Healthyregions
When Well-being Creates Economic Growth

FINAL TECHNICAL REPORT

1.10.2007 - 24.10.2010

November 2010

Ingrid VANHAEVRE – CRIOC

Marianne DE TROYER - METICES-TEF, ULB

OIVO
Onderzoeks- en Informatiecentrum
van de Verbruikers Organisaties

CRIOC
Centre de Recherche et d'Information
des Organisations de Consommateurs

Foundation of Public Interest
Boulevard Paepsem 20
B-1070 Brussels

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2.1. Context

In the Europe of today the regions are important economic and decision-making poles. They are the link between the local structures, such as the municipalities and the (supra)national echelons. The citizens expect from the regions that they make the services accessible which improve their quality of life and their personal development. However, numerous regions are confronted with social disparities, health problems and unwell-being. Therefore, there is a real need for co-ordination of the regional and local policies and initiatives for the health promotion and prevention. It is in that context that the project "Healthy Regions" was conceived.

The project enters in the framework of the European Public Health Programme (2008-2013) and in the Strategy of Lisbon which, in view of the globalisation, the demographic evolution and the environmental challenges, aims to make Europe more attractive for investors as well as workers and to improve the citizens' quality of life as well as that of the future generations.

Too often health is seen as a cost and not as a source of (indirect) income for the region.

This project tries to deal with that aspect by applying the opposite approach, i.e. that public health – as the triangle of needs for the growth in the figure below shows – is a fundamental factor for the innovating character and that the regions can simultaneously save money and generate economic development thanks to a strategic concentration on the public health.

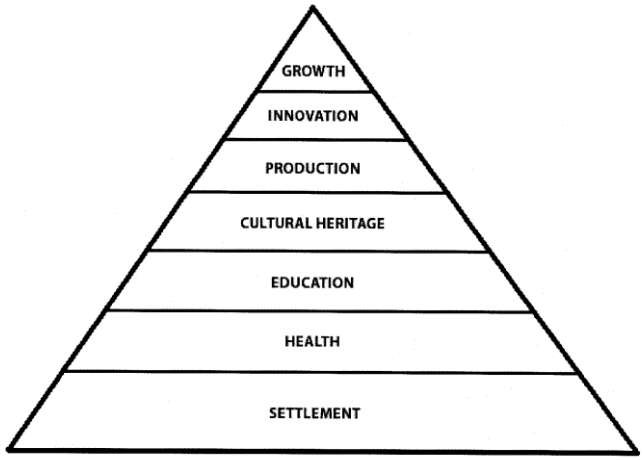


Figure 1: The triangle of needs for growth

2.2. PARTNERS

Six regions in Europe are project partners:

- Brussels (Belgium)
- Region of South Denmark (Denmark)
- Schleswig-Holstein Region (Germany)
- Veneto Region (Italy)
- Orebro County Council (Sweden)
- South West Public Health Group (United Kingdom).

2.3. OBJECTIVES

The objective of the "Healthy Regions" project was to put health on the political agenda of the regions within the Member states and to help them strategically examine all the initiatives for the public health promotion and prevention as well as all the existing projects.

The aim of this action was to:

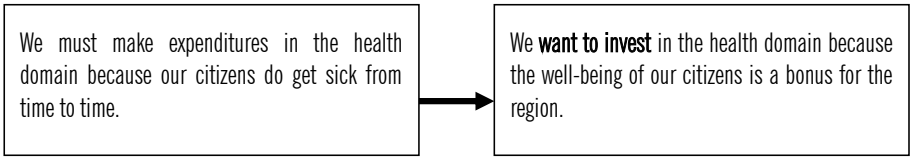
- determine what gaps there are in the "health" competences of the region;
- show the opportunities to seize in order to turn these regions into "healthy regions";
- activate concrete projects that can serve as examples of good practice.

By doing so, the project wanted to make the mentalities of the political decision-makers change.

The concept of the Healthy Regions project sets out three key themes that underline the idea of health as an investment:

- Investing in citizens' good health saves public money, as it is cheaper to prevent than to cure
- Healthy citizens are a precondition for innovation and growth
- Judicious and strategic investments in health as a business sector can lead to innovation and new areas for regional development and knowledge, creating employment and economic growth.

A change of mindset and the strategic view on health investment from "something we have to deal with because citizens do get sick from time to time" to "something we want to deal with because the well- being of our citizens makes our region grow and develop" supports the overall philosophy of the Healthy Regions project; namely that health in many ways can become a factor to create economic growth.



2.4. Method

The "Healthy Regions" project concentrated on three complementary sections that can be presented schematically as follows:

1. The "Health Competencies" were dealt with by means of an analysing grid ("Mapping or Dialogue Tool") that started the dialogue between the various actors and allowed to determine the competencies and existing good practices as well as the gaps with regard to health at the local level. The dialogue tool was tested in its visual form as a spider web in Brussels. In a later stadium, it was used as a guidance for the interviews with our stakeholders.
2. The tool "Traffic light matrix" could be used to more closely analyse the health sector as an economic sector and by doing so to make the link between the health sector and the regional development. In Belgium this tool was not used.
3. On the basis of the results, pilot projects could be initiated in various environments (school, family, enterprise). These projects could serve as a showcase of the concept of "Healthy Regions" and as examples for other regions. In Belgium the attention was focused on running initiatives.

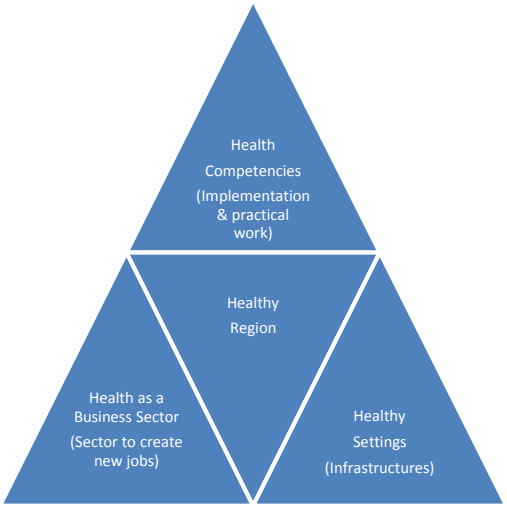


Figure 2: The scheme of the Healthy Regions concept

The aim of the project was to develop and activate a new concept for "Healthy Regions", in order to play a facilitating role for putting practical methodologies (guidelines, recommendations, tools) at the disposal of the regions so that they could easily develop strategies in the field of health promotion and prevention that stay close to the citizens.

Through the six regions that are involved in the project the functionality and efficiency of the "Healthy Regions" concept are examined in order to determine if the concept could be a helping tool for the decision-making in the field of the development of the regional health policy strategies and of practical pilot projects. We will see that this is not evident in Brussels.

2.5. Implementation in the Brussels-capital region

In the Brussels-Capital Region, "health" competencies are divided between a large number of political actors and institutions. It is therefore very complicated to apply the "Healthy Regions" concept at the regional level. As a result, practical procedure initiated rank and file was preferred to a more theoretical top-down approach. Among other things, the project was aimed at associations, at the most local level, that is to say at local authority level. The purpose was to test and evaluate the procedure and tools in order to find out if the concept could be taken up in a more comprehensive way by others.

In the course of the project it became clear, however, that Brussels is a very complex political, economic and social entity where dialogue and synergy prove difficult and where a formal or informal structure for concert is lacking. Consequently, a group discussion with the stakeholders proved difficult and the implementation of the Healthy Regions project finally consisted of individual talks with the stakeholders about their own strategic views, organisational structures and actions they undertake in the field of health. This resulted in a summarizing document for the stakeholders, explaining how matters are being dealt with in Brussels.

2.6. Distribution of the results

Final results of the project are available on the website of the project: http://www.healthyregions.eu/ .

Among others, this website provides a list of « good practices », in addition to the given tools, which contain projects that were and/ or are carried out in different European regions.

2.7. Coordination

Project coordinator : South Denmark European Office in Brussels

Henriette Hansen, hha@southdenmark.be

http://www.southdenmark.be

2.8. Partners for Belgium

CRIOC

Centre de Recherche et d'Information des Organisations de Consommateurs – Consumer Organisations' Research and Information Centre

Ingrid Vanhaevre, ingrid.vanhaevre(at)oivo-crioc.org

http://www.crioc.be

TEF-ULB

Université Libre de Bruxelles

Marianne De Troyer, mdetroyer(at)ulb.ac.be

http://www.ulb.ac.be - http://www.soco-ulb.be/

3. The Brussels-Capital Region in Belgium

3.1. Belgium, a federal state

Belgium became an independent country in 1830, uniting citizens from different cultures under the same flag.

The Constitution was revised several times. The complexity of the Belgian social structure, with its patchwork of cultures and languages, makes it very difficult to divide the country into coherent pieces. To settle these problems, the Constitution was changed several times which gradually led to a transformation of Belgium into a federal state composed of three communities (French-speaking, Flemish-speaking and Dutch-speaking) and three regions (Flanders in the north, Walloon in the south and Brussels-Capital), each region and each community having its own council and its own government (Note: The Flemish council and government and those of the Dutch-speaking Community and the Flanders Region are the same). The first steps were taken from 1970 onwards and the last important step took place in 2001. Even though the federal state retains power, the different entities were given certain autonomy.

Figure 3: The Brussels-Capital Region.

Source: http://www.belgium.be/en/about_belgium/government/federale_staat/map/

For the Healthy Regions project we preferred to work at the level of the Brussels-Capital Region. This may well be (only) a 'constitutional' entity, but at the same time it is also a real functional administrative entity. The Brussels-Capital Region was granted its institutions during the third reform of the State in 1988-89. The confidence of the inhabitants of Brussels as to their social entity status is gradually growing.

3.2.1. Brussels, a complex administrative entity

Brussels is Belgium's capital as well as the capital of the Flemish- and French-speaking Communities. After years of discussions, it has its own institutions since 1989. The Government is composed of 4 ministers: one Minister-President, two French-speaking ministers and two Flemish-speaking. Those ministers are supported by 3 State-Secretaries.[1]

The Brussels' Parliament or Brussels Council consists of 75 members divided into two linguistic groups (72 for the French-speaking and 17 for the Flemish-speaking Belgians). They vote the laws (ordinances) for the Brussels-Capital Region and the regional budget and control Government policies.

Three additional institutions are of importance in the Brussels political landscape: the COCOF (Commission of the French-speaking Community), the VGC (Commission of the Flemish-speaking Community) and the COCOM (Common Community Commission). Those institutions are in charge of the implementation on Brussels territory of the Communities' policies related to cultural, educational and person-related matters.

Another important actor in Brussels is the Brussels-Capital Health and Social Observatory, the research department of the College of the Common Community Commission (COCOM).[2] The Brussels-Capital Health and Social Observatory gathers, analyses and publishes information (e.g. indicators) about health intended to help decision-making for the various actors involved in Brussels health policies (politicians, professionals, associations, etc.); it lends its expertise to actors through various activities; and in its role as a research centre for the Joint Community Commission, the Observatory actively participates as technical representative for Brussels in working groups of the Inter-ministerial Health Conference.

The Brussels-Capital Region is not a uniform economic entity, and even less a social entity. It is home for about 1,1 million inhabitants.[3] Roughly a quarter of the city's total population is of foreign origin. Slightly more than half of the non-Belgians (50.8 pc) originate from the countries of the EU-15.

Its territory covers 162 km^2 and consists of 19 bilingual (French-Dutch/Flemish) communes. These communes represent the smallest administrative level and are closest to the citizens (or residents) and their daily concerns. The communal authorities are composed by an executive body ("Bourgmestre" and "Echevins") and by a legislative body (Communal Council which is elected by direct, universal and compulsory suffrage every 6 years). The different municipal board members ("Echevins") share the Commune competencies.

The Brussels-Capital Region is also home for the European Commission, the European Council and some of the meetings of the European Parliament, as well as many other international organisations.

[1] http://www.bruxelles.irisnet.be/en/region.shtml

[2] http://www.observatbru.be/documents/home.xml?lang=en

[3] *Statistical Indicators of the Brussels-Capital Region, Structure of the population 2009*, Brussels 2009, p. 18-32.
http://www.bruxelles.irisnet.be/en/region.shtml
http://portail.irisnet.be/nl/region/region_de_bruxelles-capitale/n_statistiques/
http://www.bruxelles.irisnet.be/fr/region/region_de_bruxelles-capitale/n_statistiques/analyses_et_statistiques/donnees_statistiques_thematiques/population_et_menages.shtml
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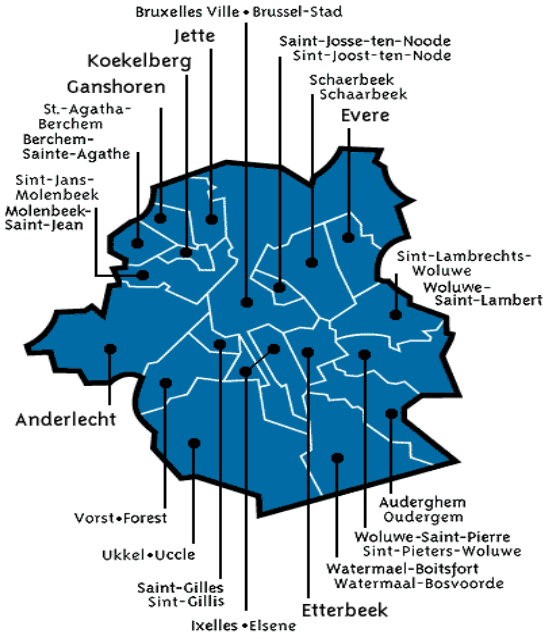

Figure 4: The 19 municipalities of the Brussels-Capital Region

3.2.2. The Brussels-Capital Region

3.2.2.1. An urban environment

Brussels has the typical characteristics of a big city, which strongly influences the health of its inhabitants.[4] Since a number of years, the town is also enlisted in the "Healthy Cities" project. This project does however cover more than just the town centre and also wants to include the 19 communes of the region. (See section 4.2)

The indicators for the physical and mental welfare, here in the context of an urban environment, include among other things the unemployment, social exclusion, deterioration of the quality of life...

We only give a few significant socio-economic figures for the Brussels Region, taken from the report on the Health Indicators of the Brussels Region 2010[5]:

- Unemployment

  The employment rate in Brussels was situated between 53.2 pc and 56.9 pc in 2009 and thus does not fulfil the European objective. The number of job seekers in 2009 was situated between 14.0 pc and 17.6 pc and increased that year by 7.9 pc in comparison to 2008. This way, the economic crisis had a bad influence to the negative evolution that began in 2006.

  It is remarkable to see that the unemployment rate among young people (under 25) in Brussels was at an average of 33.5 pc in 2009.

  Non-European Brussels inhabitants are more often unemployed (33.0 pc) than Brussels inhabitants with the nationality of a country of the EU27 (14.0 pc).

  In 2009, one out of every five not working job seekers (19.9 pc) was already unemployed for a long period of time (inactivity of at least 5 years).

  We also want to underline here that Brussels is an important work provider for people from all over the country. Less than half of the jobs are held by Brussels inhabitants.

- Poverty[6]

  Brussels is the region with the highest percentage of people living under the poverty risk limit.[7] The poverty risk percentage is situated between 12.6 and 40.0. Thirty-five per cent of all the Brussels households have great to very great difficulties to make ends meet.

  More than 5 pc of the Brussels population lives of the minimum wage (social insertion or allowance for elderly people) and their numbers continue to increase.

[4] The Brussels-Capital Health and Social Observatory, *Gezondheidsindicatoren van het Brussels Gewest 2010*, Brussels 2010, http://www.observatbru.be/documents/publications/publications-sante/tableaux-de-bord-sante.xml?lang=nl

The Brussels-Capital Health and Social Observatory is the Research Centre for the Joint College services of the Brussels-Capital Joint Community Commission.

[5] *Statistical indicators of the Brussels-Capital Region, 2009*, Brussels 2009.

[6] The Brussels-Capital Health and Social Observatory, *Het armoederapport 2010 (poverty report)*, Brussels 2010.

[7] The Brussels-Capital Health and Social Observatory, *Gezondheidsindicatoren van het Brussels Gewest 2010, III. Determinanten van gezondheid*, Brussels 2010, p. 129-203.

- Ageing and baby-boom

  The population of the Brussels Region has been growing and growing younger for more than 25 years. The Brussels Region is the only big city in Belgium where the portion of elderly people is decreasing since 1989 and the portion of young people is increasing. The youths are over-represented in comparison to the other large cities.

  In the course of the nineties, this rejuvenation of the Brussels population continued and in 2001 the average age in the Brussels-Capital Region was at 39.0 years.

  The continuous growth of the Brussels population since 1999 can be explained by the facts that the birth rate exceeds the mortality rate and that a large number of people from other countries came to live in the Brussels Region.

- As for the portion of isolated people, the Brussels Region comes second, after the city of Liège. The portion of single-parent families is equivalent in both cities, but topped by the city of Charleroi.

- Social inequality

  The more people's position on the social scale decreases, the more the prevalence of mental health problems and physical suffering increases.

  There is a clear social gradient for sleeping disorders, depression and anxiety disorders and the social inequalities are bigger among women than among men.

- Multiculturalism & multilingualism[8]

  Brussels inhabitants of foreign origin represent a constantly increasing portion of the population, but they do not constitute a homogenous group. Some people who live in Brussels are part of the first, second or third generation after the work migration from Italy, Spain, Portugal, Greece, Turkey, Morocco and later Eastern Europe; there are more or less temporary migrants that come to Brussels to work in the European institutions, for NATO or big multinationals; there are people who seek refuge in Belgium after tragic events in their country of origin; and finally there are those who seek a better life, but are living a clandestine life for the time being.

  The impact on health is not the same for all of these situations. The living conditions (housing, work, etc.), in the country of origin before the migration as well as in the country of refuge, the eating habits, the culture, the religion and the traditions of the country of origin all play an important role. The mental and physical health can moreover be influenced by the traumatising or not traumatising context of the migration and the discrimination that certain groups of migrants are confronted with. Finally, other elements such as the knowledge of the language of the refuge country, the social aid by other members of the community etc. can also be important, e.g. with regard to the access to health care and the quality of the treatment.

  The mortality rates are the lowest for the Brussels population originated from a EU-27 member state: after standardisation for the age, premature deaths for this population group is almost only half as high than for the Brussels inhabitants of Belgian origin.

  The portion of people who say themselves that they are not in good health is much larger for the Brussels inhabitants with the Moroccan or Turkish nationality.

- Much illiteracy

  The teaching level is lower in Brussels than in the other regions.

- The socio-economic access to health care

[8] The Brussels-Capital Health and Social Observatory, *Gezondheidsindicatoren van het Brussels Gewest 2010, III. Determinanten van gezondheid*, Brussels 2010, p. 129-203.

The offer of health services in the Brussels Region is ample and diverse. So the geographical accessibility of the services is generally sufficient. However, an undeniable part of the Brussels population lives in precarious social conditions and the financial cost of the health care is a problem for many Brussels inhabitants. In 2004 17.5 pc of the families in Brussels say they had to postpone a health treatment for financial reasons (in comparison to 10.1 pc in the country as a whole). The major portion of low incomes that we find among this group can of course explain this high percentage, but even with equal incomes, the Brussels inhabitants more often postpone or abandon the request for care than the people living in the rest of the country. No doubt, other elements also play a role, e.g. the high housing cost the Brussels families have to bear.

3.2.2.2. Major contradictions

The Brussels-Capital Region is one of the regions in Europe that generate the most wealth. However, this wealth does not profit to all its inhabitants.

Brussels is a region of big contrasts: e.g. in terms of fiscal revenue, it contains the poorest municipalities of the country as well as communes where fiscal income is largely exceeding the national average.

We must however not lose sight of the contradictions between and within the different neighbourhoods (within the municipalities).

Moreover, the Brussels-Capital Region is, as mentioned above, a city region with sharp socio-economic contradictions. Because the Brussels population contains all social layers, from the poorest to the richest, the social inequalities in the field of health are very clear in the region. Differences exist for all the aspects of health: among others the portion of people that find they are in poor health, the prevalence of mental health problems, obesity and diabetes etc.

We quote just one example from the welfare barometer 2009.[9]

- In 2007 28 pc of all births in the Brussels Region took place in a household without any income from work and 17 pc among isolated mothers. These children run an increased risk of dying in the perinatal period or in the course of their first year: children that are born in a household without income from work are subject to twice as much risk of being stillborn or dying in the first month of their life than children in a household with 2 incomes.

[9] The Brussels-Capital Health and Social Observatory, *Welzijnsbarometer, Brussels armoederapport 2010*, Brussels 2010, (Welzijnsbarometer 2009, p. 60-62.)

3.2.3. The health policy[10]

Health administration split into three regions (Flanders, Wallonia and Brussels) and the three communities (Flemish, French and German speaking). Federal authority plays a key role in coordinating and financing the healthcare system through a national system of health insurance. Regions are responsible for hospital accreditation, home healthcare planning for elderly people and mental health. Communities are competent in the fields of prevention and health education.

In Brussels in particular, there are many levels of political and social structures. Indeed, here too the competencies are divided between the federal, regional and local levels.

Figure 5 shows the main administrative domains that are directly linked to the health domain (shaded in green). Indeed, health is more than just the offering of health services and prevention. It can e.g. not be separated from subjects like urbanisation, environment, social security, sports, employment etc. Indirectly, there are of course also synergies with security, culture, education, housing...

In figure 6 the reader finds a scheme with the 16 ministers who are competent for (part of) one of these domains. In the region, it is indeed not only the regional instances but, as we noted earlier, also the two communities (Flemish community and French Community) as well as the federal level that are involved. And each time, these ministers conceive their proper policy for their domain of competence, mostly in a separate policy declaration that is approved by the parliament.

Three additional institutions are of importance in the Brussels political landscape: the COCOF (Commission of the French-speaking Community), the VGC (Commission of the Flemish-speaking Community) and the COCOM (Common Community Commission). These institutions are in charge of the implementation on Brussels territory of the Communities' policies related to cultural, educational and person-related matters.

The Brussels Region also disposes of the Brussels-Capital Health and Social Observatory, which is the Research Centre for the Joint College services of the Brussels-Capital Joint Community Commission.

The municipalities watch over housing, security, etc. They also dispose of a *Centre public d'Action sociale* (CPAS – public centre for social action).

Since the devolution of public health policy to the communities in 1980, so-called Inter-ministerial Conferences have been regularly organized to facilitate cooperation between the federal Government and the communities. The Inter-ministerial Conferences for Health Policy are composed of the ministers responsible for health policy from the federal and regional governments. They have no binding decision-making power, but they are the forum for consultation between the governments, with respect for the autonomy of each of them. Within their framework, protocol agreements are made concerning the most divergent problems in the field of public health.

In the Brussels Region we, together with the stakeholders, notice a lack of formal and informal structures for concert. Synergy between policy domains is minimal or non-existing. At the federal level inter-ministerial committees are set up, but that is hardly ever or not at all done at the regional level. Exchanges mainly pass via informal channels and on the basis of personal contacts. One exception is the "Brussels Healthy City" project, that has the support of the 16 competent ministers. This project is due for evaluation in 2010.

[10] See also, among others, CORENS Dirk, *Health system review: Belgium, Health Systems in Transition,* 2007; 9(2): p. 1–172 - http://www.euro.who.int/__data/assets/pdf_file/0007/96442/E90059.pdf

	Agriculture	Aid to persons	Cemeteries and funerals	Communications	Development aid	Religion	Culture	Defence	Economy & commerce	Employment & work	Use of the languages	Energy	Education	Environment	Fiscal matters	Immigration	Justice	Nationality	Housing	Scientific research	International relations	Scientific research	Health	Safety	Social security	Sport	Tourism	Transport	Public works	Urbanism
Federal authority	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓			✓		
Region	✓		✓			✓			✓	✓		✓		✓	✓			✓	✓		✓	✓						✓	✓	✓
COCOM		✓																			✓	✓	✓							
French-speaking Community		✓					✓						✓								✓	✓	✓			✓				
COCOF		✓					✓						✓								✓	✓	✓			✓	✓			
Flemish-speaking Community		✓					✓						✓								✓	✓	✓			✓	✓			
VGC		✓					✓						✓										✓			✓				
Communes		✓	✓			✓	✓						✓	✓	✓			✓	✓					✓		✓			✓	✓

Figure 5: the competences of the different levels in the Brussels-Capital Region

Source: CRISP available on http://www.rbc.irisnet.be/crisp/fr/tableau.htm

The columns in green are areas that could be of interest in the framework of the healthy regions project.

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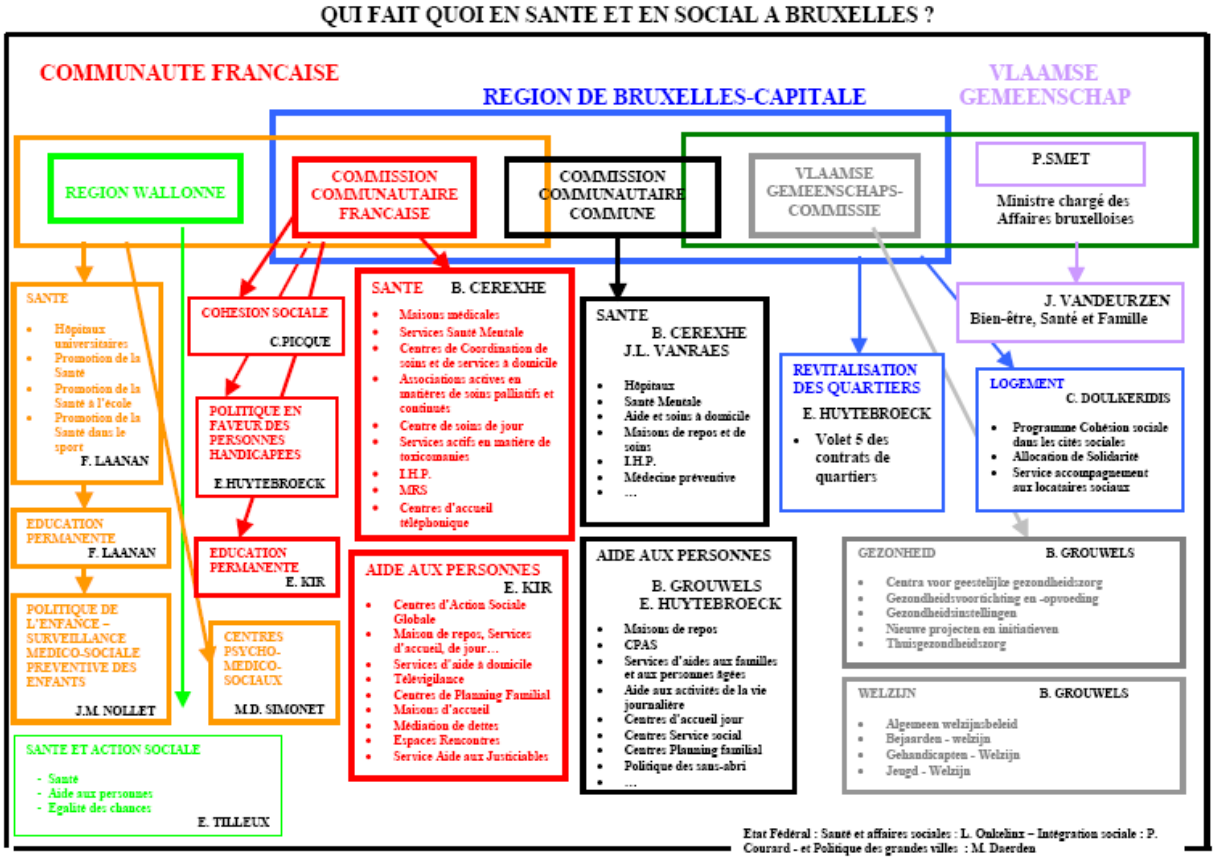

Figure 6: Competences of 16 ministers in the Brussels-Capital Region with regard to health.

Source: COCOF http://www.cocof.irisnet.be/site/common/filesmanager/sante/compet

4. Contacts with stakeholders

4.1. Interviews with stakeholders

The stakeholders who work in the health domain in Brussels are very diverse. Not only the working field is heterogeneous, but the policy is scattered over many echelons and policy domains as well. For this project we opted for the individual approach of a number of crucial actors from these various domains and discussed the Healthy Regions concept with each of them separately, what they expect of it and what opportunities/difficulties they foresee, what are the strong and weak points of a strategic approach in a health policy for the Brussels-Capital Region.

4.1.1. The community commissions

In order to make the exercise of community competences easier in Brussels, three community committees were created at the same time as regional institutions (1989).

- The French Community Commission (COCOF);
- The Flemish Community Commission (VGC);
- The Common Community Commission (COCOM).

Knowledge, education, public health and social security benefits are part of community competences.

We interviewed the French commission and discussed their strategies, concrete functioning and the synergy with the authorities, the regional and local actors. Together we made a swot analysis for the region and discussed the elements of the dialogue tool.

We did not have a direct interview with the members of the VGC, but we spoke with representatives of the LOGO (that falls under the VGC) together with the VIGeZ (see infra).

The French Community Commission - COCOF[11]

Generally, the French Community Commission has the jurisdiction over the French-speaking mono-community institutions of the Brussels region. By using regulations, it is qualified to act as an organizing power over cultural, education and personalisable matters.

Besides, the French Community Council can delegate jurisdiction. Thereby, since the 1st of January 1994, the French Community Commission has been able to legislate, through decrees, as regards to institutions coming under its Community, especially on health policy matters.

Health policy matters of the French Community Commission meet two objectives:

- A diversified and important healthcare offering;
- Improving healthcare services.

The health policy of the French Community Commission consists in accrediting and funding healthcare institutions, which provide uppermost extramural health care services. It is a first line ambulatory policy, which comes within the framework of a public health procedure proposing a territorial, global, multidisciplinary and integrated health approach.

The French Community Commission participates in the project "Health strategies for the Brussels-Capital Region" of the WHO (see below). The project is based on a cross-industry and transverse approach on health issues.

[11] www.cocof.irisnet.be

4.1.2. VIGeZ & LOGO Brussels

VIGeZ[12] is the Flemish expert centre for health promotion and sickness prevention. It provides strategies, advice, methodologies, and support for the implementation and training for health care workers and professionals. It is destined to workers in the field as well as policy-makers that deal with health promotion and prevention.

LOGO is short for Lokaal Gezondheidsoverleg (local concert about health).[13] It was created by the Flemish Community and is a network of organisations that commit themselves to jointly carrying out a programme. In the lap of the VGC (Flemish Community Commission)[14] there is one LOGO for Brussels: the Brussels Gezondheidsoverleg. In its policy the VGC states that it subscribes to the values proposed by the WHO for a sustainable development of health and life quality in cities. Health is not merely the absence of sickness, but a balance between physical and mental well-being that is influenced by leisure time, housing, mobility, environment… For that purpose cooperation with regional partners is sought.

Extra attention from the LOGO goes to target groups that are vulnerable and difficult to reach, such as underprivileged, elderly people that have grown lonely, foreigners etc. Metropolitan health problems like TB, aids and access to preventive health care, are also dealt with.

The VIGeZ as well as the LOGOs start from an inter-sectorial collaboration and opt for community projects where direct participation of the target groups comes first.

In district projects in underprivileged parts of town they see, apart from the improved health status, also potential social, economic and political advantages: reinforcement of competences of inhabitants and families (social benefit); an energetic and more productive society (economic profit); and effective pleading for less socio-economic health differences (political profit).

Next to prevention both organisms aim to provide structural work for a health policy in schools or at work, or for a health neighbourhood together with the local inhabitants. In the multilingual Brussels city the LOGO has contacts with the French-speaking community.

The LOGO was involved in a community project, called “Brabantwijk”, together with many other Brussels actors.

4.1.3. Brusselse Welzijns- en gezondheidsRaad (BWR)[15]

The Brusselse Welzijns- en gezondheidsRaad (BWR) gives concrete form to the Local Social Policy. They organise concert and cooperation between the Dutch-speaking and bilingual welfare offer in Brussels. The Flemish Community and the Flemish Community Commission subsidise several experiments with local social policy in Brussels (via the Stedenfonds among others).

The BWR is a link between the policy level and the organised citizens. In that way it does not have direct contact with the individual inhabitants of Brussels, but with organisations. It works from local zones within the municipalities.

Because of the specific characteristics of the Brussels metropolitan there is a strong emphasis on intercultural collaboration and the battle against the underprivileged status.

The BWR also participates in the project « Brussels health city ».

[12] http://www.vigez.be/

[13] http://www.vgc.be/Welzijn+en+Gezondheid/GezondeStad/Lokaal+gezondheidsoverleg/

[14] http://www.vgc.be

[15] http://www.bwr.be/

4.1.4. Municipalities: 3 out of 19 municipal board members (échevins)

All 19 municipalities of the Brussels-Capital Region were addressed via different channels. To begin with they received a letter with the request to complete the dialogue tool.

In spite of repeated telephone contacts and e-mails, only three municipalities returned a completed form: Uccle, Saint-Gilles and Ixedlles. The poor response is probably due to the fact that every municipality does not have a municipal board member that is explicitly competent for health matters.

In a second attempt the municipal board members were sent a new letter, this time with the request for a personal interview about their activities and the Healthy Regions concept.

Again only three échevins from as many municipalities responded positively: Uccle, Saint-Gilles and Forêt. All three are municipalities with major social inequalities within their community.

The municipalities organise multiple and very diverse activities, but the projects are strongly linked with the personal implication of the actors and with the political situation in the municipalities. It is also remarkable that a large number of initiatives in the social working field are sometimes poorly known and that there is little synergy with them. All three municipalities concentrate on the implementation of the prevention policy (vaccinations) of the public authorities. The functioning of the CPAS (public centres for social welfare) that are available in every municipality, in some cases also explicitly touches the health promotion domain.

Important tools in the municipal health policy are the health houses ("maisons médicales") where an multidisciplinary team of health workers handle the curative approach as well as the health prevention and promotion.

The dialogue with the regional initiatives – the Brussels-Capital Region's Observatory for Health and Welfare and/or the project Brussels healthy city – is not always in place.

4.1.5. Community structure - Samenlevingsopbouw[16]

"Samenlevingsopbouw Brussel" is active in the field of society building and financed by the Flemish Community (policy domain of Welfare, Public Health and Family). Within the system of multi-annual programmes and year plans the working in projects is put forward.

These projects are temporary and well-defined initiatives with the aim to come to a wider participation and integration of vulnerable groups in the social activities. In the multi-annual plan 2009-2015 – that is situated in the sphere of the battle against poverty and the development of the districts – there are three tracks: access to fundamental rights, the right to housing and the physical and social viability. Even though health is not explicitly named, the theme is in practice strongly entwined with these three tracks.

One of the local initiatives in the physical and social viability track is the project in the “Brabant” neighbourhood (2008-2015) (in English “The Brabant quarter moves”). The location is a district not far from the North train station, where there is a lot of noise, prostitution, problems with public cleanliness, with urinating in public... The project started with the set-up of a health snapshot (2008) and of a contact point for the reporting of noise problems... The inhabitants are permanently and directly involved in the project and walks of inhabitants and politicians were organised as well as conferences with inhabitants. This resulted in charters about e.g. mobility, public cleanliness. This project is a model approach that consists of the cooperation between all the involved parties of policy-makers, policy executors, NGOs in the civil society as well as the local inhabitants themselves. A systematic evaluation of the project is made.

[16] http://www.samenlevingsopbouwbrussel.be

4.1.6. Intercultural mediation - Foyer[17]

Foyer is a non-profit organisation situated in Molenbeek, but active in all 19 municipalities. It is active on the municipal, regional and international levels, focusing on the global integration problems of ethnic minorities.

Foyer organises actions to improve the integration of children and youngsters (e.g. activities with children and youngsters, with many accomplishments in art, theatre and sports; and activities preparing underprivileged youngsters for the labour market); initiatives that lead towards a better emancipation (e.g. activities for the emancipation of women of all population groups and ages; district activities for men and fathers) - key-activities here are dealing with intercultural and multilingual education, and strengthening the language awareness; initiatives to improve the civic spirit (e.g. activities related to mediation and prevention in health care and social services; housing projects, protection of the rights of individuals, refugees, undocumented persons, travellers, gypsies; receiving newcomers, etc.).

The Foyer has three organisational poles: schooling, work and health. The health cell aims to handle curative as well as preventive matters. For the inter-cultural mediation it works together with all the other institutions when asked.

Newt to the target groups there is also the creation of language groups that deal with a theme on their own initiative, in order to obtain a better access to health care.

4.2. Project Brussels healthy city

In 2002, the Brussels-Capital Region obtained the label « Health city » by the WHO. The project startup (in December 2001) and its real implementation at the regional (in June 2003) and international levels (in January 2006) permit to present tendencies concerning subjective health in elaborating life politics in town. The usefulness of a permanent reinforcement of the active participation of the inhabitants within operations and local partners was proved. Brussels health city acts as an experiment laboratory in terms of quality of life in urban areas.

The non-profit association was chaperoned by the 16 competent ministers and the entire working field is directly involved in the activities of the technical committee.

In 2003 and 2006, the association issued two appeals for making a project on local development whose subjects were public space and mobility. Eight projects conceived by groups of inhabitants were selected in Forest, Ganshoren, Jette, Laeken, Molenbeek and Schaerbeek. The selected projects include issues from the management and occupation of space to multimodality in town, including creating an educational garden, developing municipal swimming-pools, revitalizing a district, etc.

« Health strategies for the Brussels-Capital Region » aim to work towards decompartmentalising health giving priority to a transverse approach, where economic, town planning, environmental and social factors are determining in the state of “well-being” or “subjective health” of the citizen. A non-profit organization also consists in bringing together a variety of institutional, political, academic, social actors and citizens around common projects. Two main objectives are promoting citizen mobilisation for a better quality of life in districts and reinforcing the own possibilities (empowerment).

In a scheme presentation, "governance" is based on 3 elements: partnership - vertical (responsibilities on EU, national, regional, municipality and local level) as well as horizontal (tuning of competences on the same administrative level); transversal - a

[17] http://www.foyer.be

coordinating approach of different issues taking into account the interactions between them; and the active participation of the stakeholders, in particular the local inhabitants.

The methodology rests on 3 axes: to draw up a diagnosis of the health situation, with the participation of the inhabitants and/or users of the districts; the development of local projects related to the health determinants in a broad sense (environment, physical, mental and social health); and the introduction of exchanges of practices between operators and inhabitants.

It does not only start from strong links between health and the quality of the environment (political, economic, housing, transport...) and life (life styles...), but also from a bottom-up approach, based on local projects developed by the inhabitants: visits of the neighbourhood, panel discussions, exchanges with local actors and politicians and plans for action with the local operators.

The association also makes recommendations to decision-makers on a higher level (e.g. RDP). Since 2002 the Brussels region disposes of a Brussels Regional Development Plan. It will be revised in 2011. Priority 7 (out of 12) covers "social action: education, public services, health". It is up to the Brussels healthy city association to collect the recommendations about health for Brussels, to discuss them with all concerned parties and to get them generally accepted in order to have them integrated in the new regional plan.

4.3. Need for synergy and dialogue

This limited selection and the previous description of the health domain in the Brussels-Capital Region clearly show the multitude and diversity of the actors, the approaches, the working methods and the concrete projects. This is even more underlined in the two basic documents about the competences on the one hand and the concrete initiatives on the other hand, that are set up for the stakeholders and referred to on the Healthy Regions website.

The distance between the working field and the policy-makers – on so many different echelons – is also very variable. Too often we see that the flow is not optimal and a plea is made for a larger exchange which would allow a better mix of bottom-up and top-down approach.

Some crucial actors have a great interest for potential levers that are required to put health matters on the political agenda.

There is a strong sense of need for more synergy and mainly more exchange and concert at the policy-making level.

An important factor is the knowledge about the health condition that is collected by the Brussels-Capital Health and Social Observatory in her reports. This is a minimal requirement for a more evidence-based policy. In the real actions the actors prove to very diversely use or not use this knowledge. Multiple initiatives of the civil society moreover start from a bottom-up approach in which the diagnosis is made in cooperation with the inhabitants/participants.

All these contacts moreover show that there is a gap in the knowledge and/or familiarity with other health initiatives. A better exchange of information about all that is going on in the health domain in the Brussels landscape is without any doubt a must to be able to come to a regional strategic approach.

The demand for more networking is loud, even more so because a frequent remark is a criticism on the shortage of (financial) means. The particular Brussels situation, where a large variety of policy-makers exercise their influence and many competency domains are involved, also makes a patchwork of the financing measures. This implicates that e.g. a lot of means of the working field go to the search for funds. But on the other hand the political influence also weighs relatively heavy on the policy execution that can be governed by very temporary priorities.

It is remarkable that some of the concrete initiatives – particularly on the municipal level – still are a one-man shot, corresponding with the personal engagement of the involved persons. It is also at that level that the networking with other actors is sometimes minimal.

In the working field the ideas of community projects and direct participation of the civil society are firmly imbedded. There is also a demand for more dialogue between all the stakeholders. The demand for a 'health in all policies' or an 'inter-sectorial' approach is consequently big at this level.

It is evident that the tackling of the inequalities in health matters must be given extra attention, but the strive for more sustainable development is also a central theme.

The project "Brussels-Capital Health" could be an important step toward a possible common regional policy. In spite of all the good-will and due to the (lack of) available means, the initiative does not go much further than the support of concrete actions, leaving the discussions about the theoretical framework unattended too much. The role that was given to the project to make way for the maximal integration of the health recommendations in the Regional Development Plan, can be a start.

Let us not forget however that we operate in a typical Brussels context, with two official language communities and even more political decision-making levels, which does not the streamlining any easier. Fortunately, the actual projects on the field are not that severely marked by this situation.

5. Results of the project working programme

5.1. Working with the project partners

Partner meetings

We attended the six project meetings (two each project year) and the final conference with one or two project partners, namely from CRIOC and ULB. Each time we presented the regional progress from the Brussels-Capital region next to our participation in the discussions.

The representative of the ULB was member of the steering committee and also attended these meetings.

Moreover, she worked actively on the Healthy Regions concept and led the discussion on that subject.

On a European level, the exchange with the EU project partners was concentrated on the six project meetings, in particular because of the different situations and the divergent ways of functioning in the different regions.

It was a stimulating experience to work with so many partners from other countries. Most of the direct collaboration also originated from and came into being during these partner meetings that were not only efficient and stimulating but pleasant as well. We experienced debate and disagreement, but still always managed to come to functional compromises. One of the positive elements in the project was that finally the compromises were to be realized within the region in accordance with the local situation. During the partner meetings we also learned a lot from the work methods of the hosting partner and about some initiatives of the specific regions we visited.

Website and Forum

From the beginning the forum was open but because of the concentration on the local activities this has not been used as effectively as it could have been. Maybe it would have been more functional if it had been directly linked to the Healthy Regions website. Even though it would have been very difficult to elaborate the concept of this website from the very beginning and the forum would have been more practically focused on the project work packages and internal exchange, it would have allowed for the website to grow more naturally and for the tools to be more interactive between the project partners.

5.2. Working with the actors in the Brussels-Capital region

We started the project by listing the actors of the public health sector in the general framework (prevention workers, authorities, the academic world (universities)).

This desk research consisted of:

- Identifying and collecting all information on the policies and structures linked to health as well as specialised organisms in the region and their functioning;
- Identifying and collecting all information on the concrete activities (projects, trainings, education, publications…) of stakeholders.

We originally planned one stakeholder meeting after having carried out this desk research. As we did not receive a warm welcome from the principal actors of the Region for various reasons (they were already implicated in European projects that give them very little return on investment, they were not convinced by the format of the dialogue tool and the traffic light matrix, they missed the synergies of the political level more…), we not only decided to work at the level of the municipalities like in Denmark (which means on the level of the 19 districts of the Region of Brussels), but we also intended to set up a stakeholder meeting to bring together the different stakeholders.

The resistance of the same principal actors limited the challenge of that meeting so that we changed our strategy and went to visit the stakeholders individually. At these occasions we could not only present the project – using among other things the EU project brochure and the own presentation documents in French and/or Dutch) – but could at the same time explain the project tools and discuss the strategies and activities of these actors in depth.

Most of the actors develop very diverse initiatives. The municipal board members ("échevins") work at a purely municipal level and any exchange between municipalities is non-existing. However, in function of the municipality, there is collaboration with federal, regional and/or local actors. These collaborations are nevertheless insufficiently known. Even though the other actors know each other, cooperation are most often occasional and informal there as well. Especially on the Dutch-speaking side, the exchanges are more frequent. The Dutch-speaking part of the region has the same diversity of policy domains, but is more restraint in size of the target group since the number of Dutch-speaking inhabitants of Brussels is smaller and the strategic aims from the Flemish Community reach further. On the side of the French-speaking Community, the activities are just as diverse, but handled in a mainly dissipated battle array.

The need for networking is lively felt, but exchanges are rare and joint collaborations even rarer. Only in the framework of the project Brussels Healthy City do we see meetings of vary different actors. As mentioned earlier in the conclusions of our individual interviews with a number of stakeholders, the role attributed to this project to make the health recommendations find their way to a maximal integration in the Regional Development Plan, can become a start for a more regional strategic approach.

5.3. Conceptual paper & Mapping template

This part is adapted from the Healthy Regions website – http://www.healthyregions.eu/process.html and inspired by the final project reporting of the region Östergötland-Örebro in Sweden.

5.3.1. The Framework Paper

For a period of 3 years, the 6 European regions worked together to create a new concept for the creation of Healthy Regions that shows how a proactive, preventive, holistic, democratic and mainstreamed focus on health and well-being at a regional level can be an economic and social growth factor. The underlying principles for the development of the Healthy Regions concept were drawn up in the Framework Paper, which was produced in the very beginning of the project, in order to ensure that the concept builds on relevant European strategies and priorities together with accepted definitions and concept.

Through an active application of the Healthy Regions Concept, health and health promotion can be made a political prestige area, and a region can be able to promote health alongside with their social, political and economic agendas. The aim of introducing the concept is to raise the profile of health across policy areas and to demonstrate how regions can contribute to socially and economically sustainable growth through a focus on health and well-being.

In Brussels some stakeholders underlined that this concept of growth should be largely understood as sustainable development.

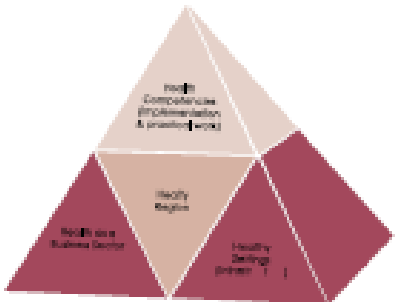

Figure 7: The healthy regions concept

The Healthy regions concept shows how a region can work in a holistic way to be considered a "Healthy Region" within the following areas:

- Health as a business sector

This area focuses on the regional development potential within the health sector, i.e. whether the region has a strategic view of the regional key competencies within health, development potentials and possible areas within the health sector with growth potential in terms of the creation of new employment, understood broadly as e.g. hospitals, medico, e-health, "Healthy Tourism" etc.

- Health Competencies

This area focuses on institutional health competences, i.e. how the region cooperates with local communities, how the region and local communities work strategically with health promotion, and how they plan, execute and evaluate health promotion activities.

- Healthy Settings

This area focuses on the activities close to the citizens and the infrastructures that are used to implement concrete health promotion activities. Is there a close link between the regional health strategy and the concrete health promotion and disease prevention activities implemented in settings close to the citizens?

The Healthy Regions project produced tools to support all 4 parts of the triangle.

The International Congress on the local and regional health programs (April 2008, Mons, Belgium) gave us the opportunity to exchange views with the participants about the project.

5.3.2. The dialogue tool

The dialogue tool is meant to start the process of focusing on how a region can become a "Healthy Region" and on the broad understanding of competencies. Other available tools like the Verona Benchmark, Partnership tool etc. could be used as a supplement to this tool, for instance to go deeper into an analysis of the overall strategic health situation in the region. http://www.healthyregions.eu/healthyRegion/regions.html

As the official languages in Brussels are Dutch and French, we translated it – as we did for all information – in both languages. When we decided to work on a municipality level, as did the Danish project partner, we sent the dialogue tool to all 19 municipal board members ("echevins") for reaction. We had indeed with them already contacts before within the framework of other projects. However, the response this time was very low, even after having contacted them all again in person.

Therefore we used the tool that the German partner had simplified into a spider web. See the French version in figure 8. We sent it to a list of almost 50 actors but again we did not receive many answers. That is why we changed our originally planned approach and went to speak with a number of individual stakeholders in person.

Moreover, we went to look the health policy in another Belgian region and discussed the dialogue tool with the Health Observatory of the Hainaut province (HOH, see infra).

5.3.3. The mapping tool

The mapping tool provides an overview of specific institutional health competencies on a local level. We used it for ourselves to realise the overview on the competencies and structures in the Brussels region.

5.3.4. The traffic light matrix

The use of the Traffic Light Matrix could provide a strategic and focused view on health as a business sector, and can help to remain the innovative aspect of the project, namely to combine health with regional development. http://www.healthyregions.eu/businessSector/business.html

In the Brussels-Capital region we didn't use this tool.

Health web in your living environment: your region, your municipality…

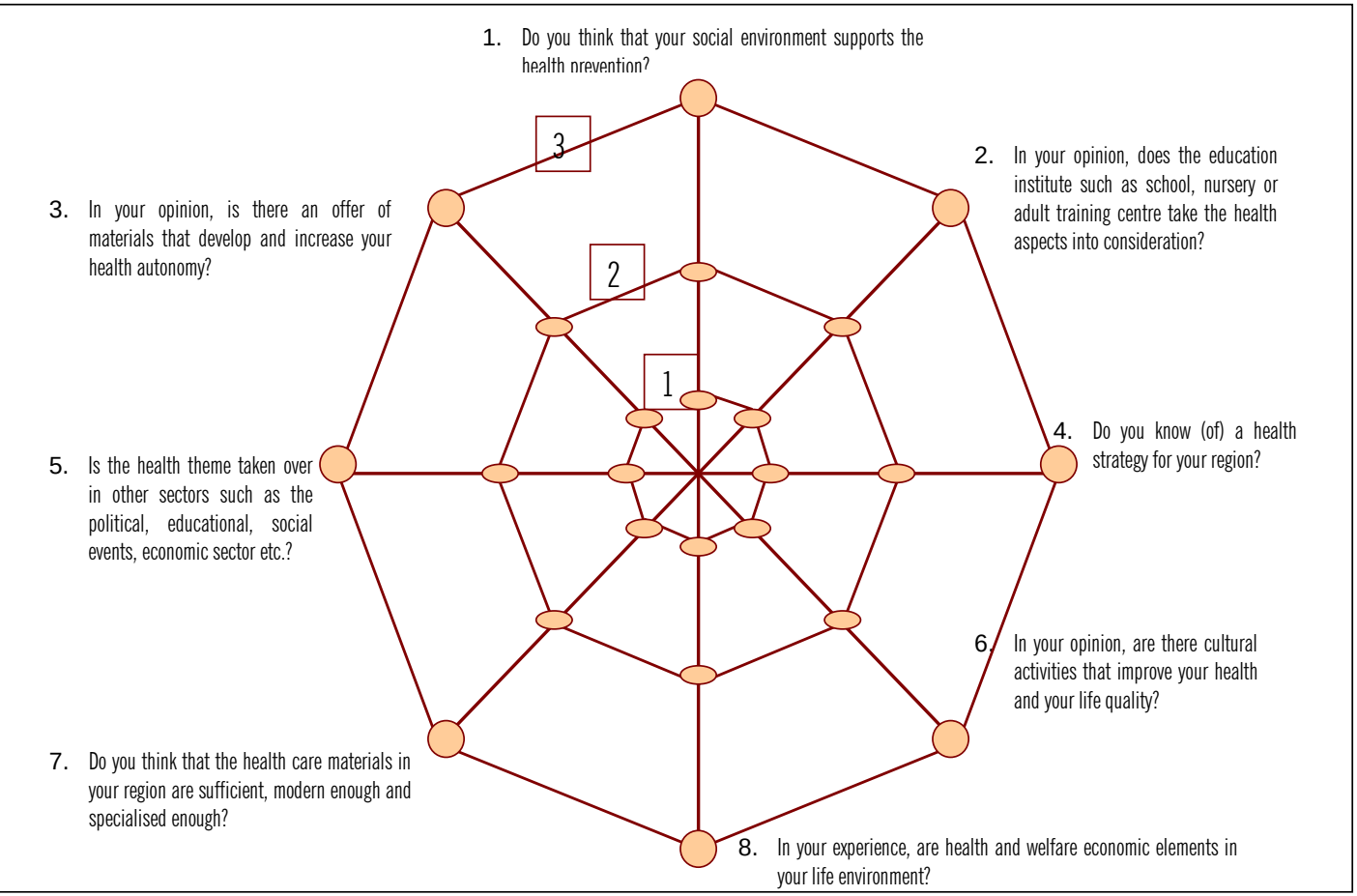

Figure 8: Dialogue tool: a spider web

Please respond to the 8 questions following your personal opinion and using a scale of 1 to 3 (1,25; 1,5; 1,75...):

- Level 1 = hardly
- Level 2 = partly
- Level 3 = largely

Indicate your opinion on the 8 axes of the web. Afterwards these points will be linked, giving us a new web.

Please also indicate what municipality or community you come from:

☐ one of the municipalities of Brussels-Capital

Which one?

.....

.....

☐ The French Community

☐ The Flemish Community

In what field and/or on what subjects do you work?

.....

.....

5.4. BEST PRACTICES PROJECTS CATALOGUE

5.4.1. Projects catalogue

The projects catalogue gathers examples of public health pilot projects from the six participating regions that have been implemented and, in some situations, also evaluated.

E.g. for Brussels, a Nutritional Education Programme was included to discover the various food categories with the children of the schools of a Municipality of the Brussels-Capital Region.

However, for this catalogue we did not limit ourselves to the Brussels territory but selected projects from all over the country for Belgium.

Another project dating 2007 called 'Commune en forme' (in English "To be a fit municipality") included a contest organised on the initiative of the federal minister of Public Health and coordinated by the *Centre de Recherche et d'Information des Organisations de Consommateurs* (CRIOC). The geographical coverage was national: the three regions, i.e. Flanders, Wallonia and Brussels, were involved. This contest was placed in the framework of a promotion action for the National Nutrition and Health Plan for Belgium (PNNS-B), which aims to define a coherent nutritional policy.

"Je cours pour ma forme (JCPMF)[18] (in English "I run for my Form ") is a physical condition programme based on running and organised by the *ASBL Sport et Santé,* in cooperation with the magazine "Running et Santé" (Zatopek).

Safety gymnastics and manual handling of loads in educational environment aims to promote health in a secondary school in Tubize. The school developed a project of ergonomic class to cure the observation of the bad sitting position and a course of "safety gymnastics" thus found all its meaning to prevent the risks of accidents at work and musculo-skeletal disorders.

Community "Health Workshop" (Atelier communautaire) Forêt-Quartiers-Santé (FQS – Forêt/Vorst health district) counts almost 2200 meetings a year with residents of the municipality: a topic is presented by an external "expert" followed by a discussion of the subject among the participants. The municipality tries to approach the problem of the "inequalities in health".

5.4.2. Other projects

The Belgian project partners also looked at other initiatives from the Healthy Regions concept point of view. The results of these analyses were presented to the other project partners in a project meeting.

Because so many local activities are already going on, we studied two existing projects stakeholders were working on instead of developing new pilot projects. So we looked at the Federal Nutrition and Health Plan (in which all regions are involved)[19], at the Federal Plan for Sustainable Development[20] and at the (Brussels) Regional Development Plan[21]. The results of this analysis were presented to the project partner at one of the project meetings.

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[18] http://www.jecourspourmaforme.be/FR/

[19] https://portal.health.fgov.be/portal/page?_pageid=56,7422388&_dad=portal&_schema=PORTAL

[20] http://www.fedweb.belgium.be/nl/publicaties/poddo_duurzame_ontwikkeling_plan_2009_20012.jsp
http://www.fedweb.belgium.be/fr/publications/sppdd_plan_developpement_durable_2009_20012.jsp

[21] http://www.prd.irisnet.be/
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http://www.bruxelles.irisnet.be/fr/entreprises/maison/batiments_terrains_urbanisme/plan_regional_de_developpement_prd_.shtml

5.4.3. The Health Observatory of the Hainaut province (HOH)

In the province of Hainaut, the Health Observatory of Hainaut (HOH) is active. The local dynamics with regard to health promotion are in fact rather poor in the French Community in general. Even though structures such as the CPLS and associations do exist, the means that are made available are poor and there are few actors who relay the needs of the population to the political level. In that sense, the HOH is Hainaut is an exception.

The Province of Hainaut puts epidemiological data, a methodological support and intervention and communication tools at their disposal through the Health Observatory of Hainaut. It also offers trainings and the access to a documentation centre.

The HOH carries out actions to improve the health of the inhabitants of the province. The health promotion contributes to giving the population groups the means to assure a better control over their health status and to even improve it.

At the municipal level, the HOH organises a multi-sectorial "week of the well-being" in two 2 municipalities each year, integrating cultural, health promotion, nature and physical activities, as well as sustainable development.

The Observatory of Hainaut developed a Tri-annual plan 2010 -2012. The principles of the plan are multiple: start from the needs of the population; tackle the inequalities in health care; develop local actions close to the inhabitants; work together with other initiatives on a federal and regional level; and apply an inter-sectorial approach in a context of regional development.

We had a discussion with the Observatory for health of the Hainaut province and asked them about their health programme and their opinion on the dialogue tool.

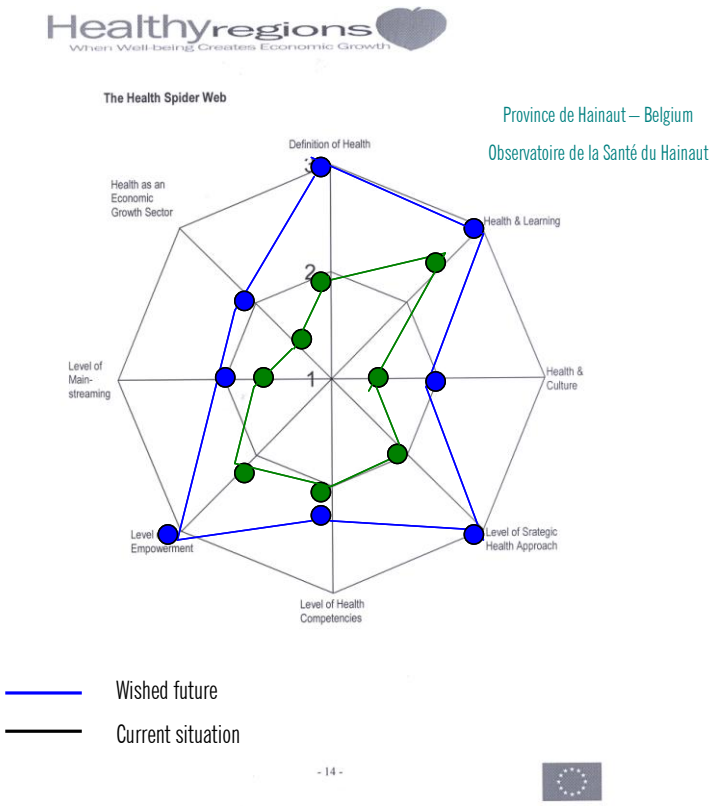

Figure 9: Web from the Hainaut region

The discussion on the dialogue tool led to the conclusion that it could be useful in two situations:

- To adopt a detached attitude in an organisation like HOH or to complete the operational evaluation of an organisation; and
- As great stirring or brainstorming tool, but then the tool must be used, in this given case, in a meeting with an animator who explains each of the concepts.

To do a strategic run-down in an organisation can be interesting, for instance by giving practical examples for each theme. "Are we on the right track or not? Shouldn't we redirect our action on that point?"

The implicated persons must however know in advance what the concepts are that we refer to: health and learning, health and mainstreaming, health and economic growth, etc. One important dimension is missing: i.e. the dimension of "health inequalities", so the dialogue tool should be completed with the "Equitylens" tool from New Zealand[22]. In that case, it should cover all the sub-

[22] http://www.moh.govt.nz/moh.nsf/pagesmh/3968

dimensions of the health inequalities (housing, services at the disposal of the citizens, etc.). In the French-speaking part of Belgium this would mean the HOH and the CPLS, organisations that are involved in the practice of the health promotion.

In order to have a pretty complete tool, we must insist on the fact of referring to concrete examples that have been realised, for there is also the difference between the idea that one has of a matter and the reality of taking this matter into consideration.

The tool can also be used as brainstorming tool in other cases, like the municipalities. But in that case, the tool must be used in a meeting with an animator who explains each of the concepts. Then it would rather become an animation tool. That might function in the municipalities where there is already a local interest for the health promotion. This animation could then have an alarm function at a more strategic level and could further serve as a political relay device.

So the dialogue tool is a tool that the organisations, the politics must adapt to their proper needs.

Moreover, the three levels are not refined enough, particularly for the "health and economic growth" aspect: small things there can be realised, but it could be difficult to score them with 3 levels.

5.5. Project evaluation

We were actively involved in the evaluation process set up by the external expert in project evaluation.

The participating regions of the Healthy Regions project were very diverse. This was quite a stimulating challenge. But it also made a particular situation of the Brussels Region inside the partnership. Because the policy context on a regional level was so complex, we chose for instance to work on a municipality level. However, while the competences of the municipalities are limited and the other political and social levels are so important in the regional health policy, we based ourselves on the overall regional level for our policy overview.

Even more, because of the particular situation in Brussels, as we explained before, we had to adapt the Healthy Regions methods and tools to the local situation.

The project ended on 24 October 2010.

6. Interim Financial Report

See separate document.

7. Project team

METICES-TEF, ULB

Mrs DE TROYER Marianne

Mr. LEBEER Guy

OIVO

Mrs. VANHAEVRE Ingrid

Project Coordinator CRIOC

Mrs. TAUPINART Elizabeth

Left CRIOC in May 2008

Mrs. DEWULF Virginie

Left CRIOC in July 2009

Mrs. RECHT Pascale

Left CRIOC in January 2010

Mrs. BONIVER Delphine

Left CRIOC in May 2010

Junior Researchers

Mrs. RENARD Carine

Head of Research unit

Left CRIOC in November 2009

Mrs. DEVILLE Anaïs

Legal adviser

Mr. BOIKETE Christian

Head of Unit Public Relations

Responsible editor: Marc Vandercammen
CRIOC
Foundation of Public Interest
Boulevard Paepsem 20, B-1070 Brussels
Tel. +32 / 2 / 547 06 11 – Fax +32 / 2 / 547 06 01
www.crioc.be
NE 417541646

Edition 2010