACS), feasible for elementary schools and secondary schools.

Methods

The development of the PACS framework is based on three strategies. The first strategy was the evaluation of two Flemish school-based physical activity interventions, one in elementary and one in secondary schools. The second strategy was to review relevant literature about local and international initiatives related to PACS. Third, academic experts, policy experts and field 'sport and physical activity leaders' of the Flemish School Sports Association were consulted.

Results

Next to mandatory and high-quality PE, the framework supports five components for physical activity promotion in students during and outside school hours: (1) sports and physical activity during lunch break, (2) active schoolyards or playgrounds, (3) active commuting to school, (4) health education and (5) after school sports and physical activity. Sustainable partnerships connect the school, family, students and local community players, stimulating input to execute and reinforce these components. The

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⁵ University of Bedfordshire, Faculty of Education & Sport, Bedfordshire, United Kingdom

PACS framework shows that the potentially sustainable partnerships are situated on two main levels, namely the regional and the local level.

Conclusion

The development of the PACS framework is an effort to integrate community school principles in an evidence-based implementation framework for physical activity promotion. Further studies of innovative system-wide and intersectoral interventions such as PACS need to focus down on young people's experiences of physical activity and their engagements with physical culture more broadly as these are shaped within digital society.

Keywords

School, physical activity, partnerships

Practice of the Health Observatory of Hainaut Progress of the project 'healthy communes': a variety of steps

by

Waroquier V¹, Demarteau M¹

Context

The evolution of the health mission and the principles guiding the provincial health actions in Hainaut.

Goal

To implement health promotion in all 'communes' of the province and to reach 35 percent of 'healthy communes' in 2009.

Method

- to initiate a network 'healthy communes' to encourage exchanges of good practices with a connection between national and international politics
- to organize a training course and create a methodological tool on 'How to start up a health project in local territory'
- to support health local actions with the professionals and the citizens

The method is based on the key steps of a healthy commune and its adaptations to the local and provincial realities.

Results

For the period of 2007 and 2008, 40 communes have proposed health actions in collaboration with the Health Observatory of Hainaut that is to say a little more than 60 percent.

In 2009, 53 communes have been participating in the activities suggested by the Health Observatory of Hainaut within the context of the project 'healthy communes' that is to say a little more than 75 percent.

Conclusion

The diversity and the synergy between the actions developed by the different sectors of the Health Observatory of Hainaut to answer to the local

¹ Observatoire de la Santé du Hainaut, Havré, Belgium

needs as well as the communication policy elaborated by the institution have contributed to the expansion of the project 'healthy communes'.

The formalization of the network asks some crucial questions that need to be answered: the political leadership, the implication and the adequacy of existing policies (C.L.P.S., Villes-Santé,...) and the constraints related to all types of networks (temporality, etc.).

Keywords

Network, steps, diversity

The development of a multi party partnership in an environmental health context: the heavy metal case in the Noorderkempen (Belgium - Flanders)

by

Wynants K¹, Lodewyckx C¹

The area around the Noorderkempen is historically polluted (toxic heavy metals, negative perception of environmental health risks,...). In order to reach a state of physical, mental and social wellbeing, this community must be enabled to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Through a community development process we are aiming to create a 'healthier environment' on a local scale. The process is based on different values (social justice, participation, learning, cooperation,...) and commitments:

- Developing practice and policy that protects environmental health.
- Encouraging networking and connections between communities, organisations, policy makers.
- Influencing policy and programmes from the perspective of communities
- Promoting social change that is long term and sustainable.
- Reversing inequality and the imbalance of power relationships in society.
- Supporting community-led collective action

The process is facilitated by two local environmental health workers through different facilitation methods and activities: interactive process designing phase, consultative workshops, declaration of engagement,... Since the start of the process about 60 participants joined the partnership including factories, workers organisations, local, regional and Flemish government, environmental and health agencies, community workers, citizens, general practitioners,... They are divided in a three level cooperation: a steering group, different project groups and a communication working group. They developed a specific local environmental health action plan (LEHAP) that they will implement from 2009 on until 2011.

Keywords

Environmental health, community, partnership, interactive process.

¹ Local environmental health workers, Turnhout, Belgium

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