Prevention and Health Promotion Plan in Wallonia

Part 1: Definition of health priorities

Horizon 2030
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A. Introduction

Lifestyles have changed considerably over the past 50 years and there have been spectacular advances in medicine. These two factors have produced a major transformation in our population’s state of health, with largely positive consequences, such as a significant increase in life expectancy, and more
adverse consequences, such as the exponential growth of chronic illnesses which are a considerable burden on both quality of life and the healthcare budget. Added to this are other health issues, which are very present in our society, such as mental health problems. And there are yet more that are still very relevant today, even though science is continuing to progress in the fight against infectious diseases.

All these wide-ranging health problems have one point in common: they are avoidable, or at least most of them are!

A set of prevention measures, uniting different strategies and actions relating to both individual people, and groups and society, will help to combat the risk factors identified as being responsible for the appearance of certain diseases. For instance, according to the World Health Organization (WHO), 75% of chronic diseases could be avoided by encouraging healthier lifestyles!

So prevention is clearly a major issue! Who doesn't want to grow old in good health and make the most of the years given to us.

Moreover, a society composed of individuals in good health, whatever their socioeconomic level, is clearly a balanced and more productive society, and an indisputable element of sustainable development.

Since the intra-Francophone agreements, Wallonia has become competent in the field of health prevention and promotion. This is a great opportunity to redefine the landscape in this field and to develop a new framework that is in perfect harmony with the needs of the population.

This Prevention and Health Promotion Plan aims to help improve the state of health of all Walloons thanks to a solid and sustainable system.

Our health system has been the subject of various reforms resulting in a division of competences, which needs to be analysed in advance of the proposed strategies.

First of all, it was essential to make an analysis of the epidemiological data of the health indicators and of the major health determinants to obtain a good overview of the situation in Wallonia. This analysis was performed in order to prioritise the health problems and determine the strategies to deal with them.

Hence, to ensure the plan's objectives are part of a coherent approach, the health guidelines and priorities defined at an international and national level have to be taken into account. Wallonia would like its prevention and promotion plan to be part of a common framework while focusing on regional
and even local Walloon particularities. Within this context, this plan was presented to the prevention experts at the WHO European centre in Copenhagen in November 2016, in order to benefit from their advice and the validation of the chosen methodology; they acknowledged the work that had been done and suggested the next stages for the second phase of the plan.

During the first part of the plan, the general objectives pursued regarding the priority health themes will be defined, as well as the transversal strategic objectives applicable to all these themes, which are based on international recommendations that have been proven efficient.

In the second part of this plan, the strategic goals will be broken down into operational, observable and measurable objectives.

This plan will be deployed in the long term, by 2030.
B. Contexts

The identification of the division of competences in terms of health is essential insofar as this allows the identification of the levers for which Wallonia is the decision-maker.

I. Political and institutional context

1. The French-speaking institutional landscape in terms of health

Following the Sixth State Reform, many of the health-related competences were transferred from federal level to the regions and the communities. As a result of this reform, the competences have shifted towards the federated entities, which have acquired greater autonomy. Nevertheless, the Federal Government continues to exercise certain competences in terms of healthcare and prevention within the framework of the sickness and invalidity insurance scheme. Hence, in addition to the reimbursement of medication and healthcare, the Federal Government intervenes, among other things, in the cost of preventive medicine health services, national prophylactic measures, the organic legislation of certain healthcare institutions, their operating costs and the conclusion of agreements with the communities with a view to shouldering part of the cost for services provided within the framework of screening programmes.

Parallel to this state reform, agreements between the French-speaking federated entities also transferred certain health competences from the French Community to the Walloon Region and the federated entities of Brussels.

To better integrate these new competences, a new public interest organisation was set up in Wallonia in 2016: the Agence wallonne de la Santé, de la Protection sociale, du Handicap et des Familles (Walloon Agency for Health, Welfare, Disability and Families), as it is officially known, or to give it its more commonly used name, the Agence pour une Vie de Qualité (AViQ) (Quality of Life Agency). AViQ is based on three branches: the Well-being and Health branch, the Disability branch and the Families branch.

More specifically in terms of health, AViQ manages many areas that were formerly federal, regional or community based, including health prevention and promotion, the organisation of frontline care, the policy relating to mental health and elderly persons (including nursing homes), or providing care inside

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1 Special Act of 8/08/1980 on institutional reforms, amended by the Special Act of 6/01/2014
2 Article 34 of the Law on compulsory healthcare insurance and benefits, coordinated on 14 July 1994
3 Decree of 3 December 2015 relating to the Agence wallonne de la santé, de la protection sociale, du handicap et des familles.
and outside care centres. A transitional period, ending 31/12/2018, is however provided for to gradually integrate some of these areas.

The French Community has retained part of its health competences and in particular manages *Promotion de la Santé à l’école* (Promoting Health in schools), the *Office de la Naissance et de l’Enfance* (ONE) (Birth and Early Childhood Agency) and *Contrôle médico-sportif* (Sports Medical Screening).

Consequently, as regards health prevention and promotion, the French-speaking institutional landscape includes the competences that have remained within the French Community aimed at a specific audience on the one hand, and on the other hand, the competences that have been transferred to the Walloon Region and the Communal and French Community Commissions for the Brussels-Capital Region, aimed at the entire population.

In short, the Walloon Region is competent to organise all health promotion and education activities except elements specifically reserved for the French Community. In practice, there are overlapping areas, between the approaches aimed at a particular audience or programme, where it is necessary to create advantages to optimise the effectiveness of the actions.

Besides the health policy, synergies must be created by associating other ministers whose competences can have an impact on health, especially the minister for sport, the minister of the environment, the minister for education, etc.

Indeed, the desire is to push forward the implementation of health in all policies and approaches, since health is largely influenced by social, economic, cultural and environmental factors, etc., which all act as health determinants.

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4 Special Decree of 3 April 2014 relating to the competences of the French Community which have been transferred to the Walloon Region and the French Community Commission.
5 In particular, preventive medicine activities regarding babies, children, students and pregnant women (preventive consultations from 0 to 6 years, pregnancy monitoring, preconception period), health promotion in schools (including the promotion of dental hygiene in schools), vaccinations, newborn hearing screening and metabolic diseases.
   - Mainly health promotion, cancer screening, reporting communicable diseases, birth and death certificates, the fight against addictions, exposure to cigarette smoke, and nutrition.
6 Mainly health promotion, cancer screening, reporting communicable diseases, birth and death certificates, the fight against addictions, exposure to cigarette smoke, and nutrition.
2. Reference founding texts regarding health promotion

This plan is part of an international context that is rich in terms of defining health promotion strategies. More specifically, Belgium has committed to applying a series of World Health Organization resolutions, not all of which have yet been transposed into Belgian law. Hence, in order to determine coherent objectives for the plan, the health guidelines and priorities defined at international, national and Walloon level must be taken into account. Wallonia endorses the need to be part of a common framework while taking into account its regional and even local particularities.

a) At international level

As regards the WHO, the authority on international health, an abundance of specific texts, some of which have become part of public international law, act as a reference especially in the areas of health promotion and prevention.

They reflect the following concept: "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". (WHO, 1948)

These texts also assert that health is a human right that must be exercised on equal terms by everyone, without discrimination.

Among the most noteworthy texts are:

- The Constitution of the World Health Organization (WHO). It was adopted immediately after the Second World War by the International Health Conference in 1946 and came into force in 1948 during the first World Health Assembly. The constitution of the WHO states that: "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

  The WHO’s definition of health (1946) is in fact still the reference for member countries when defining their health policies.

- The Alma-Ata Declaration of 12 September 1978 on primary healthcare. This declaration strongly reaffirms that "health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and
that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social economic sectors in addition to the health sector”.

- The Ottawa Charter. The charter was recognised, in 1986, as the founding text for health promotion with the goal of promoting health for everyone, especially by "enabling people to increase control over and improve their health". To reach a state of complete physical, mental and social well-being, the individual - or group - must be able to identify and realise aspirations, satisfy needs, and to change or cope with the environment. Health promotion also includes health determinants and the importance of environments favourable to health as an essential component.

The Ottawa Charter incorporates five key action areas that have been integrated into the present paper:

- build healthy public policy;
- create supportive environments for health;
- strengthen community action for health;
- develop personal skills;
- re-orient health services.

The charter rightly identifies the prerequisites essential to health: individuals must have access to shelter, education, adequate food, a certain income, a stable ecosystem, sustainable resources, the right to social justice and equity. It is essential to keep these prerequisites in mind.

Since 1986, a series of eight world conferences on health promotion have contributed to the transformation of public health. The theme of the Ninth Global Conference (Shanghai 2016) was 'Health Promotion in the Sustainable Development Goals'. One ambition of the Shanghai conference is to improve the population’s ‘Health literacy’. This is defined by the WHO as the "cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health". Indeed, by enabling people to have greater control over their health and its determinants, we are contributing to a more prosperous, fairer and more sustainable future⁷.

⁷ http://www.who.int/healthpromotion/conferences/9gchp/shanghai-declaration-zero-draft-fr.pdf?ua=1&ua=1
These objectives echo those of The 2030 Agenda for Sustainable Development, adopted by the United Nations in 2015. The WHO is committed to favouring health for all based on the inextricable link between the health of the next generation and global health. This agenda has an unprecedented reach and importance: its goals encompass the economic, environmental and social pillars of sustainable development and place strong emphasis on equity, frequently expressed in the rhetoric of 'leaving no-one behind'. The third goal is entitled: 'Ensure healthy lives and promote well-being for all at all ages'. The agenda considers health as a goal in itself, but also health and its determinants as a determinant of sustainable development and vice versa.  

The WHO’s only two specific instruments with binding value, which nevertheless have no specific jurisdictional mechanism, are:

- The WHO’s Framework Convention on Tobacco Control (2003), considered to be a response to a global threat;
- The revised version of the International Health Regulations which came into force in 2005, a binding international legal instrument adopted by the WHO.

It is also important to underline the ‘WHO global disability action plan 2014-2021: better health for persons with disabilities’ and its three goals:

- to remove barriers and improve access to health services and programmes;
- to strengthen and extend rehabilitation, habilitation, assistive technology and support services, and community-based rehabilitation;
- to enhance the collection of relevant and internationally comparable data on disability, and research on disability and related services.

Indeed, persons with disabilities just like any other persons in a vulnerable situation require special attention in terms of health prevention and promotion.

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8 WHO, A69/15
9 Internal AViQ Ri file: Cadre juridique et politique international et européen du plan wallon prévention et promotion de la santé
10 http://apps.who.int/iris/bitstream/10665/42812/1/9242591017.pdf. The convention was signed by Belgium on 22/01/2004, ratified on 1/1/2005 and it came into force in Belgium on 30/01/2006 (http://www.who.int/fctc/signatories_parties/fr/).
As regards the OECD\textsuperscript{13}, the Walloon Region is participating in and following the work of the Health Committee, which provides assistance on different themes such as mental health, antimicrobial resistance, the quality of healthcare, and issues associated with inequalities in terms of health or health professions. One of the OECD's recommendations aims to improve the collection of indicators concerning patient needs in order to make an assessment of the quality of health services in every country.

\textit{b) At European level}

As regards the Council of Europe, the European Social Charter (ratified 2 March 2004)\textsuperscript{14} and, more specifically, Article 11, lays down the "right to protection of health" and stipulates that "(...) the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed \textit{inter alia}:

- to remove as far as possible the causes of ill-health;
- to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
- to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

The six regional committees within the WHO (Africa, South-East Asia, Europe, the Americas, Eastern Mediterranean and Western Pacific) meet every year to define their regional policies. In November 2006, Belgium signed the \textbf{European Charter on counteracting obesity in Istanbul}.

In September 2012, during the sixty-second session of the WHO Regional Committee for Europe, the 53 countries of the European Region approved a new framework policy for the Region: Health 2020. It aims to support the whole-of-government and whole-of-society measures to "significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality"\textsuperscript{15}.

This is a flexible framework for health policies in all the Member States of the European Region that provides political decision-makers with a reference framework and strategic guidelines in terms of counteracting health inequalities and improving the health of the current and future population.

\textsuperscript{13} https://data.oecd.org/fr/resultatrecherche/?q=sante
\textsuperscript{14} https://www.coe.int/fr/web/turin-european-social-charter/signature-ratifications
\textsuperscript{15} http://www.euro.who.int/fr/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/about-health-2020
http://www.euro.who.int/__data/assets/pdf_file/0005/87458/B89568.pdf
At European Union level, the Health 2020 strategy incorporates the concept of **health in all policies**. Indeed, it is no longer sustainable to consider health as the prerogative of a single sector. The equitable and sustainable improvements obtained in terms of health result from a policy conducted efficiently by all the sectors, and society's efficient and participatory collaboration.

The goal is to achieve the highest possible level of health, regardless of ethnicity, gender, age, social status or financial means. The Member States recognise that acting on health's socioeconomic and environmental determinants can effectively alleviate a large number of inequalities.16

**The Walloon Prevention and Health Promotion Plan fully ties in with this approach.**

As is the case in the other European countries, health has improved over the past few decades in Wallonia although it has been subject to a certain dualisation: a clearer improvement in the privileged sections of the population and sometimes stagnation and even deterioration in the others. Numerous efforts are therefore still required, especially in terms of health inequalities. By dealing with these issues in a systematic and transversal manner, the Walloon Prevention and Health Promotion Plan marks Wallonia's commitment to striving towards better health for all.

**c) At national level**

Given the distribution of competences in terms of health, memoranda of understanding have been concluded between the federal state and the federated entities in order to elaborate an efficient and coherent preventive policy between these entities.

For this purpose, the **Interministerial Conference for Public Health** is a real tool allowing these agreements to be fulfilled. In particular, a "memorandum of understanding between the federal authority and the authorities referred to in articles 128, 130 and 135 of the Constitution in terms of prevention" was concluded on 21 March 201617.

A prevention policy organised in an efficient and functional manner will help to promote the population's health and thus help to control the mandatory healthcare insurance's expenditure.

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16 Health 2020, policy and strategy framework
17 Memorandum of understanding of 21 March 2016 between the federal authority and the authorities referred to in Articles 128, 130 and 135 of the Constitution in terms of prevention.
d) At regional level

Prior to the Sixth State Reform and the Sainte Emilie agreements, the French Community was responsible for this area and had established a five-year plan to promote health, firstly from 1998 to 2003 then from 2004 to 2008, with the latter having been prolonged several times since 2009. This five-year plan defined the themes to be prioritised for the operators, although it did not establish a defined framework with follow-up indicators.

It is therefore necessary to act upon this transfer of competences in order to acquire a permanent management and follow-up tool for this Walloon plan in order to help it develop in a relevant manner, according to evolving needs and their indicators as well as the results obtained. Furthermore, the Déclaration de Politique Régionale 2014-2019 ‘Oser, Innover, Rassembler’ (Regional Policy Statement 2014-2019 ‘Dare, Innovate, Unite’) lays down the broad outlines of the health policies to be implemented. This statement emphasises the link between promotion/prevention and frontline care as well as the importance of acting on the health determinants and structuring the offer in terms of promotion/prevention on a territorial and coherent basis.

One of the main messages in the statement is that "The government will pay particular attention to integrating the role of the general practitioner into the prevention and health promotion policies, especially through the promotion of the electronic health record via the Walloon Health Network", and another is that "to enable everyone to live in good health, it is first necessary to act on the many determinants of our health: food, physical exercise, employment, housing, the environment, support for parenting and prevention, etc. To achieve this, the government will especially ensure that it:

- favours the emergence of health promotion networks in order to have information on the initiatives taken locally and to ensure greater coherence and better coverage of the territory;
- ensures the complementarity and coherence of the health promotion policies and mechanisms especially between the regional and community competences".
3. Identifying the existing key actions in terms of prevention and health promotion

**a) At international level**

Following the last World Health Assembly in May 2016, Belgium signed the Country Cooperation Strategy with the WHO. It consists of a strategic collaboration framework between Belgium and the WHO and describes the priority areas of collaboration, which are as follows:

- People-centred health systems (integrated care, approach based on a person’s life course, social inequalities in health, performance of the care system);
- Non-communicable diseases (actions on risk factors such as smoking, malnutrition, alcohol and mental health);
- State of preparedness, monitoring and response in health crisis situations (generic crisis plan);
- Environment and health;
- Communicable diseases (sexually transmitted diseases, tuberculosis, etc.).

Furthermore, a policy dialogue has been established between Wallonia and the WHO to elaborate the plan. It is within this framework that the WHO experts have given a variety of methodological advice, examples of good practice and their support for the first part of the plan, which was presented at a work meeting in November 2016.

**b) At national level**

The above-mentioned Prevention memorandum of understanding\(^{18}\) takes the following concerns into account: continuity of care, promoting the participation of all population groups in prevention programmes, reduction in health inequalities and health in all policies (HiAP).

The priorities resulting from the memorandum are as follows:

- Stay in good health: food, tobacco, alcohol, drugs and psychoactive drugs, addiction to gaming, sexual health, oral & dental health and suicide prevention;
- Vaccinations and infectious diseases: especially hepatitis C and tuberculosis;
- Screening programmes: newborn screening, cervical cancer, breast cancer and colon cancer.

\(^{18}\)Memorandum of understanding of 21 March 2016 between the federal authority and the authorities referred to in articles 128, 130 and 135 of the Constitution in terms of prevention.
c) At regional level

Before the transfer of competences, the Government of the French Community had finalised a five-year health promotion plan that defined the priorities, as well as the collective aspects of the preventive medicine policy.

The following themes were given priority in the last five-year health promotion plan:
1. The prevention of addictions;
2. The prevention of cancer;
3. The prevention of infectious diseases;
4. The prevention of injuries and the promotion of safety;
5. The promotion of physical activity;
6. The promotion of oral & dental health;
7. The promotion of cardiovascular health;
8. The promotion of well-being and mental health;
9. The promotion of health in early childhood;
10. The promotion of a healthy environment.

Following the transfer of competences, Wallonia has also become responsible for the organisation of frontline care, the elderly persons policy, and the mental healthcare reform for adults, children and adolescents. It also works with the Federal authorities on pilot projects concerning integrated care for chronic diseases. Bringing together all these competences offers the chance to gain a continuous and coherent view of health. Besides health, other regional competences will have an impact on health determinants, such as agriculture, social action, the economy, housing, the environment, etc.
4. Definition of the concepts behind prevention and health promotion

Since 1948, the WHO has defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Health promotion, within the meaning of the Decree of 14 July 1997, "should be understood to refer to the process that aims to enable individuals and the community to act on the determinants of health and thereby improve it, by encouraging the population to commit to taking responsibility for their everyday lives in a collective and supportive manner, combining personal choice and social responsibility. Health promotion aims to improve the well-being of the population by making a concerted effort to bring all the public policies into play (Article 1)".

In 2010-2011, the assessment of the health promotion policy mechanisms in the French Community concluded that the concept of health promotion, on which the decree is based, is still valid today. It is designed to contribute to public health (the WHO’s Health For All) as well as offer other functions such as protection, monitoring, and the organisation of the care or prevention system.

The Health Promotion Decree of 1997 also defines the concept of preventive medicine as being "the methods of prevention that comply with the legal provisions governing healthcare practice and the procedures for organising health services, to help prevent illness or to find, as quickly as possible, among the population, those who are susceptible to be or are affected by one of these illnesses, the existence of which risks causing a serious deterioration in the invalid's state of health, while sometimes also carrying the risk of spreading the disease to the invalid's close circle of family and friends, and, finally, often risks weakening the material and social situation of the invalid and their family" (Article 1). However, this definition will be revised when the new health promotion decree is written, in order to refine this concept.

The area of prevention covers different types of action depending on when they intervene in the course of the disease:

1. Before the appearance of the disease: ‘primary prevention’

Primary prevention is the set of acts aimed at reducing the incidence of a disease in a population and, therefore, at reducing the risk of new cases appearing, insofar as this is possible. Consequently, health behaviours and their determinants are taken into account at this stage of prevention.

2. At the very beginning of the disease: ‘secondary prevention’
The goal of secondary prevention is to curb the development of diseases through actions concerning individual persons or the general population. Hence, this stage of prevention covers the acts aimed at taking action when the disease first appears in order to prevent it developing or to eliminate the risk factors. From this point of view, screening - insofar as it enables the detection of a disease or the presence of risk factors - is a vital element of secondary prevention.

3. Once the disease is established: 'tertiary prevention'
Finally, the WHO envisages 'tertiary prevention' which enters at a stage where it is important to "reduce the prevalence of chronic disabilities or recurrences in a population" and reduce complications, disabilities or relapses as a result of the disease. In other words, it is necessary to diminish the effects and after-effects of a condition or its treatment. Furthermore, tertiary prevention is aimed at the patient’s rehabilitation from three points of view: medical, social and psychological.

4. Quaternary prevention
Quaternary prevention concerns the prevention of unnecessary medical care or the prevention of over-medicalisation and aims to prevent excessive medical intervention. It involves establishing the 'primum non nocere' principle, which is more concerned with medical practice.

5. Example of the efficiency of a voluntarist policy in terms of prevention: North Karelia
In the beginning of the 1970s, the mortality rate from heart disease in Finland was the highest in the world and North Karelia was the most affected region in the country. In all families in the region, physically active men in their prime were dying prematurely. The goal of the North Karelia project was to reverse the situation by modifying the lifestyle habits of its population. A goal that was successfully achieved: in the space of 35 years, death from heart disease fell by 85% in the population of North Karelia. This project continues to be a model today for the promotion of healthy lifestyles. Even taking into account other factors favourable to this trend, especially improvement in treatments, the majority of this success is attributed to investments in prevention initiated in North Karelia in the early 1970s.
Start of project in North Karelia

Expansion of project to the whole of Finland

North Karelia

Whole of Finland

Year

Fall in mortality rate* from heart disease in men aged 35 to 64, from 1969 to 2006, in North Karelia and in the whole of Finland

* Mortality per 100,000 people: adjusted for age according to the population in Europe.

Adapted from Puska, Torppa and Salomaa, 2009(7).
II. Epidemiological context in Wallonia

The analysis of the institutional and epidemiological contexts relating to the main data in terms of mortality and morbidity in Wallonia has enabled the identification of a range of priority health problems in Wallonia.

Wallonia presents the usual characteristics of the EU15 countries, in particular the contrast between more and less privileged areas and an ageing population. However, Wallonia differs from the other two regions of the country: Flanders has an older and wealthier population while the situation in Brussels is one of duality, with a population that is younger on average.

1) Description of the population

On 1 January 2016, Wallonia had 3,602,216 inhabitants (with 51% women).

The population is distributed over five provinces of differing sizes (from 280,000 to 1,377,000 inhabitants), 20 judicial districts and 269 communes. Besides the two major urban centres of Liège and Charleroi, Wallonia has seven towns with more than 50,000 inhabitants, all located along the former industrial valley that crosses Wallonia. 54% of the population is urban, i.e. a slight drop since the 1980s.

Wallonia has rural - and even very rural - regions, with a population density sometimes falling below 30 inhabitants per km². The average in Belgium in 2015 was 365 inhabitants per km² and 213 inhabitants par km² in Wallonia.

In Wallonia, the average age is 40.9 (2015). 17.5% of people are 65 or over and the ageing index (65+/-20 years) is 0.73 (in 2014) compared with 0.79 for Belgium as a whole. Wallonia has 11% single-parent families (compared with 9.7% in Belgium). The average household size is 2.3 people. 35.2% of inhabitants in Wallonia live alone. The proportion of single-person households has increased by more than 40% in 25 years, between 1990 and 2015.

There are approximately 40,000 births and as many deaths in Wallonia every year. The total fertility rate is 1.74 (under the required limit for balanced demographic renewal).
2) Life expectancy at birth and at 65 years old

In Belgium, life expectancy at birth has continued to increase since the end of the 19th century thanks, first and foremost, to improved hygiene conditions and to advances in healthcare. In 2015, life expectancy at birth was 81 years.

Nevertheless, there are disparities between the regions. Hence, life expectancy is not as high in Wallonia (79 years in 2015) as it is in the Brussels Region (81 years) or Flanders (82 years). There has been a slight increase in the difference between Wallonia and the rest of Belgium since the end of the 1990s.

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19 Life expectancy at birth in a population represents the average lifetime (i.e. the average age at death) of a fictitious generation subject to the conditions of mortality in that period. Life expectancy at a given age represents the average number of remaining years to live.

20 [Statbel website](http://statbel.fgov.be/fr/statistiques/chiffres/population/deces_mort_esp_vie/tables/)

21 IWEPS, "Les chiffres-clés de la Wallonie", 2016 edition
There are also disparities between men and women. In 2015, Walloon women could expect to live five years longer than men, i.e. 82 years instead of 77.\textsuperscript{22} However, the difference between the life expectancy at birth of men and women has followed a downward trend over the past few years: we have gone from a difference of almost seven years in 1997 to five years in 2015.

The judicial districts of Mons, Charleroi and Philippeville have the lowest life expectancy in Wallonia (in other words, people can expect to have a shorter life in these places).\textsuperscript{23} Disability-free life expectancy at the age of 65 is 11 years for women and 10 years for men in Wallonia compared with 12 years for women and 11 years for men in Belgium. Although women live longer than men, they do not stay in good health much longer.\textsuperscript{24}

Life expectancy in OECD countries

Life expectancy at birth and GDP (2013 or nearest year)  

Life expectancy at birth and health expenditure (2013 or nearest year)


Life expectancy in years

GDP per inhabitant

Overall in OECD countries, life expectancy is proportional to GDP and to the share of it dedicated to healthcare.

\textsuperscript{22} \url{www.statbel.fgov.be}

\textsuperscript{23} IWEPS, “Les chiffres-clés de la Wallonie”, No 13, 2016

\textsuperscript{24} KCE Report 259B (2016) (p. 51-52)
3) Mortality, causes of death and premature death

**Mortality**

According to the Walloon Observatory of Health, in 2013, 18,449 men and 19,827 women died in Wallonia, corresponding to a crude death rate of almost 11% for men and women. These rates are higher than in the other two regions of the country (Flanders: 10% for men and 9% for women - Brussels: 8% for men and 9% for women).

After standardisation, mortality is still higher in Wallonia than in the other regions. The differences with Flanders are greater because standardisation has erased the differences due to the fact that the Flemish population is older than the Walloon population.

### Standardised death rates all causes (for 1,000 population) per region, Belgium, 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wallonia</td>
<td>10.6</td>
<td>10.3</td>
</tr>
<tr>
<td>Flandres</td>
<td>9.6</td>
<td>8.7</td>
</tr>
<tr>
<td>Bruxelles</td>
<td>9.5</td>
<td>9.3</td>
</tr>
</tbody>
</table>

Source: Statistics Belgium. OWS calculations
The main causes of death in Wallonia

Diseases of the circulatory system are one of the main causes of death in Wallonia. In 2013, it was the primary cause of death in women (30%) and the second cause of death in men (26%) after malignant tumours (27%). Non-natural deaths (accidents, suicide, homicide, etc.) represent 7% of the causes of death.

Proportion of deaths according to cause of death categories by sex, Wallonia, 2013

Source: Statistics Belgium. OWS calculations

Women   Men

Cause of death categories

Circulatory system / Malignant tumours / Other natural causes / Respiratory system / Non-natural causes / Digestive system / Mental & behavioural problems / Infectious & parasitic diseases

Proportion of deaths

Over a period of nearly 30 years, the proportion of deaths associated with circulatory system diseases has fallen by 14 points in women (45% of causes of death in 1987 and 31% in 2013) and 11 points in men (37% in 1987 and 26% in 2013). Since 2008, malignant tumours have been the primary cause of
death in men, not cardiovascular diseases. Among women, the proportion of deaths linked to respiratory system diseases has doubled since 1987.
Distribution of the first three causes of death according to sex, Wallonia, 1987-2013

Source: Statistics Belgium. OWS calculations

Women
<table>
<thead>
<tr>
<th>Year</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory system</td>
<td>Malignant tumours</td>
</tr>
<tr>
<td>Proportion of first three causes of death</td>
<td></td>
</tr>
</tbody>
</table>
The majority of deaths occur after the age of 65 (75% of deaths among men and 87% of deaths among women). Cause-specific mortality in the general population is therefore strongly influenced by causes of death after 65 years old.

**Causes of death vary according to age:**

<table>
<thead>
<tr>
<th>Age range</th>
<th>Non-natural causes (%)</th>
<th>Mental &amp; behavioural problems (%)</th>
<th>Digestive system (%)</th>
<th>Infectious &amp; parasitic diseases (%)</th>
<th>Circulatory system (%)</th>
<th>Other natural causes (%)</th>
<th>Malignant tumours (%)</th>
<th>Respiratory system (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-14 years</td>
<td>38%</td>
<td>2%</td>
<td>43%</td>
<td>2%</td>
<td>10%</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>15-24 years</td>
<td>66%</td>
<td>6%</td>
<td>18%</td>
<td>3%</td>
<td>39%</td>
<td>3%</td>
<td>3%</td>
<td>34%</td>
</tr>
<tr>
<td>25-44 years</td>
<td>43%</td>
<td>12%</td>
<td>35%</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
<td>3%</td>
<td>15%</td>
</tr>
<tr>
<td>45-64 years</td>
<td>38%</td>
<td>10%</td>
<td>35%</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
<td>3%</td>
<td>15%</td>
</tr>
<tr>
<td>65-79 years</td>
<td>38%</td>
<td>10%</td>
<td>25%</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
<td>3%</td>
<td>15%</td>
</tr>
<tr>
<td>80 years +</td>
<td>22%</td>
<td>17%</td>
<td>15%</td>
<td>13%</td>
<td>16%</td>
<td>22%</td>
<td>2%</td>
<td>4%</td>
</tr>
</tbody>
</table>

*Source: Statistics Belgium. OWS calculations*

Proportion of deaths per cause of death category

1-14 years (etc.) 80 years and +

Age ranges

Non-natural causes / Mental & behavioural problems / Digestive system / Infectious & parasitic diseases / Circulatory system / Other natural causes / Malignant tumours / Respiratory system

Deaths in the 1-14 years age range (76 deaths) are mainly due to non-natural causes (36%) and malignant tumours (20%). Among non-natural causes, almost three-quarters (72%) are accidents (with
almost half of them due to road accidents) As regards malignant tumours, almost half of them (48%) are tumours of lymphatic and blood-forming tissues (such as leukaemia and lymphoma).

In the 15-24 age range (173 deaths), 66% of deaths are due to non-natural causes, the majority being road accidents (49%) and just over a quarter due to suicide (26%).

In 25 – 44-year-olds (1,012 deaths), non-natural causes represent 43% of the causes of death (a quarter are due to road accidents and almost half to suicide). The main natural causes of death are malignant tumours (18% of causes of death) and circulatory system diseases (10% of causes of death, a third of which are due to ischemic heart disease).

In 45 – 64-year-olds (6,020 deaths), the main causes of death are malignant tumours (39% of deaths, just over a third of which are respiratory system tumours) and diseases of the circulatory system (18% of deaths, two-fifths of which are caused by ischemic heart disease). Non-natural causes represent 10% of deaths (almost half are due to suicide).

Among 65 – 79-year-olds (10,396 deaths), the main causes of death are also malignant tumours (34%) and circulatory system diseases (25%). Then there are respiratory system diseases (12%, a little over half of which are chronic obstructive pulmonary diseases).

Among people aged 80 or more (20,452 deaths), the main causes of death are circulatory system diseases (34%), malignant tumours (15%) and respiratory system diseases (13%). Non-natural deaths represent 5% of deaths (two-fifths of these accidental deaths are due to accidental falls and 5% to suicide).

In the 'other causes' category, there are endocrine, nutritional and metabolic diseases; diseases of the blood and blood-forming organs; certain immune system problems (except for cancer); diseases of the nervous system; skin diseases; diseases of the osteoarticular system, the muscles and connective tissue; diseases of the genitourinary system; conditions associated with pregnancy, giving birth and postpartum disorders and, finally, birth defects.
**Premature death in Wallonia**

Premature death is defined as all deaths that occur before the age of 65.

A proportion of these premature deaths are actually 'avoidable': half of the deaths that occur before the age of 65 are in fact due to causes that can usually be controlled without either additional medical knowledge or new equipment.

The avoidable mortality rate in premature deaths is comparable for men and women.

Among avoidable premature deaths, it is possible to distinguish two categories according to the type of action that would be the most efficient in their prevention:

- the first relates to the modification of certain individual behaviours, especially smoking, alcohol consumption and an unbalanced diet.
- the second concerns an improvement in the way people are handled by the healthcare system, especially the prevention of certain conditions through screening.

In Wallonia, in 2013, premature death represented 19% of deaths, i.e. 7,424 deaths. The situation is different for men and women. In men, 26% of deaths are premature. Among these deaths, 81% are due to natural causes and 19% to non-natural causes. In women, 13% of deaths are premature, with 87% of these deaths due to natural causes and 13% to non-natural causes.

We observed a more significant fall in premature deaths among men (-6 points between 1987 and 2013) than in women (-3 points between 1987 and 2013) and this fall is essentially due to a drop in natural premature deaths.
In women, almost 40% of deaths that occur before the age of 65 are attributable to cancer, i.e. a little over 1,000 deaths a year on average between 2011 and 2013. The two main forms of cancer responsible for these premature deaths are lung cancer (10% of premature deaths) and breast cancer (9% of premature deaths). Lung cancer has become the main type of cancer to cause premature death in women, whereas for the period 2004-2009, breast cancer was still in the lead. In men, cancer is responsible for almost 30% of premature deaths, i.e. almost 1,500 deaths a year on average, with lung cancer most frequently linked to these deaths (10% of premature deaths).

Circulatory system diseases are the second cause of premature death in women (14% of premature deaths) and the third in men (18% of premature deaths). In both sexes, the primary cause of death in this category is ischemic heart disease (4% of premature deaths in women and 8% in men).
Non-natural causes are responsible for 13% of deaths before the age of 65 in women and 19% in men. In this category, suicide is the primary cause of premature death (7% of premature deaths in women and 10% in men).

Among Walloons aged between 25 and 44 years old, suicide is the primary cause of mortality among men and the second among women. Among those aged between 15 and 24, it is the second cause of mortality among men and the third among women. In 2013, the suicide mortality rate in Wallonia was 20 deaths per 100,000 inhabitants\textsuperscript{25}. This rate is higher than the Belgian average (17/100,000 in 2013)\textsuperscript{26} or the European one (14/100,000 in 2012). It is higher than in neighbouring countries (out of 100,000 inhabitants in 2012): France (16), Germany (13), Luxembourg (11) and the Netherlands (10)\textsuperscript{27}. In Wallonia, the suicide mortality rate did however fall between 1987 and 2013, especially among men, where it fell from 42 to 31 deaths per 100,000 inhabitants. Among women, the drop was less spectacular, falling from 14 to 11 deaths per 100,000 inhabitants. On the other hand, among 50 – 54-year-olds, there was a marked increase in the suicide rate, rising from 28 to 37 deaths per 100,000 inhabitants between 1991 and 2013. The same pattern can be seen in the European Union as a whole: an overall drop in the suicide rate between 2000 and 2010 but an increase among 50 – 54-year-olds\textsuperscript{28}.

Alcohol-related deaths represent 5% of premature deaths in women and 7% in men, i.e. an average of 140 deaths per year in women and 350 in men.

\textsuperscript{25} Wallonie Santé “Indicateurs de la santé mentale” drawn up by the Walloon Observatory of Health in 2016.
\textsuperscript{26} Figures obtained on the ISP website: https://spma.wiv-isps.be/SitePages/Home.aspx
\textsuperscript{27} Figures obtained from the WHO website: http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/
\textsuperscript{28} Wallonie Santé “Indicateurs de la santé mentale” drawn up by the Walloon Observatory of Health in 2016.
Ten main causes of premature death and proportion of these causes within premature deaths for women and men, Wallonia, 2011-2013

<table>
<thead>
<tr>
<th>Cause</th>
<th>Women (N=8049)</th>
<th></th>
<th>Men (N=14,957)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of deaths</td>
<td>%</td>
<td>No. of deaths</td>
<td>%</td>
</tr>
<tr>
<td>Cancer</td>
<td>3,197</td>
<td>39.7</td>
<td>4,470</td>
<td>29.9</td>
</tr>
<tr>
<td>Circulatory system</td>
<td>1,142</td>
<td>14.2</td>
<td>2,678</td>
<td>17.9</td>
</tr>
<tr>
<td>External causes (non-natural)</td>
<td>1,064</td>
<td>13.2</td>
<td>2,908</td>
<td>19.4</td>
</tr>
<tr>
<td>Respiratory system</td>
<td>501</td>
<td>6.2</td>
<td>1,102</td>
<td>7.4</td>
</tr>
<tr>
<td>Use of psychoactive substances</td>
<td>434</td>
<td>5.4</td>
<td>852</td>
<td>5.7</td>
</tr>
<tr>
<td>Nervous system and sense organs</td>
<td>240</td>
<td>3.0</td>
<td>385</td>
<td>2.6</td>
</tr>
<tr>
<td>Digestive system</td>
<td>198</td>
<td>2.5</td>
<td>336</td>
<td>2.2</td>
</tr>
<tr>
<td>Infectious and parasitic diseases</td>
<td>194</td>
<td>2.4</td>
<td>335</td>
<td>2.2</td>
</tr>
<tr>
<td>Endocrine, nutritional and metabolic diseases</td>
<td>186</td>
<td>2.3</td>
<td>296</td>
<td>2.0</td>
</tr>
<tr>
<td>Perinatal mortality</td>
<td>96</td>
<td>1.2</td>
<td>119</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Source: Statistics Belgium. OWS calculations

There are also significant disparities between the regions concerning premature death. As the following maps show, there are major health differences between the regions. These have increased over the last few decades for both sexes.29

The map below illustrates the existing disparities between the country's different regions. **Between 2003 and 2009, rates for alcohol-related premature death in men were generally higher in Wallonia than in Flanders. The most unfavourable situation is found in the province of Hainaut.**

---

Premature death caused by cerebrovascular diseases in men is also higher in Wallonia than in Flanders as indicated in the map below\textsuperscript{31} (data 2003 to 2009).

Premature death from lung cancer was also higher in Wallonia than in Flanders between 2003 and 2009\textsuperscript{32} for both men and women.

Diabetes, which is another major cause of premature death, also shows a geographic gradient. The province of Hainaut and the Bastogne area are the most affected in terms of premature death owing to diabetes mellitus. There are also pronounced regional disparities regarding this disorder.  

In terms of years of life lost (YLL), i.e. the number of life expectancy years lost owing to premature death, ischemic heart disease, lung cancer and cerebrovascular diseases were the top three between 1990 and 2013.

However, the progress made regarding deaths linked to road accidents is worth noting: they fell by 55% in 23 years thanks to so-called passive prevention measures that rely on technology, the development of the environment and legislation, combining actions that aim to make the environment safer and change the way people think and behave, in order to favour the reinforcement and application of safety measures.

Infectious respiratory diseases and Alzheimer's disease increased between 1990 and 2013, which is linked to the ageing population.

*Main causes of years of life lost in 1990 and 2013 in Belgium*

| LEADING CAUSES OF YLLS TO PREMATURE DEATH, 1990 AND 2013, AND PERCENT CHANGE, 1990-2013 |
|---------------------------------|-----------------|-----------------|
| Communicable, maternal, neonatal, and nutritional diseases | Ischemic heart disease | Lung cancer |
| Non-communicable diseases | Cerebrovascular disease | Self-harm |
| Injuries | Road injuries | COPD |
| COPD | colorectal cancer | Breast cancer |
| Alzheimer disease | Lower respiratory infections | Road injuries |

YLLs are years of life lost due to premature mortality.

Rankings are based on YLLs per 100,000, all ages, not age-standardized.

COPD = chronic obstructive pulmonary disease

Source: [http://www.healthdata.org/belgium](http://www.healthdata.org/belgium)
4) Morbidity

Chronic diseases

The diseases Walloons suffer from in their everyday lives are not necessarily those that they die from or those that lead to the greatest consumption of healthcare. Therefore, the statistics relating to deaths and those resulting from healthcare consumption data provide a very imperfect image of the reality of the population's well-being and the way it can be improved.

Hence, according to the 2013 Health Interview Survey, three-quarters of Walloon respondents consider themselves to be in good or very good health. This proportion drops with age and stands at 61% (men) and 59% (women) in persons aged 65 or more. Overall, one in three people reported suffering from a chronic disease, and two out of three after the age of 65. The social gradient, based on the last diploma obtained, is enormous.

The main chronic conditions Walloons say that they have suffered from in the last 12 months are as follows, in order of frequency (based on a list of 38 proposals):

<table>
<thead>
<tr>
<th></th>
<th>Men 15+</th>
<th>Men 65+</th>
<th>Women 15+</th>
<th>Women 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>High blood pressure</td>
<td>High blood pressure (33%)</td>
<td>Arthritis</td>
<td>Arthritis (51%)</td>
</tr>
<tr>
<td>2</td>
<td>High cholesterol</td>
<td>High cholesterol</td>
<td>Lower back pain</td>
<td>Lower back pain</td>
</tr>
<tr>
<td>3</td>
<td>Lower back pain</td>
<td>Arthritis</td>
<td>High cholesterol</td>
<td>High cholesterol</td>
</tr>
<tr>
<td>4</td>
<td>Arthritis</td>
<td>Lower back pain</td>
<td>High blood pressure</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>5</td>
<td>Allergies</td>
<td>Prostate problems</td>
<td>Thyroid problems</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>6</td>
<td>Neck pain</td>
<td>Diabetes</td>
<td>Neck pain</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>7</td>
<td>Rheumatoid arthritis</td>
<td>Neck pain</td>
<td>Allergies</td>
<td>Neck pain</td>
</tr>
<tr>
<td>8</td>
<td>Migraine headaches</td>
<td>Rheumatoid arthritis</td>
<td>Migraine headaches</td>
<td>Thyroid problems</td>
</tr>
<tr>
<td>9</td>
<td>Asthma</td>
<td>Incontinence</td>
<td>Depression</td>
<td>Cataract</td>
</tr>
<tr>
<td>10</td>
<td>Depression</td>
<td>Allergies</td>
<td>Rheumatoid arthritis</td>
<td>Incontinence</td>
</tr>
</tbody>
</table>

Source: HIS, Belgium 2013

The conditions that Walloons suffer from in their everyday lives are not necessarily those that they will die from or the reason for which they are most frequently hospitalised. For instance, there are many
osteoarticlar problems, allergies (especially before 65 years old) and urinary incontinence after 65 years old, and depression. However, high blood pressure and high cholesterol feature in the 10 most frequently mentioned problems. In addition, there are thyroid problems, which affect 14% of women aged 15 and over (20% after 65). These proportions are much higher in Wallonia than in the country's other two regions. The same is true for osteoporosis.

According to this Belgian Health Interview Survey (2013)34, more than one in four Belgians (i.e. almost 28.5%) over the age of 15 reported suffering from a chronic disease.

One difficulty inherent to ‘chronic diseases’ is the lack of consensus regarding their definition and the list of diseases to be included in their register. Incidentally, the definition proposed by the WHO is quite broad: "They are of long duration and generally slow progression".

The most commonly retained characteristics are that they are incurable and cause functional problems, disabilities and a deterioration in quality of life. They are also of long duration, starting slowly and insidiously, with symptoms appearing gradually, and are non-contagious. Their aetiology is complex with risk factors that are difficult to identify, comprised of modifiable factors on the one hand and non-modifiable factors on the other.

The percentage of people suffering from a chronic disease increases with age. It increases from 10% in young people aged 15 to 24, to almost half (50%) the population of people aged 75 or more.

The majority of these chronic diseases are more frequent among less-educated populations. Indeed, the social inequalities of health can particularly be seen in the problem of chronic diseases: people with a low socioeconomic level are more subject to developing risk behaviours and thus developing chronic diseases. What is more, being ill can also lead to poverty.

The social gradient relating to the last diploma obtained is telling:

*Proportion of men and women (15 years and +) stating they suffer from a chronic disease according to the last diploma obtained*

![Graph showing social gradient](image)

Source: HIS, ISP, 2013

Moreover, in the Flemish Region, the survey reveals that the number of people affected by chronic diseases is lower (27%) than in the Walloon Region (30%) or the Brussels Region (31%). More than one in three people aged 65 or more are affected by at least two chronic diseases and suffer from morbidities.

**Circulatory system diseases**

The following results appear in the Health Interview Survey:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Proportion of Walloons who state that they suffer from a problem</th>
<th>Proportion of these people who are followed by a specialist</th>
<th>Men/women differential</th>
<th>Social gradient</th>
<th>Tendency (over time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart attack</td>
<td>1.4</td>
<td>83.8</td>
<td>Yes (M)</td>
<td>No</td>
<td>Stable</td>
</tr>
<tr>
<td>Coronary insufficiency</td>
<td>1.8</td>
<td>82.6</td>
<td>Yes (M)</td>
<td>Yes</td>
<td>Stable</td>
</tr>
<tr>
<td>Other serious heart diseases*</td>
<td>1.9</td>
<td>86.5</td>
<td>Yes (M)</td>
<td>Yes</td>
<td>N/A</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>15.3</td>
<td>92.4</td>
<td>No</td>
<td>Yes</td>
<td>Tendency to increase</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>15.7</td>
<td>84.6</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
</tbody>
</table>
The majority of cardiovascular disorders increase with age and follow a social gradient.

The proportion of patients suffering from cerebrovascular diseases is not significantly different between men and women but after the age of 75, when it is higher, the absolute number of women is far higher than that of men in the population.

**Proportion of people (Belgium) suffering from high cholesterol who are on a diet or who take medication by age group according to their statements**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>15—24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25—34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35—44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45—54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55—64</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65—74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>75+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source HIS, ISP, Belgium, 2013

We noted the relatively small proportion of people suffering from high cholesterol who adapted their diet compared with those taking medication after the age of 55. The proportion of people adapting their diet is higher in Brussels than in the other two regions.

**Cancer**

Cancer is one of the most frequent chronic diseases. In 2014, the cancer register recorded 23,459 new cancer diagnoses in Wallonia: 12,119 in men and 11,340 in women. Based on the figures from 2014, 36% men and 31% women will suffer from cancer before reaching the age of 75. In general, cancer increases with age. It mainly affects the elderly aged 60 or more and **the most frequently diagnosed**
new cases in Wallonia are, in order, prostate, lung and colon cancer in men, and breast cancer followed by lung and colon cancer in women.  

According to the cancer register, this "increase in the number of tumours is mainly due to ageing and demographic growth, while in women, an additional increase is expected owing to an increase in smoking".  

A study by the Walloon Observatory of Health shows the following frequency based on figures from 2010:  

Incidence of the main types of cancer in Wallonia in 2010 absolute number and relative percentage  

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prostate</td>
<td>Sein</td>
</tr>
<tr>
<td></td>
<td>Lung</td>
<td>Colon-rectum</td>
</tr>
<tr>
<td></td>
<td>Colon</td>
<td>Poumon</td>
</tr>
<tr>
<td></td>
<td>Head &amp; neck</td>
<td>Poumon</td>
</tr>
<tr>
<td></td>
<td>Bladder</td>
<td>Corps de l'utérus</td>
</tr>
<tr>
<td></td>
<td>Lymph.no.</td>
<td>Melanome malin</td>
</tr>
<tr>
<td></td>
<td>Rein</td>
<td>Lymph.non Hodgkin</td>
</tr>
<tr>
<td></td>
<td>Lymannom.</td>
<td>Ovaire</td>
</tr>
<tr>
<td></td>
<td>Oesophagus</td>
<td>Thyroide</td>
</tr>
<tr>
<td></td>
<td>Leucémies</td>
<td>Tête et cou</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Col de l'utérus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>211</td>
</tr>
<tr>
<td>0</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>211</td>
<td>233</td>
<td>1796</td>
</tr>
<tr>
<td>289</td>
<td>351</td>
<td>514</td>
</tr>
<tr>
<td>231</td>
<td>255</td>
<td>313</td>
</tr>
<tr>
<td>225</td>
<td>255</td>
<td>313</td>
</tr>
<tr>
<td>0</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>211</td>
<td>233</td>
<td>1796</td>
</tr>
<tr>
<td>289</td>
<td>351</td>
<td>514</td>
</tr>
<tr>
<td>231</td>
<td>255</td>
<td>313</td>
</tr>
<tr>
<td>225</td>
<td>255</td>
<td>313</td>
</tr>
</tbody>
</table>

Prostate / Lung / Colon / Head & neck / Bladder / Lymph.no. / Kidney / Melanoma / Oesophagus / Leukaemia  

Breast / Colon / Lung / Uterus / Malig. melanoma / Lymph.non Hodgkin / Ovarian / Thyroid / Head & neck / Cervix  

The types of cancer on the increase in women are lung cancer (increase in smoking), cancer of the nervous system and pancreatic cancer, the latter being more frequent than in the country's other two regions.  

35 http://www.kankerregister.org/  
36 http://www.kankerregister.org/media/docs/publications/Com._dePresseFRC09122015.pdf
Mortality owing to the main types of cancer in Wallonia in 2010: absolute numbers and relative shares of deaths per cancer type

**Men**
- Lung / Colo-rectal / Prostate / Pancreas / Bladder / Leukaemia / Head & neck / Liver / Oesophagus / Lymph.no.

**Women**
- Sein / Lung / Colo-rectal / Pancreas / Ovarian / Leukaemia / Liver / Lymph.non Hodgkin / Bladder / Stomach

Survival rates at five years are presented below for men and women, per region. The chances of survival after being diagnosed with cancer have increased over the past few years, both in men and women. However, the percentages remain higher for the Flemish and Walloon Regions than in Brussels.

**Table No 3: Survival at 5 years in men, Belgium 2007-2011**

<table>
<thead>
<tr>
<th>Cancers Invasifs</th>
<th>Région</th>
<th>N at Risk</th>
<th>Survive relative à 5 ans (%)</th>
<th>Survive relative à 5 ans (%) IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tous cancers (cancers de la peau non mélanome exclus)</td>
<td>Belgique</td>
<td>164213</td>
<td>58,2%</td>
<td>[57,8%–58,5%]</td>
</tr>
<tr>
<td></td>
<td>Région Flamande</td>
<td>101512</td>
<td>59,7%</td>
<td>[59,2%–60,1%]</td>
</tr>
<tr>
<td></td>
<td>Région Wallonne</td>
<td>60468</td>
<td>55,8%</td>
<td>[55,2%–56,5%]</td>
</tr>
<tr>
<td></td>
<td>Région de Bruxelles-Captaie</td>
<td>12133</td>
<td>55,5%</td>
<td>[54,2%–56,7%]</td>
</tr>
<tr>
<td>Côlon-rectum</td>
<td>Belgique</td>
<td>22857</td>
<td>63,7%</td>
<td>[62,7%–64,7%]</td>
</tr>
<tr>
<td></td>
<td>Région Flamande</td>
<td>14553</td>
<td>64,8%</td>
<td>[63,0%–66,0%]</td>
</tr>
<tr>
<td></td>
<td>Région Wallonne</td>
<td>6358</td>
<td>62,7%</td>
<td>[60,8%–64,6%]</td>
</tr>
<tr>
<td></td>
<td>Région de Bruxelles-Captaie</td>
<td>1635</td>
<td>57,9%</td>
<td>[53,9%–61,6%]</td>
</tr>
<tr>
<td>Poumon</td>
<td>Belgique</td>
<td>27631</td>
<td>15,1%</td>
<td>[14,5%–15,7%]</td>
</tr>
<tr>
<td></td>
<td>Région Flamande</td>
<td>16544</td>
<td>15,5%</td>
<td>[14,7%–16,2%]</td>
</tr>
<tr>
<td></td>
<td>Région Wallonne</td>
<td>9177</td>
<td>14,7%</td>
<td>[13,7%–15,7%]</td>
</tr>
<tr>
<td></td>
<td>Région de Bruxelles-Captaie</td>
<td>1910</td>
<td>15,6%</td>
<td>[14,6%–15,5%]</td>
</tr>
<tr>
<td>Prostate</td>
<td>Belgique</td>
<td>43978</td>
<td>94,4%</td>
<td>[93,8%–95,0%]</td>
</tr>
<tr>
<td></td>
<td>Région Flamande</td>
<td>28970</td>
<td>94,8%</td>
<td>[94,1%–95,5%]</td>
</tr>
<tr>
<td></td>
<td>Région Wallonne</td>
<td>12214</td>
<td>94,0%</td>
<td>[92,7%–95,1%]</td>
</tr>
<tr>
<td></td>
<td>Région de Bruxelles-Captaie</td>
<td>2794</td>
<td>92,3%</td>
<td>[89,4%–94,5%]</td>
</tr>
</tbody>
</table>
## Men, relative survival at 5 years per region, 2007-2011

### Invasive cancers

<table>
<thead>
<tr>
<th>Region</th>
<th>Relative survival at 5 years (%)</th>
<th>Relative survival at 5 years (%) IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cancers (non-melanoma skin cancers excluded)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Belgium

- **Flemish Region**
- **Walloon Region**
- **Brussels-Capital Region**

*Note: all the percentages in column five should be written with a decimal point instead of a comma, e.g. 58.2%*

## Table No 4: Survival at 5 years in Women, Belgium 2007-2011

### Femmes, survie relative à 5 ans par région, 2007-2011

<table>
<thead>
<tr>
<th>Cancers Investis</th>
<th>Région</th>
<th>N at Risk</th>
<th>Survie relative à 5 ans (%)</th>
<th>Survie relative à 5 ans (%) IC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tous cancers (cancers de la peau non mélanome exclus)</td>
<td>Belgique</td>
<td>139689</td>
<td>67.5%</td>
<td>[67.1% - 67.8%]</td>
</tr>
<tr>
<td></td>
<td>Région Flamande</td>
<td>81002</td>
<td>60.0%</td>
<td>[57.5% - 68.4%]</td>
</tr>
<tr>
<td></td>
<td>Région Wallonne</td>
<td>46007</td>
<td>67.2%</td>
<td>[66.6% - 67.7%]</td>
</tr>
<tr>
<td></td>
<td>Région de Bruxelles-Brabant</td>
<td>12690</td>
<td>65.5%</td>
<td>[64.3% - 66.7%]</td>
</tr>
<tr>
<td><strong>Sein</strong></td>
<td>Belgique</td>
<td>49105</td>
<td>88.9%</td>
<td>[87.8% - 89.7%]</td>
</tr>
<tr>
<td></td>
<td>Région Flamande</td>
<td>28474</td>
<td>88.5%</td>
<td>[87.9% - 89.1%]</td>
</tr>
<tr>
<td></td>
<td>Région Wallonne</td>
<td>16150</td>
<td>88.4%</td>
<td>[87.2% - 89.2%]</td>
</tr>
<tr>
<td></td>
<td>Région de Bruxelles-Brabant</td>
<td>4478</td>
<td>65.6%</td>
<td>[64.0% - 67.4%]</td>
</tr>
<tr>
<td><strong>Célon-rectum</strong></td>
<td>Belgique</td>
<td>18505</td>
<td>64.7%</td>
<td>[63.7% - 65.7%]</td>
</tr>
<tr>
<td></td>
<td>Région Flamande</td>
<td>11402</td>
<td>65.3%</td>
<td>[63.9% - 66.6%]</td>
</tr>
<tr>
<td></td>
<td>Région Wallonne</td>
<td>5581</td>
<td>64.3%</td>
<td>[62.4% - 66.2%]</td>
</tr>
<tr>
<td></td>
<td>Région de Bruxelles-Brabant</td>
<td>1522</td>
<td>62.7%</td>
<td>[61.9% - 65.7%]</td>
</tr>
<tr>
<td><strong>Poumon</strong></td>
<td>Belgique</td>
<td>10321</td>
<td>21.7%</td>
<td>[20.7% - 22.8%]</td>
</tr>
<tr>
<td></td>
<td>Région Flamande</td>
<td>5485</td>
<td>21.4%</td>
<td>[20.0% - 22.8%]</td>
</tr>
<tr>
<td></td>
<td>Région Wallonne</td>
<td>3860</td>
<td>22.7%</td>
<td>[21.0% - 24.4%]</td>
</tr>
<tr>
<td></td>
<td>Région de Bruxelles-Brabant</td>
<td>978</td>
<td>19.6%</td>
<td>[16.6% - 23.2%]</td>
</tr>
</tbody>
</table>

Source: Fondation Registre du Cancer

*Same as above except for:

All cancers (non-melanoma skin cancers excluded)*
**Diabetes**

In Belgium (2014), one adult in 16 (aged between 20 and 79) suffers from diabetes (one adult in 13 in Europe). In Europe, 52 million people are believed to be affected by diabetes. If this is the case, this figure will exceed 69 million by 2035. The prevalence of diabetes in people over 15 years old is 6% in Belgium and 8% in Europe. However, according to the ISP, the figures concerning diabetes in Belgium are limited and incomplete. The ISP considers that one third of patients suffering from type 2 diabetes in Belgium are unaware of it. The prevalence is therefore actually thought to be higher.

It is possible to estimate the number of people treated for diabetes by the number of prescriptions for oral anti-diabetic medication and insulin. Type 1 diabetes occurs most often in childhood or early adulthood. It is known as insulin dependent. It concerns approximately 10% of cases and cannot be prevented. Type 2 diabetes is the most common sort (approximately 90% of cases). It results from impaired insulin sensitivity in cells and responsive hyperinsulinemia. This type of diabetes usually occurs after the age of 40 (although it is also observed in overweight or obese children and adolescents). It can be avoided by maintaining a healthy body weight and regular physical activity. For type 1 diabetes, sufferers have to take insulin. For type 2 diabetes, treatment consists, above all, in managing the excess weight and regular physical activity, although it can also be supplemented by oral anti-diabetic medication, and even insulin injections depending on the evolution and severity of the disease.

In Wallonia (2013), 107,968 people were treated for diabetes. Out of a total population of 3,563,060 (1 January 2013), this represents approximately 3% of the population.

As regards the number of people treated for diabetes according to age (for Belgium), approximately 4% of patients are between 0 and 24 years old; 15% are between 25 and 49 years old; 53% are between 50 and 74 years old; 21% are between 75 and 84 years old and 6% are over 85. With regard to patients

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37 http://www.idf.org/sites/default/files/DA-regional-factsheets%202014_FR_v2.pdf
39 http://www.diabete-abd.be/
42 Calculated on the basis of table No 6
treated by oral anti-diabetic medication, they are over 50 years old and 68% of them are aged between 50 and 74.43

**Proportion of diabetic patients in Belgium (2013)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>N=128157</th>
<th>PATIENTS UNDER INSULIN</th>
<th>PATIENTS UNDER ORAL ANTIDIABETICS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Passport</td>
<td>Care trajectory</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>62,080</td>
<td>5.3%</td>
<td>12.4%</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>66,499</td>
<td>4.4%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Age groups</td>
<td>00-24</td>
<td>5,403</td>
<td>1.9%</td>
<td>0.1%</td>
</tr>
<tr>
<td></td>
<td>25-49</td>
<td>10,273</td>
<td>3.2%</td>
<td>4.2%</td>
</tr>
<tr>
<td></td>
<td>50-74</td>
<td>67,517</td>
<td>5.5%</td>
<td>13.2%</td>
</tr>
<tr>
<td></td>
<td>75-94</td>
<td>27,170</td>
<td>5.0%</td>
<td>15.4%</td>
</tr>
<tr>
<td></td>
<td>95+</td>
<td>9,840</td>
<td>4.9%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Long term care (65 years or +)</td>
<td>Home care institutions</td>
<td>6,975</td>
<td>4.9%</td>
<td>16.1%</td>
</tr>
<tr>
<td></td>
<td>No LT Care</td>
<td>52,819</td>
<td>5.6%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Entitlement to increased reimbursement (18 years or +)</td>
<td>No</td>
<td>70,936</td>
<td>4.4%</td>
<td>12.4%</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>46,381</td>
<td>6.1%</td>
<td>12.1%</td>
</tr>
</tbody>
</table>


Little is yet known about the risk factors for type 1 diabetes. As regards type 2 diabetes, the main risk factors are: heredity, excess weight, poor diet, a sedentary lifestyle, high blood pressure, age, ethnic origin and intolerance to glucose.44

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43 Calculated on the basis of table No 6  
**Infectious diseases**

**Monitoring infectious diseases**

Infectious diseases are mainly monitored and controlled by sentinel surveillance systems (sentinel laboratories, sentinel doctors, etc.) and by the compulsory declaration of certain infectious diseases to the health authorities. These diseases have an impact on public health and require social prophylactic measures.

**HIV and other sexually transmitted diseases (STD)**

In Belgium, 1,001 new cases of HIV were reported in 2015: while a 4.7% drop was observed compared with the previous year, this figure nevertheless remains high in Belgium and corresponds to an average of 2.7 diagnoses of HIV a day.

Among those diagnosed in 2015, 14% give a place of residence in Wallonia, 37% in Flanders and 23% in Brussels. The place of residence is unknown in 26% of cases. Between 2013 and 2015, the number of HIV infections diagnosed fell in the country's three regions: a decrease of 14% in Flanders, 15% in Wallonia, and 8% in Brussels.

This drop only concerns one of the two main risk groups within the population, i.e. people contaminated by heterosexual relations, especially those from Sub-Saharan African countries. Men who have sexual relations with men have once again become the risk group most affected by the epidemic within the population. Transmission through intravenous drug use has remained negligible (2% of diagnoses in 2015). Currently, some 15,000 HIV-infected people are subject to medical monitoring. The efficacy of the treatment with antiretroviral drugs, if it is correctly followed, makes their viral load (almost) undetectable, which contributes to considerably reducing the risk for their partner(s).

A continuous increase in other STD has been observed in Belgium since 2002. **Chlamydia is the most frequent STD in Wallonia.** In Wallonia, the number of recorded cases has risen from 163 in 2002 to 946 cases in 2015, i.e. 26.3 more cases reported per 100,000 inhabitants. The increase can be seen in women aged 15 to 29 years and in men aged 20 to 39 years. This STD, which is very often asymptomatic, can lead to relatively serious complications (mainly infertility). There has also been a continuing upward trend for gonorrhoea since 2002. In Wallonia, the number of recorded cases has

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45 ISP – Epidemiology of AIDS and HIV infection in Belgium – Situation as at 31 December 2015. 68 p.
risen from 37 in 2002 to **162 cases in 2015**. In 2014, **gonorrhoea** was mainly observed in men aged 20 to 24 years. In women, most cases occurred in the 15-24 age category. In women aged 20-24 years, there has been a significant increase in reported cases since 2011.

**Syphilis** has also increased over the same period (2002-2014). In Wallonia, 21 cases were recorded in 2002 (i.e. a reported incidence of 0.6 per 100,000 inhabitants) compared with **172 cases in 2014** (i.e. a reported incidence of 4.8 per 100,000 inhabitants). In 2015, there were 95 reported cases (2.6 / 100 000 inhabitants). The cases of syphilis were mainly observed in men aged 20 to 60 years.

Concerning the sexual behaviour of young people, the HSBC survey for the French Community revealed the following facts:

- In **2014**, **almost one in every two high school students (47%)** reported that they had already **had sexual intercourse**. The proportion of young people who say that they have already had sexual intercourse increases with the school year and/or when the standard of living falls.

- The proportion of young people who have had **sexual intercourse is higher among young people who have already had a relationship (51%)** than among those who never have (15%).

- More than nine young people out of ten (94%) state that they used a method of protection the first time they had sexual intercourse. Among those who had had several sexual relations, the same proportion of young people (93%) reported having used a method of protection during the most recent sexual relations.

- However, the use of a method of protection is less frequently reported when the standard of living decreases, whether it is the first or the most recent sexual relation.

**Certain risk situations regarding the transmission of HIV are still unknown** and the proportion of young people with an insufficient level of knowledge decreases when the academic level increases.

**Tuberculosis**

According to the WHO, Belgium is considered a country with a low incidence as it is under the threshold of 10/100,000. Remaining below 10 cases for every 100,000 inhabitants is an objective to be maintained. Tuberculosis is experiencing a downward trend in Belgium even if this has slowed since the beginning of the 1990s.

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In 2014, 959 cases were declared. Despite fluctuation over the past 25 years, the number of cases and incidence have gradually fallen (in 1990, they were 1,577 and 15.8/100,000 respectively), although more slowly than the forecasts suggested.

Tuberculosis has therefore regressed less in the last two decades. This situation can partly be explained by the increase in the number of cases stemming from countries where tuberculosis is very frequent. In 2012, 53.3% of tuberculosis patients listed in Belgium were foreign nationals. Precarity is also a factor that can influence the evolution of tuberculosis.

Incarceration is also a major risk factor in the transmission of tuberculosis. According to the Fonds des Affections Respiratoires (FARES, fund for respiratory disorders, a not-for-profit association), "prisoners comprise a high risk population group for tuberculosis, not only because they live in a closed establishment (which is sometimes overcrowded and insufficiently ventilated) but also owing to the significantly high proportion of individuals who are at a high risk of contracting tuberculosis compared with the population outside prisons. (...) The rapid turnover of the prison population is also an extra risk factor that facilitates the transmission of tuberculosis" not only in prison environments, but also outside. "The adequate control of tuberculosis in prisons must be considered as a public health priority not only for the inmates but also for the general population."

**Vaccine-preventable infectious diseases**

Diseases such as diphtheria, tetanus, polio, rubella, and Haemophilus influenzae type b (Hib) and meningococcal type C infections no longer occur, or only rarely.

Concerning whooping cough, we have observed a high increase in the number of cases in the Walloon Region since 2011. After a peak recorded in 2014, a reduction in the number of reported cases was revealed in 2016. The number of declared cases had again risen in the first three quarters of 2016, with 562 declared cases of whooping cough in the Walloon Region, 38 of which concerned children under a year old, which is the most vulnerable group. In an effort to protect this group, the Superior Health Council has recommended vaccination against whooping cough during every pregnancy, since

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September 2013. In Wallonia, the vaccination has been offered for free to pregnant women since September 2015. However, it is currently impossible to determine whether this recommendation is properly adhered to by health professionals.

Measles is present in every region in the Walloon Region: 3.6 cases per 100,000 inhabitants were reported in 2015, mainly in the form of small outbreaks mainly affecting families who are against the vaccination. In 2016, measles also affected non-vaccinated health professionals in hospital environments. Strictly speaking, this disease is not increasing but is persistent within our population, while the WHO's goal is to eradicate this disease by 2018. In 2015, the coverage rate for the first dose of the MMR (measles, mumps, rubella) vaccine was 95.9%, while the rate for the second dose administered between the ages of 11 and 12 was only 75.5%. 
Mental health

According to the Health Interview Survey (2013), 35% of the population in Wallonia experience psychological problems and 20% suffer from a serious condition. There is a far higher number of women who experience psychological problems, with the biggest difference occurring in the 15-24 age range. There is a greater prevalence of psychological problems and disorders among less well-educated populations. These figures are high compared with the European average (over 10%).

Concerning the lack of psychological well-being, the conclusions of the Health Interview Survey emphasise the increased risks for young women and households with a low level of education.

There are more women than men (10% and 6% respectively) who evoke signs of an eating disorder. Eating disorders appear less frequently in the group of people from the most well-educated households (6%). (ISP, 2013).

In the Walloon Region, 13% of men and 20% of women report a depressive disorder, which represents a considerable increase compared with the figures from 2008 (7% and 13% respectively). (ISP, 2013).

In the Walloon Region, 9% of men and 14% of women report anxiety disorder symptoms. Their prevalence increases from 9%, among those with higher education, to 15% in the group of least well-educated households. (ISP, 2013). In Wallonia, a socio-educational gradient can also be seen in self-reported depression, with a higher prevalence in educationally disadvantaged households (16%) than in more educated households (8% for intermediary levels, 5% for the higher level). (ISP, 2013). A variability in prevalence can be seen in women in Wallonia depending on the place of residence.

According to the Share survey, elderly people have a high risk of experiencing mental health problems in the French-speaking part of Belgium. Half of those over the age of 65 are believed to suffer from psychological problems, mainly depression. It is important to note that this is linked to an additional risk of suicide and a heavy burden for family carers. Furthermore, people with depression are exposed to the side effects of antidepressants. Depression is believed to be associated with gender (women are more concerned), isolation, a feeling of not having control over one's own life and socioeconomic variables (with the more disadvantaged at greater risk). A higher prevalence can be seen in women

49 Regarding the Health Interview Survey, although the sampling method used limits the appearance of numerous biases, we must remember that it doesn’t represent the true number of people; it is an extrapolation of the answers from the 10,000 people selected to respond to the survey, to the whole of the Belgian population. According to the ISP, “the results are weighed to allow the generalisation of the results obtained to all the inhabitants of Belgium”. The participation of Belgian households in these surveys is done on a voluntary basis. Those who did not wish to take part were replaced by households with comparable characteristics. The results collected therefore represent the statements of the people interviewed.


over the age of 80. The mental and cognitive health of elderly people is also impacted by normal and pathological ageing.

In the Walloon Region, 35% of women and 27% of men suffer from sleep disorders. In women between the age of 15 and 44, the prevalence of sleep disorders affects approximately 31 to 32% of people, but it rises to 38 to 40% as of the age of 45 (ISP, 2013).

In general, mental health problems are more frequent in women (with a peak among young women) and in people with a low level of education.

Finally, the life expectancy at birth of women and men suffering from severe mental illness is 15 to 20 years less on average\(^\text{53}\).

In Wallonia, the ISP noted an increase in problems related to anxiety, depression and sleep in the surveys between 2008 and 2013, while the indicators were stable until 2008. According to the conclusions, more people said they had had suicidal thoughts, although the number of suicides has remained stable. The rise in the consumption of antidepressants confirms this trend.

### Suicide attempts and suicidal ideation

Information concerning suicidal ideation and suicide attempts is based on the results published by the Institute of Public Health following the analysis of the results of the 2013 Health Interview Survey\(^\text{54}\).

According to the 2013 Health Interview Survey, "women are more at risk of going through with it than men, who are more at risk of dying". Furthermore, "the risk of death by suicide increases with age while the risk of attempting suicide decreases".

In Wallonia, 5.5% of respondents stated having made a suicide attempt during their lifetime, and 0.3% during the past year. Moreover, 5.1% of respondents have reported having had suicidal thoughts in the course of 2012.

To explain the apparent contradiction between the higher prevalence of mental health problems in women and the higher prevalence of suicide in men, a hypothesis that is sometimes put forward is the greater propensity (in our current society in any case) among women compared with men to talk about negative psychological suffering. If this hypothesis is true, this means that mental health


\(^{54}\) [https://his.wiv-isp.be/FR/SitePages/Accueil.aspx](https://his.wiv-isp.be/FR/SitePages/Accueil.aspx)
problems are underestimated in men because they are less often spoken about (in surveys and among health professionals).

**Intentional and unintentional injuries**

In everyday language, the term ‘accident’ refers to an unforeseen, sudden and harmful event, a definition that suggests the unavoidable nature of this event. The WHO defines an accident as "an event independent of human will, caused by an outside force acting rapidly resulting in physical and mental injury". Accidents are divided according to the place where they occurred: road accidents, work accidents, school accidents, home and leisure accidents.

In order to extend event prevention (its non-occurrence) to control of the severity of its consequences, the preferred term is 'injury'. On an international level, a consensus has been reached on the concept of injury prevention, i.e. the reduction and control of the consequences of an event referred to as an accident. Envisaging prevention from the point of view of injuries increases the number of intervention strategies by exceeding those that are limited to the identification of at-risk persons and the modification of their behaviours. Prevention therefore extends to modifications to the physical environment, legislation and the technologies likely to influence the severity of the injuries. From this point of view, it is essential to establish a dialogue between the sectors concerned.

There are two categories of preventable injuries:

- Intentional injuries as a result of acts of violence: homicide, assault, suicide, self-harming. According to the definition of the World Health Organization (WHO), 'violence' is "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation".

- Unintentional injuries are often classified according to where they occurred: road, work, leisure and sport, school, home; or according to their mechanism: e.g. falling, drowning, burns, poisoning or suffocation.

**Accidents**

According to the 2013 health survey, 7% of the Belgian population say that they have suffered an accident requiring medical attention during the 12 months prior to the survey. In 56% of cases, the
accident victims had to be admitted to hospital or another health-care institution, while in 44% of cases, hospitalisation was not necessary although care had to be provided by a doctor or a nurse. The percentage of accident victims having to be admitted to a hospital or another health-care institution is higher among individuals with a lower level of schooling (78%) than among those who benefited from higher education (48%).

Over the period of 12 months prior to the survey, 1% of the population reports having been injured in a road accident, 2% say they have been injured in an accident at home, 2% in an accident during leisure activities, 3% in an accident at work and 1% in an accident at school. Further to their accident, the victims had to suspend the normal course of their activities for (at least) one week in 33% of cases involving a road accident, in 48% of cases involving an accident at home, in 39% of cases involving an accident during leisure activities, in 36% of cases involving an accident at work and in 11% of cases involving an accident at school.

More men (8%) than women (6%) suffer accidents requiring medical attention. The risk of suffering an accident requiring care is highest among young people aged 15 to 24 years (10%) and elderly people aged 75 years and over (9%). In the 35-44 year age group, twice as many men (8%) as women (4%) suffered an injury in an accident requiring medical attention.

The difference between the relative number of men and women having suffered an accident requiring medical attention can be seen only as regards accidents during leisure activities: 3% of men suffered such an accident, i.e. twice as many as women (1.5%). The victims of road accidents are twice as numerous in the 25-34 year age group (2%), accidents at home affect primarily the 55-64 year age group (3%) and especially the over-75s (8%), and those injured in an accident during leisure activities are more numerous among young people aged 15 to 24 years (6%) and young adults aged 25 to 34 years (3%).

Differences appear depending on the place of residence as regards accidents having required medical attention. In fact, the risk of such an accident is higher among those who live in semi-urban areas (9%) than in rural areas (6), and this is particularly noticeable with regard to accidents during leisure activities (4% and 2% respectively). Moreover, a larger number of accident victims having required medical attention is recorded in the Flemish Region (8%) than in the Brussels Region and Wallonia (6%), especially in the context of accidents during leisure activities (3% of residents of Flanders compared with 2% of residents of Wallonia). However, the percentage of accidents for which admission to a hospital or another health-care institution was necessary is lower in the Flemish Region (45%) than in Brussels (74%) and the Walloon Region (77%).
The type of accident suffered also varies depending on sex or age and is doubtless linked to the particular activities undertaken at each stage of life. Accidents at school are most frequently reported in the 6-11 year age group. Accidents during leisure activities affect mainly men and the 15-34 year age group. Road accidents peak among the 25-34 year-olds. Finally, accidents at home are more frequent among elderly people aged 75 and over.

**Road accidents**

According to the 2008 health survey, as regards road accidents 1.2% of Belgian citizens state that they have been injured in the past twelve months. There is no difference between men and women. In the Belgian population, the frequency of injuries varies depending on the socio-economic level: higher secondary diploma (1.6%) and higher education diploma (0.9%).

In the Walloon Region, as in Belgium as a whole, the number of people injured in road traffic accidents varies depending on age. The injured are concentrated mainly in the following age groups: 15-24 years and 45-54 years.

In the Walloon Region, no difference emerges depending on level of education, but there is a difference depending on degree of urbanisation. Here the frequency is significantly higher in semi-urban areas (2.2%) than in urban areas (0.6%).

**Accidents at work**

Again according to the 2008 health survey, 3% of the working population (15-64 year-olds) of Belgium state that they have been injured in an accident at work during the 12 months prior to the survey. More men (4%) than women (3%) state that they have been injured in an accident at work, a difference that remains significant after standardisation to take account of age. As of the age of 45 years, the frequency of accidental injuries at work falls (2%). Young people in the 15-24 year age group (6%) report injuries due to an accident at work more frequently, especially young men. Among older people (55-64 years), the rate of injuries due to an accident at work is higher among women.

As regards the frequency of injuries due to an accident at work during the 12 months before the interview, no difference is observed depending on the level of education in Belgium as a whole. On the other hand, fewer injuries due to an accident at work are reported in semi-urban areas (2.3%) and rural areas (2.7%) than in urban areas (4.3%), a significant difference after standardisation to take account of age and sex.

In the Walloon Region too, unlike at national level, there is no difference between men and women as regards the rate of accidental traumas at work. As is the case for the Belgian population as a whole,
however, a difference is found in Wallonia depending on the age group: the frequency is lower (0.4%) in the group of older people (55-64 years) than in the other groups.

Another particularity of the Walloon Region, compared with Belgium as a whole, is that the rate of accidents varies depending on the level of education: the rate of accidental traumas at work is higher among those with a lower secondary diploma (7.5%) than in the group with a diploma of higher education (2.5%). The difference remains significant after standardisation to take account of age and sex.

**Accidents in a school environment**

0.9% of the population of Belgium state that they have been injured in an accident at school during the 12 months prior to the survey. The percentage of the population who have been injured due to an accident at school is highest among children aged 0-14 years (2.8%) and young people aged 15-24 years (1.4%).

By focusing on school-aged children (6-11 years, 12-18 years and 19-24 years), it may be observed that 2.3% of children in the 6-24 years age group have reported having been injured accidentally at school in the year prior to the interview.

Those injured in an accident at school are more numerous among children aged 12-18 years (almost half), followed by young children aged 6-11 years (42%). Moreover, more boys (57%) than girls (43%) report having suffered an accident at school.

**Table 1: Distribution (%) of victims of accidental injuries at school, depending on age and sex, among children/young people of school age**

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Garçons</th>
<th>Filles</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-11 ans</td>
<td>16,9</td>
<td>25,4</td>
<td>42,3</td>
</tr>
<tr>
<td>12-18 ans</td>
<td>35,6</td>
<td>13,9</td>
<td>49,5</td>
</tr>
<tr>
<td>19-24 ans</td>
<td>4,9</td>
<td>3,3</td>
<td>8,2</td>
</tr>
<tr>
<td>Total</td>
<td>57,4</td>
<td>42,6</td>
<td>100,0</td>
</tr>
</tbody>
</table>

Table 1: Distribution (%) of victims of accidental injuries at school, depending on age and sex, among children/young people of school age

**Age groups**

- Boys
- Girls
- Total

**6-11 years**

**12-18 years**
Accidents at home

Three per cent of the total population of Belgium report having suffered an accident at home or while engaged in leisure activities during the 12 months prior to the survey.

This indicator does not show any significant difference between men (4%) and women (3.1%). Significantly fewer accidents are observed at home / when engaged in leisure activities among people aged 45-64 years (2%) compared with younger people (rate varies between 3% and 6%). Moreover, this rate reaches 7% among people aged 75 years and over and tends to concern women.

Falls among elderly people

As regards falls among elderly people, these occur more frequently in the Brussels Region (28%) than in the Flemish and Walloon Regions (19% in both cases). There are no regional differences (after adjustment for age and sex) with regard to the number of falls reported.

According to the 2013 health survey, one person in five (20%) aged 65 years and over – and even one person in four (26%) among the over-75s – state that they have fallen at least once in the year prior to the survey. Around one fall in ten results in a fractured hip or other serious injuries that often lead to a functional decline or even death. Recovery after a fall among elderly people often depends on their previous condition. The functional condition before the fall is therefore a decisive factor in the functional condition after the fall.
Violence

According to the 2013 health survey, 10% of the population of Belgium aged 15 years and over state that they have suffered violence (verbal, psychological, physical or sexual, or theft) during the 12 months prior to the survey.

As many men as women report having been the victim of acts of violence during the 12 months prior to the survey.

More people aged between 15 and 54 years (11 to 13%) report having suffered violence. The proportion then falls with age and concerns only 4% of elderly people aged 75 years and over. This percentage of victims among the elderly is lower than that observed in the group of younger people (12% of 15-24 year-olds) and this difference remains significant after standardisation to take account of sex.

The distribution of the percentage of victims of violence does not depend on levels of education. More residents of urban communes (11%) report having suffered acts of violence during the course of the 12 months prior to the survey than those in semi-urban communes (8%). The percentage of people aged 15 years and over who declare that they have suffered acts of violence in the past 12 months is higher in the Brussels Region (15%) and in the Walloon Region (12%) than in the Flemish Region (9%).

In the Walloon Region, the distribution of victims of violence per sex is similar to that seen at national level. Here again, age plays a role: the percentages of victims are higher among those aged between 15 and 64 years (13% to 15%), but they fall to 6% in the 65 to 74 year age group and to 2% as of 75 years. As is the case for the country as a whole, the level of education does not seem to be a discriminating factor for victims of violence. Unlike the national results, the number of victims does not vary depending on the degree of urbanisation of the place of residence. The prevalence of victims of violence in the Walloon Region remained relatively stable between 2004 (13%) and 2013 (12%).

Type of violence suffered

According to the 2013 health survey, in Belgium

- 4.2% of the population aged 15 years and older state that they have been the victim of theft, armed theft or burglary
- 7.2% of the population aged 15 years and older state that they have been the victim of verbal or psychological violence
- 2.0% of the population aged 15 years and over state that they have been the victim of physical violence during the 12 months prior to the survey.

*Place where the violence was perpetrated*

Five per cent of the population aged 15 years and over indicate that they have been the victim of violence at home, 4% in a public place or on the public highway and 1% elsewhere; 4% of the population aged 15 to 64 years have been the victim of violence at work or at school.
III. Focus on health determinants

As explained above, a person’s state of health is characterised by complex interactions between several individual, socio-environmental and economic factors.

The *Dahlgren and Whitehead*\(^{55}\) model below shows the health determinants at four interacting levels.

**Socio-economic, cultural and environmental conditions**
- Agriculture and food production
- Education
- Working environment
- Living and working conditions
- Unemployment
- Water and sanitary facilities
- Health services
- Housing
- Social and community networks

**Factors linked to personal lifestyle**
- Factors linked to sex, age and constitution

- The first level, ‘Factors linked to personal lifestyle’, concerns personal behaviour and lifestyle, influenced by the models that govern relations with those around us and the community as a whole. These relations can be favourable or unfavourable to health. Underprivileged people tend to display behaviour that is unfavourable to health more often, such as smoking, a sedentary lifestyle and/or an inadequate diet. *This behaviour is rarely due to a choice that is deliberately harmful to health but instead is determined by a series of socio-economic...*
factors: poverty and difficulty in meeting expenses, inadequate health literacy, isolation, poor self-esteem, etc.

Moreover, life skills are the aptitudes for adaptive and positive behaviour that enable individuals to cope effectively with the demands and challenges of daily life (WHO definition). In particular, they constitute a group of psychosocial and interpersonal skills that help people to take informed decisions, resolve problems, think critically and creatively, communicate effectively, establish healthy relations, show empathy and manage their lives healthily and productively.

• The second level, ‘Social and community networks’, comprises social and collective influences: the presence or lack of mutual support in difficult situations has positive or negative effects. *These social interactions and these peer pressures influence individual behaviour favourably or unfavourably. They are themselves influenced by the socio-economic context. However, acting on a collective approach can be an important lever for health policies.*

• The third level, ‘Factors linked to living and working conditions’, relates to access to work, access to essential services and facilities: water, a home, health services, food, education, but also acceptable working conditions. In this stratum, more precarious housing conditions, exposure to more dangerous and stressful working conditions, the lack of paid work or more limited access to services create differential risks for socially underprivileged individuals.

• The fourth level, ‘Socio-economic, cultural and environmental conditions’, encompasses the factors that influence society as a whole. These conditions, such as the economic situation of the country and labour market conditions, impact on all the other strata. Similarly, cultural beliefs regarding the position of women in society or deep-rooted attitudes towards minority ethnic communities can influence their standard of living and socio-economic position.

Clearly then, if it is to be effective, the Walloon Plan for prevention and health promotion will need to be based on the concept of health in all the policies and act on the risk factors at every level, adopting the approach *make the healthy choice the easy choice.*
The main risk factors

One interesting approach is to analyse the weight of diseases attributable to the main risk factors.

According to the 2015 report on the performance of the Belgian health system, 22% of Walloon men and women aged over 15 years smoke on a daily basis, 16% of Walloon men and women aged over 18 years are obese, 66% of Walloon men and women aged between 18 and 64 years do less than 30 minutes of physical activity every day and 5% of Walloon men and women aged over 15 years have at-risk alcohol consumption levels.\textsuperscript{56}

\textsuperscript{56} KCE Report 259B (2016) (p. 55)
Problems linked to nutrition and their consequences (excess weight, obesity and denutrition)

The quality of an individual’s diet is a leading determinant for chronic diseases and as such is a priority theme in the regional plan for health promotion and prevention: cardiovascular diseases, cancers, digestive and respiratory diseases, but also mental health involving in particular self-image, the influence of eating patterns on mood and sleep.

It is also a determinant for the improvement of well-being.

Diet affects everyone, regardless of age and living environment.

In Belgium in 2014, 51% of the population aged between 3 and 64 years had a BMI (Body Mass Index) considered to be normal, 29% of the population were considered to be overweight and 16% to be obese. Conversely, 4% of the population were underweight. (60)

In 6th year primary school (for the 2009-2010 school year), 24% of pupils in the French-speaking community were overweight and 10% were obese. In the Walloon Region, the proportion of overweight pupils in 6th year primary school varies between 27% in the province of Hainaut and 17% in the province of Walloon Brabant, while the proportion of obese pupils varies between 12% in the province of Hainaut and 5% in the province of Walloon Brabant. (58)

The figures below show the percentages of adults aged over 18 years who are overweight and obese. With the exception of the oldest group, the percentage of overweight and obese adults increases with age.

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57 Weight status is calculated on the basis of the body mass index (BMI). The BMI measurement is currently the method most widely used to determine whether an individual is overweight or obese. The BMI is calculated by dividing the weight in kilograms of a person by the square of their height in metres.

58 ‘The Wallonia-Brussels Federation in figures’, 2013
Percentage of the adult population who suffer from being overweight (BMI ≥ 25) per sex and per age group

![Graph showing percentage of the adult population who suffer from being overweight per sex and per age group.](image)

Source: Health Survey, Report 2: health behaviour and lifestyle, Belgium, 2013

1) overweight
   - Men
   - Women

Percentage of the adult population who suffer from obesity (BMI ≥ 30), per sex and per age group

![Graph showing percentage of the adult population who suffer from obesity per sex and per age group.](image)

Source: Health Survey, Report 2: health behaviour and lifestyle, Belgium, 2013

2) obesity
   - Men
   - Women

In terms of daily consumption of fruit and vegetables, after standardisation to take account of age, as many women (13%) as men (11%) eat the recommended daily quantity of fruit and vegetables. After
standardisation to take account of sex, the group of 55-74 year-olds (15%) is the only one to significantly exceed that of the 6-14 year age group (8%).\(^{59}\)

**Percentage of the population aged over 6 years who eat the recommended daily quantity of fruit and vegetables per sex and per age group in the Walloon Region (2013)**

![Figure 30](image_url)

**Figure 30:** Percentage of the population (aged six years and over) who eat the recommended daily quantity of fruit and vegetables (at least five portions), per sex and per age group, Health Survey, Belgium, 2013, Walloon Region

**Men**

**Women**

In the Walloon Region, the prevalence of the daily consumption of sweetened soft drinks, after standardisation to take account of age, is significantly higher among men (33%) than among women (26%). The highest percentage is seen among 15-24 year-olds (48%), but also among 25-34 year-olds (46%), where men stand out (56%). From the age of 45 years, the percentage is lower after standardisation to take account of sex (from 22% among the 45-54 year-olds to 14% among the 75 year-olds and over).\(^{60}\) The idea that water is the preferred drink and that satiety receptors detect liquid calories less easily are concepts that are not yet widely known to the general public. While the caloric content of soft drinks is starting to be known, that of alcoholic drinks (7 kcal/g of alcohol) is rarely mentioned.

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\(^{59}\) Health Survey, Report 2: Health behaviour and lifestyle, Belgium, 2013

\(^{60}\) Health Survey, Report 2: Health behaviour and lifestyle, Belgium, 2013
Almost one child in three (62%) says that they have sugary or savoury snacks every day. This percentage falls to 52% among the 15-24 year-olds and 32% among the 75 year-olds and over.

At the same time, another phenomenon that needs to be specifically dealt with is widely found among the elderly: denutrition, which we can define as a pathological state caused by a persistent imbalance between the metabolic needs of the organism and the intake and/or use of this intake, in energy and/or proteins and/or micronutrients. It may be linked to a reduction in intake or an increase in metabolic needs. It is characterised by a loss of lean body mass and often of body fat (...). It leads to measurable changes in the physiological bodily functions responsible for a worsening of disease prognoses. This is a complex, multifactor phenomenon with considerable consequences in economic and human terms. Many variables can result in denutrition: social isolation, socio-economic status, oral and dental health, deglutition disorders and diseases affecting the digestive system, lack of autonomy in acts of daily life, psychiatric and cognitive disorders. So dealing effectively with this phenomenon requires a global vision and intervention at multiple levels.
**Sedentariness**

In the Walloon Region, the percentage of the population aged 15 years and over who say that they do at least 30 minutes of physical activity (moderate or intense) per day is relatively low (31%). The percentage is twice as high among men (44%) as among women (19%).

The highest rate is among young adults (15-24 years): 46% say they do at least 30 minutes of physical activity per day, but this percentage is not significantly different (after standardisation to take account of sex) from that observed among the 25-34 year-olds (44%) and the 35-44 year-olds (36%). This percentage then falls to 10% among older people (75 years and over).

*Percentage of the population (aged 15 years and over) who do sufficient physical activity to have a positive impact on their health by age and by sex.*

Source: Health Survey, Report 2: Health behaviour and lifestyle, Belgium, 2013

*Figure 10: Percentage of the population (aged 15 years and over) who do sufficient physical activity to have a positive impact on health, per age group and per sex. Health Survey, Belgium, 2013, Walloon Region.*
**Tobacco consumption**

Tobacco consumption is a major cause of morbidity and mortality. If they do not give up, half of smokers will die from a disease caused by smoking. Of these people, some die young: a quarter of these smokers will die between the ages of 35 and 69 years. However, this mortality is not a fatality, even among those who have been smoking for a long time: by stopping at the age of 50 years, a smoker reduces this risk of death by half. It is eliminated almost entirely by stopping at the age of 30 years\(^6\). According to the health survey by interview, in 2013 among the population aged 15 years and over, "the largest relative number of smokers (25%) and daily smokers (21.5%) was found in the Walloon Region. Among non-smokers, 20% are ex-smokers and 55% have never smoked". In Wallonia, daily smokers smoke on average 16 cigarettes per day.

The figure below shows the percentage of the population aged 15 years and over who smoke daily per region and per year.

*Percentage of the population (aged 15 years and over) who smoke daily, per region and per year*

![Percentage of the population (aged 15 years and over) who smoke daily, per region and per year](image)

Source: Health Survey, Report 2: Health behaviour and lifestyle, Belgium, 2013

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Even if it is higher than in the rest of the country, the percentage of heavy smokers (over 20 cigarettes per day) is also falling in Wallonia over time, dropping from 12% of the population in 2004 to 8% in 2013. As in the rest of the country, one daily smoker in ten has a serious nicotine addiction, that is they smoke over 20 cigarettes per day and have their first cigarette within half an hour of waking up. The survey also shows that the average age at which an individual smokes the first cigarette is 16 years but that regular smoking is found on average at the age of 18 years.

According to a FARES analysis (fund for respiratory disorders) based on the data from the health survey by interview, “in this sample, the share of women who smoke daily is lower than that of men, but it is falling more slowly, resulting in a closing of the gap between these proportions. In fact, in 1997, 31.2% of men were daily smokers, compared with 19.7% of women, a difference of 11.5 percentage points. In 2013, 21.6% of men and 16.4% of women were daily smokers, a difference reduced to 5.2 percentage points.” In addition, the lower the level of their diploma, the more likely people are to smoke. “The difference between the heaviest smokers (individuals with a diploma of lower secondary education) and lighter smokers (individuals with a diploma of higher education) is not falling, passing from 12.0 percentage points in 1997 to 16.0 percentage points in 2008 and then dropping back to 14.2 percentage points in 2013.”
### Trend in the consumption of tobacco in Belgium

**Table 2** | Évolution des indicateurs concernant la consommation de tabac

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Fume actuellement</td>
<td>30,3</td>
<td>28,6</td>
<td>27,6</td>
<td>24,5</td>
<td>23,0</td>
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<tr>
<td>Fume quotidienment</td>
<td>25,5</td>
<td>24,1</td>
<td>23,7</td>
<td>20,5</td>
<td>18,9</td>
</tr>
<tr>
<td>Fume 20 ou plus cigarettes/jour (grands fumeurs)</td>
<td>10,5</td>
<td>9,7</td>
<td>10,1</td>
<td>7,4</td>
<td>6,5</td>
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<tr>
<td>Ne fume plus (ex-fumeur)</td>
<td>24,1</td>
<td>30,6</td>
<td>19,9</td>
<td>21,8</td>
<td>21,3</td>
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<td>N’a jamais fumé (plus de 100 cigarettes dans sa vie)</td>
<td>45,6</td>
<td>40,8</td>
<td>52,5</td>
<td>53,7</td>
<td>55,8</td>
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<td>A déjà fumé quotidienment pendant plus d’un an</td>
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<td></td>
<td></td>
<td>41,1</td>
<td>39,0</td>
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</tr>
</thead>
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<tr>
<td>Fume actuellement</td>
<td>32,2</td>
<td>31,2</td>
<td>26,5</td>
<td>24,9</td>
<td>21,8</td>
</tr>
<tr>
<td>Fume quotidienment</td>
<td>24,9</td>
<td>24,6</td>
<td>22,9</td>
<td>18,7</td>
<td>17,2</td>
</tr>
<tr>
<td>Fume 20 ou plus cigarettes/jour (grands fumeurs)</td>
<td>7,2</td>
<td>5,4</td>
<td>6,1</td>
<td>4,7</td>
<td>4,1</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Averages in the Population of Smokers Aged 15 and Over:</th>
<th></th>
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<tbody>
<tr>
<td>Age moyen à la première cigarette fumée entièrement</td>
<td></td>
<td></td>
<td></td>
<td>16,2</td>
<td></td>
</tr>
<tr>
<td>Age moyen au début du tabagisme régulier</td>
<td></td>
<td>17,5</td>
<td>17,4</td>
<td>18,1</td>
<td></td>
</tr>
<tr>
<td>Nombre moyen d’années de tabagisme quotidien</td>
<td></td>
<td></td>
<td>20,7</td>
<td>21,3</td>
<td></td>
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<td>Pourcentage de fumeurs quotidiens de 15 ans et plus qui…</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Présente une (très) forte dépendance tabagique</td>
<td></td>
<td></td>
<td>13,9</td>
<td>11,2</td>
<td>9,5</td>
</tr>
<tr>
<td>A déjà tenté d’arrêter de fumer</td>
<td></td>
<td></td>
<td></td>
<td>68,4</td>
<td>71,4</td>
</tr>
</tbody>
</table>

Source: Health Survey, Report 2: Health behaviour and lifestyle, Belgium, 2013

Table 2 Trend in indicators concerning the consumption of tobacco

- Percentage of the population aged 15 years and over who:
  - currently smoke
  - smoke daily
  - smoke 20 cigarettes or more/day (heavy smokers)
  - no longer smoke (ex-smokers)
  - have never smoked (no more than 100 cigarettes in their life)
  - at one time smoked daily for more than one year

- Percentage of young people aged 15 to 24 years who:
  - currently smoke
  - smoke daily
  - smoke 20 cigarettes or more/day (heavy smokers)

- Averages of the population of smokers aged 15 years and over:
  - Average age when smoke first whole cigarette
  - Average age when smoking starts regularly
  - Average number of years of daily smoking
  - Percentage of daily smokers aged 15 years and over who:
    - have a serious nicotine addition
    - have already tried to stop smoking.
Tobacco consumption has followed a downward trend over the past three decades. However, the problem remains concerning, in particular among the group of 15-24 year-olds, because in 2013, 19% were still smoking in Wallonia and 22% in the rest of the country.

According to the HBSC survey (2014) conducted in secondary schools in French-speaking Belgium, 9% of adolescents say that they use tobacco daily. This percentage is admittedly falling compared with the data gathered in 1998 and in 2010. However, these data should be analysed with caution since, as the authors point out, this fall “could be partly explained by a change in the formulation of the question on experimenting with smoking, which precedes that on the frequency of current tobacco consumption”. The proportion of young people who say that they smoke tobacco daily increases as their school career advances, without any distinction in terms of sex. Finally, one secondary school pupil in five has reportedly already used an electronic cigarette.

**Alcohol consumption**

The data resulting from the survey by interview (2013) show that in Wallonia, in 2013, in the population aged 15 years and over, 82% had had at least one alcoholic drink in the 12 months prior to the survey; 35% had drunk alcohol weekly but not daily while 16% had drunk daily. The 51% of Walloons who drink weekly have on average 11 glasses per week.

Table No 8 below shows the situation at national level.

**Table No 8: alcohol consumption among those aged 15 years and over**
**Table 1: Trend in indicators concerning the consumption of alcohol**

<table>
<thead>
<tr>
<th>Percentage of the population aged 15 years and over who:</th>
<th>1997</th>
<th>2001</th>
<th>2004</th>
<th>2008</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>have drunk alcohol in the last 12 months</td>
<td>84.1</td>
<td>80.5</td>
<td>84.2</td>
<td>80.4</td>
<td>81.8</td>
</tr>
<tr>
<td>drink alcohol every day</td>
<td>7.7</td>
<td>9.6</td>
<td>9.2</td>
<td>12.0</td>
<td>14.2</td>
</tr>
<tr>
<td>present a sur-consommation (F&gt;14 v/s; M&gt;21 v/s)*</td>
<td>7.0</td>
<td>9.3</td>
<td>9.0</td>
<td>7.9</td>
<td>6.4</td>
</tr>
<tr>
<td>s’adonne à une hyper-alcoolisation hebdomadaire**</td>
<td>8.1</td>
<td>8.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a consommé 6 verres d’alcool en 2h ces 12 derniers mois</td>
<td></td>
<td></td>
<td>4.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a déjà présenté une consommation problématique</td>
<td>6.6</td>
<td>7.8</td>
<td>10.2</td>
<td>10.5</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of weekly alcohol drinkers who:</th>
<th>12.0</th>
<th>16.1</th>
<th>14.4</th>
<th>13.5</th>
<th>12.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>drink too much alcohol (W&gt;14 g/w; M&gt;21 g/w)*</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>indulge in binge drinking on a weekly basis**</td>
<td></td>
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<tr>
<td>have drunk 6 glasses of alcohol in 2h in the last 12 months</td>
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<tr>
<td>have already shown signs of problem consumption</td>
<td></td>
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</tbody>
</table>

* Excess consumption is defined (WHO) as over 14 glasses of drinks containing alcohol per week (g/w) for women and 21 glasses per week (g/w) for men.

**Binge drinking refers to the consumption of 6 or more alcoholic drinks on one occasion.


Again according to the health survey by interview, in 2013 the percentage of weekly drinkers in Wallonia who drank too much (more than 14 glasses for women and 21 glasses for men according to the WHO recommendations) stood at 15%, compared with 14% to 15% between 2001 and 2008. Eight percent of the population displayed weekly excess alcohol consumption (consumption of six alcoholic drinks or more on one occasion). This number has not increased compared with 2008.

Finally, 5% of the population of Belgium had at least one episode of ‘binge drinking’ (consumption of six alcoholic drinks in two hours) during the past 12 months. Binge drinking is increasing among young people aged between 15 to 24 years: from 12% in 2008, it rose to 14% in 2013. Twenty-nine percent
of young Walloons are said to have already displayed this type of behaviour compared with 15% of young Dutch speakers and 5% of young people in Brussels.

In Belgium, men display more at-risk behaviour than women as regards excess alcohol consumption (13% of men and 4% women) and binge drinking (9% of men and 1% of women).

Weekly excessive alcohol consumption is observed among both men and women, in all age groups, as can be seen from table No 9.

*Table: Health behaviour per age group and per sex*

<table>
<thead>
<tr>
<th>Tableau 2.6: Comportements de santé par groupe d’âge et par sexe</th>
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<tbody>
<tr>
<td><strong>Proportion de la population wallonne de 15 ans et plus (en %)</strong></td>
</tr>
<tr>
<td><strong>15-24</strong></td>
</tr>
<tr>
<td>Hommes: qui mange au moins un fruit par jour</td>
</tr>
<tr>
<td>Femmes: qui mange au moins un fruit par jour</td>
</tr>
<tr>
<td>Hommes: qui déclare pratiquer des activités physiques dans leurs loisirs</td>
</tr>
<tr>
<td>Femmes: qui déclare pratiquer des activités physiques dans leurs loisirs</td>
</tr>
<tr>
<td>Hommes: qui fume quotidiennement</td>
</tr>
<tr>
<td>Femmes: qui fume quotidiennement</td>
</tr>
<tr>
<td>Hommes: avec une surconsommation hebdomadaire d’alcool</td>
</tr>
<tr>
<td>Femmes: avec une surconsommation hebdomadaire d’alcool</td>
</tr>
</tbody>
</table>

Source: IWEPS, “The key figures of Wallonia”, No 14, 2015

Table 2.6 Health behaviour per age group and per sex

Source: National Health Survey, ISP – HISIA calculations

Note: 1. 15 glasses and more for women, 22 glasses and more for men
Proportion of the Walloon population aged 15 years and over (in %)
who eat at least one portion of fruit per day
who say they do physical activities in their leisure time
who smoke daily
who drink too much alcohol weekly
Men
Women
Wallonia
Belgium

Other drugs

In 2013, the prevalence of the use of cannabis during an individual’s lifetime (experimenting with the substance at least once during the course of their life) was 15% in the Walloon population aged between 15 and 64 years. It is more marked in the 25-34 year age group (32%) and among 15-24 year-olds (21%). The prevalence of current usage (at least once during the past 30 days) was 4% in Wallonia.

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in 2013. However, it concerns mainly 15-24 year-olds (8%) as well as 25-34 year-olds (7%). **Daily (or almost daily) use of cannabis** reportedly concerns **0.7%** of the Walloon population aged between **15 and 64 years**.

The regular consumption of cannabis could not only worsen mental health problems such as depression and psychotic disorders, but also accelerate their onset. In addition, cannabis is carcinogenic. Smoking cannabis regularly is therefore harmful to health and this harmfulness is increased by the concomitant consumption of tobacco. Among young people, it is also a cause of dropping out of school. Occasional consumption increases the risk of accident when driving a vehicle.63,64

According to the health survey by interview, in 2013 the **prevalence of use during an individual’s lifetime of an illicit drug other than cannabis** was **2.6%** among the Walloon population aged 15 to 64 years (5.6% in Brussels). The age group most concerned was **25-34 years (7.8%)**.

The prevalence of the use of **legal highs** (new synthetic drugs) during an individual’s life amounts to approximately 8% for Belgian respondents (+ 4% compared with 2011). In January 2010, a total of 170 websites sold certain predefined legal high drugs. This figure increased to 314 in January 2011, then 693 in January 2012 and **651 in 2013** (EMCDDA).

As regards treatment demands (TDI – treatment demand indicator):

- **Patients treated for a problem of alcohol or drug consumption are mainly male and of Belgian nationality.**

- A substantial proportion of requests come from individuals with little or no schooling and without employment, without stable housing in the 30 days prior to the demand for treatment: **social precarity, which often leads to social exclusion, still affects a great many users treated in the specialised Walloon centres.**

- **The substances most frequently behind treatment demands** recorded in the period 2011-2014 are **opiates** (43% in Wallonia) and **alcohol** (30% in Wallonia). Demands relating to cocaine (including crack) are mentioned by around one individual requesting treatment in 10 (10% in Wallonia). Cannabis is behind a treatment demand in Wallonia in **14%** of cases.

- **The average age at which the substance behind the demand is first taken is approximately 19 years in Wallonia.** Almost 21% of individuals requesting treatment stated that they had

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64 http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/cannabis.aspx
used injections in Wallonia. Finally, almost 50% of patients submitted the treatment demand on their own initiative in Wallonia. Demands coming from the courts are far more frequent in Wallonia (15%) than in Brussels (3%).
C. Transversal and themed approaches

Further to the transfer of competence, Wallonia has an opportunity to redefine the prevention and health promotion landscape and establish a new preventive system in the field of health. This Plan is intended as the cornerstone of this process.

The purpose of the Plan is to contribute towards improving the health of everyone in Wallonia. To this end, health will be considered to be a complete state of physical, mental and social well-being, rather than consisting solely of a lack of disease or infirmity. This Plan needs to strive to ensure that the men and women of Wallonia can benefit from this right as fairly as possible.

To do this, on the one hand the Plan defines the transversal strategic objectives applicable to all the health priorities. These objectives are essential to ensure the quality and effectiveness of health promotion and thus face current health challenges.

On the other hand, the Plan sets themed strategic objectives based on the epidemiological data set out above.

I. Transversal strategic objectives

1) To promote health in all policies (HIAP)

The HIAP concept advocated by the WHO consists of thinking about the implications of all policies, of whatever kind, for health. The Plan focuses mainly on the fields for which Wallonia has levers for action. For the other fields, cooperation protocols will have to be concluded with the other levels of power. However, health cannot be fully promoted without the assistance of other sectors, in particular the following: social action, environment, housing, justice, education, employment, mobility, spatial planning and sustainable development. Wallonia therefore has a responsibility to be proactive in decompartmentalising the sectors, regardless of the competent level of power, and to take the lead in terms of health promotion.

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65 Preamble adopted by the International Health Conference, New York, 19-22 June 1946
The health promotion policy needs to combine different but complementary approaches: legislative, financial, fiscal and organisational in particular. This coordinated action must lead to health, financial and social policies that favour greater fairness.

This policy presupposes identifying the obstacles that stand in the way of adopting policies that are favourable to health in non-health sectors and the means to overcome these obstacles. The aim is to ensure that the easiest choice for those in charge of these policies is also the best choice from the point of view of health. The systematic evaluation of the effects on health (EIS) of a rapidly evolving environment – in particular in the fields of technology, work, energy and urbanisation – is essential and must be followed by an action guaranteeing that these effects on public health will be positive. Protecting natural environments and built-up areas, as well as conserving natural resources, must be taken into account in any health promotion strategy.

In this respect, the Walloon Government wishes to follow the example of Finland, where integrated evaluations including health are required in all legislative proposals. Under the Plan, the promotion of well-being and health and the reduction in inequalities will be taken into account in all social decision-making processes and integrated into the activities of all administrative or ministerial sectors.

2) To adapt the strategies to deal with the social inequalities of health

The inequalities in the field of health reflect the economic and social fractures of the society. As economic pressures worsen and the cost of health care increases, the risk of exclusion grows, often leaving by the wayside those whose health needs are greatest. Among inequalities, those relating to health seem particularly unfair as they contribute to suffering, diseases that occur earlier, are more serious, with more negative consequences. They kill on a large scale without attracting much attention while the evolution of scientific knowledge and technologies enable considerable progress.66

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66 According to the research results of the National Mortality database, in Belgium too, the risks of death for men and women depend on the level of education, professional status and quality of housing. The life expectancy of a 25-year-old man without a diploma is 5.5 years less than that of a man of the same age with a diploma of higher education, long cycle. IN Bossuyt N, Gadeyne S, Deboosere P, Van Oyen H. Socio-economic inequalities in health expectancy in Belgium. Public Health 2004; 118: 310.
Income variances in Wallonia.\textsuperscript{67}

The Walloon Government is firmly resolved to enable everyone to access their full health potential, irrespective of their social position, their origin and their personal characteristics. This approach is in line with the 2030 sustainable development objective “\textit{leave no one behind}” for vulnerable groups in society (children, the disabled, refugees, those in a precarious situation).

First and foremost, it is a matter of giving everyone the same opportunity to develop and maintain a good state of health and the maximum capacity to lead a life of satisfactory quality.

3) To promote accessibility and ensure good territorial cover in prevention and health promotion

Alongside the fight against social inequalities in terms of health which makes it possible, among other things, to improve financial accessibility, it is also important to ensure good territorial coverage as regards programmes for prevention and health promotion by guaranteeing everyone the same access to health care.

In addition, the difficulties of access to prevention include the uneven geographic density of the supply of health care and transport that is unsuitable to offset the distances involved.

The programmes developed will have to ensure that the Walloon territory is covered, while also avoiding any overlapping of activities.

4) To ensure the efficiency of the actions and introduce a culture of constant evaluation

Given the current budgetary context and the variety of players involved in prevention and health promotion, the resources available must be used as efficiently as possible. Consequently, it is important to ensure the quality of the actions, projects and programmes developed in this area. The quality is underpinned by an *a priori* examination of the actions, projects and programmes based on carefully defined criteria (diagnosis of needs and criteria for action).

The evaluation requirement that accompanies the financing must be continued throughout the project in order to contribute towards creating quality assurance to the extent that this information is useful to orient, improve or reorient the actions taken by operators. The evaluation process from the design of the project to its implementation constitutes a base for project quality assurance.

It is also important to ensure integrated promotion: no redundancy, no gaps and everyone where they are most competent.

To evaluate well, it is advisable beforehand to:
- set objectives based on identified needs, make the difference between the operational objectives for which project leaders are responsible and others (those that are influenced by the context);
- define the criteria to undertake the project, the desirable criteria for the project/action: for example, feasibility, participation, durability, etc. (quality process);
- identify the financial and human resources required.

These elements will also make it possible to monitor the action/project: continuously check – for example by means of a simple dashboard - that the project is running according to plan.

The evaluation will be participatory as far as is possible, which will be all the easier when the planning has been likewise.

To meet the needs of the population, relevant interventions that have proven their effectiveness must be proposed. Evidence Based Public Health (EBPH) is defined as taking account of scientific proof of the effectiveness and feasibility of an intervention given the economic, political and social constraints and the preferences of the community68.

Consequently, in Wallonia, the management and analysis of objective health data that are relevant for the action must take practical shape in an integrated health data collection and processing system. Taking account of the methods of gathering and processing existing data, a reliable and protected data system needs to be put in place that will underpin decision-making and undertake monitoring, reporting and evaluation, including new approaches for collecting health data in order to constantly improve the health of the men and women of Wallonia. Specific data collections, undertaken at variable intervals (constantly, annually, every two or four years, etc.) make it possible to follow developments over time and provide additional sources of information alongside the so-called routine data (consumption of health care and services) or administrative data, which can justify the development of relevant actions and programmes in education, prevention and health promotion69. To be useful, the collection of new data must meet very stringent standards requiring an appropriate budget.

Alongside this ongoing evaluation, specialised health promotion bodies provide support for operators by circulating tools and practices in line with the predefined health promotion context. This information is useful to anticipate the proper design of the health promotion project. Bodies that straddle the world of research and the world of professional practice can facilitate the transfer of

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69 Regionalisation of health promotion: from the Wallonia-Brussels Federation to Wallonia and Brussels, Higher Council for Health Promotion, June 2015, Health Education Review.
scientific knowledge and practices to mark out the field of action for operators on the ground in accordance with the institutional and political context of the Walloon Region.

5) To integrate health priorities into a life-course approach

The presentation of this Plan takes the form of a ‘life-course approach’. This approach is advocated in particular by the Minsk Declaration in the context of the WHO Europe health goals for 2020. This choice is justified by the top priority for WHO Europe, ‘Investing in health by adopting a perspective that covers the entire lifespan and increasing the responsibility of the populations’.

This approach makes it possible to connect detailed targets based on age groups in the various priority themes adopted. “Children who are given a good start in life learn better and have more productive lives. Adults in control of their lives have a greater capacity for economic and social participation as well as a better aptitude to live healthily. Elderly people in good health can make an active contribution to society”70.

The Minsk Declaration states that a ‘life course’ process is based on the interaction between multiple factors of promotion, protection and risk throughout the life of the individual. The health of individuals and of generations is seen from a temporal and social perspective, including intergenerational health determinants. The declaration would like all public authorities to adopt this perspective. This ‘life course’ theory suggests understanding human development in the light of the intentionality of individuals as well as on the basis of the social and historical contexts in which they evolve. 71

This involves adopting coherent policies that target human life as a whole, at all ages and regarding all generations, rather than simply dealing with specific needs and diseases at narrowly defined stages of life. It truly is a global and integrated approach.

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6) To integrate health priorities into an approach in line with a continuum

The ‘care course’ approach sees strategic reflection from the point of view of a health promotion/disease prevention/curative care and risk reduction/revalidation (support)/palliative care continuum.

The care course should consist of organising overall and ongoing care for patients and users as close as possible to their homes. It necessitates an evolution in our health system, which is historically centred on treatment, towards more complete care for individuals. A course is defined as the global trajectory of patients and users in their health territory, focusing attention in particular on individuals and their choices. It requires coordinated action by those involved in health promotion and in preventive and curative, medico-social and social care. Moreover, the place of the participation of patients themselves, irrespective of their age, and of their relatives is now recognised as being vitally important.

The ultimate aims of the ‘course’ approach can be summarised in the following sentence: to ensure that a population receives the right care from the right professionals in the right structures at the right time and at the best cost, making sure that the person is firmly anchored in their own environment and that the user and their relatives are involved in the care.

More specifically, the challenge is to articulate preventive medicine and health promotion. Strategies must be developed on the one hand with first-line participants and the out-patient sector and on the other hand with all those involved in the determinants of overall health, upstream and downstream of health issues, not forgetting players in other areas of the patient’s life who are concerned by the problem of health.

This requires a combined approach: at the individual level of each patient, at the collective level (patients/relatives, service providers, others) and as regards the environments.

At the individual level, the therapeutic education of the patient is part of (secondary) prevention, but cannot be limited to that. It must, however, be identified as a discipline in itself.

In order to develop this approach specifically, synergies will be created between different sectors, for instance first-line care, mental health, hospital, rest homes, disabled people, etc.

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7) To reinforce community action (bottom-up) and promote citizens’ participation and empowerment

“Community action refers to all initiatives taken by people, community groups, a community (geographic, local, regional, national; interest, identity), aimed at providing a collective, mutually supportive solution to a social problem or a common need. Community action takes multiple and diverse forms (creation of resources and services, social transformations, popular education, etc.) which pursue objectives of social justice, solidarity, democracy, a fairer distribution of wealth, equality between men and women and among peoples. These actions are undertaken with a view to education and democratic processes in order to promote the autonomy of people and communities (empowerment)73. Applied to health, it is built through dialogue and horizontal (among peers), vertical (between social strata, professional categories or age groups) and lasting solidarity (taking account of preceding or future generations)74. Having collectively pinpointed the health problems (a diagnosis), it relies on community participation. In fact, if social and health problems are collective, they require collective solutions.

The basic premise is that each stakeholder holds part of the explanation of the problems observed, their causes, possible solutions and possible curbs, and participation in the definition of the framework for interventions and the actual implementation of actions contributes towards guaranteeing appropriation by these same stakeholders and hence their success.

The main challenge is to bring about a realisation that everyone, as a player, is responsible for the balance of the mechanism put in place.

During this community action, it is important that all the players take part: citizens, professionals (health and other sectors), the institutions (public and private) and the public authorities.

This action is built on the basis of a partnership that involves the various players and sectors while cultivating confidence at every level and among everyone involved75.

74 Community action for health, a practical tool, Fédération des maisons médicales Santé Communauté Participation (SACOPAR) Centre local de promotion de la santé de Charleroi-Thuin (CLPSCT), December 2013.
75 Idem.
The first challenge is to bring about a realisation that everyone, as a player, is responsible for the balance of the mechanism put in place. The main challenge is to ensure that everyone feels capable of mobilising their expertise (technical, but above all experience) to contribute towards finding and implementing solutions, promotional actions. At the individual level, this competence involves health literacy: the possibility of mobilising resources to make the best possible use of the information available and the possible dialogue with the professionals. This vision applies, of course, in patient/nursing staff links, but also between partner service providers in a truly multidisciplinary and horizontal but not hierarchical approach. This dialogue must, of course, lie within the scope of the responsibilities defined by the law for each profession.

Empowerment consists of giving everyone the capacity to contribute towards decisions in the field of their own health and that of community action.

In fact, the citizen is a fully fledged player in the field of health promotion. This is why his participation in actions, projects and programmes relating to health priorities and actions [?] on the determinants is essential. To facilitate citizens’ access to health services and care, it is important to involve them in the process of defining, devising and assessing health needs. The participation mechanisms at local level or in the institutions are useful tools for the implementation of this involvement.
8) To develop networking and the intersectoral partnership

The global approach to health promotion, taking account of the complexity of the realities, notably institutional and political, involves creating consultation methods between various sectors such as health, education, the economy, etc. Intersectorality promotes decompartmentalisation, the expansion of the frame of reference, the pooling of diversified resources, the coordination of actions taken in different sectors and the circulation of coherent messages\(^{76}\).

There are various means of promoting this consultation:

- working as a network;
- accentuating the intersectoral partnership and alliances between public services and associations at local level;
- strengthening consultation at the various levels of authority and representation: communes, regions, federated and federal entities, stressing the synergies to be put in place to pursue coherent policies with a favourable impact on people’s health\(^{77}\).

Networking is set to develop, but operational know-how is becoming necessary (conditions to be met, methods, tools, etc.) to ensure that it is effective.

9) To create environments that are favourable to health (living environments)

It is important to take account not only of the care but also of a series of social determinates that contribute towards both prevention and the restoration of well-being. Living environments come down to the people who live there, their daily surroundings and the social and affective dynamics in which they are immersed. These living environments are always singular: they relate to the way in which the people experiment with their daily lives. The living environment is the social reality experienced within which specific health problems emerge and are formulated.

We are thinking here, among other things, outside the family home, of child-care facilities, schools, workplaces, accommodation, and leisure facilities.

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\(^{76}\) Cf. note 33.
\(^{77}\) Idem.
To place health promotion in a long-term perspective

Long-term health is a concept that remains relatively little developed. All the characteristics of prevention and health promotion naturally prompt us to see them in a context of sustainable development.

An analysis grid can be used to cross the components of sustainable development with those of the various elements of the health system. This makes it possible to redefine the framework of all the actions planned on the basis of the three recommended pillars of sustainable development (social/societal, economic and environmental), and in line with the various components of the health system (mainly prevention/promotion, care and support) in a matrix that can be used to create coherence in health policies and check whether, for each intervention, the various dimensions are taken into account.

Sustainable health matrix:

<table>
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<tr>
<th></th>
<th>Social/societal</th>
<th>Economic</th>
<th>Environmental</th>
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<tbody>
<tr>
<td>Prevention/promotion</td>
<td>E.g.: social aspects of intervention 1 (such as participation, reduction of ISS)</td>
<td>E.g.: economic aspects: cost optimisation, reduction in the share of the poorest patients, etc.</td>
<td>E.g.: environmental aspects</td>
</tr>
<tr>
<td>Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
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In addition, a series of 17 sustainable development targets has been adopted by the countries of the United Nations and taken over by the WHO in the context of the new sustainable development programme to eradicate poverty, protect the planet and guarantee prosperity for all.
To promote innovation at the service of health

Innovation initiates a potential change. It is constructed by the social environment and the questioning of practices. It must be considered in the light of the political policy. The field of health advocates this innovation which, in fine, will benefit the improvement of the health of the Walloon population. Innovation can thus be understood as a new response to a problem or a need identified with a view to improving the health of the population concerned.

Innovative projects have to meet a number of criteria, in particular that of providing a response to needs, being in line with certain values and ranking among priority problems. It is the combination of several factors that lends a project its innovative character. However, innovative projects need to be properly framed and evaluated.

It is difficult to establish actions that relate to health promotion effectively on the ground. This is why innovative projects can constitute added value for the practical implementation of measures with an impact on the health of the population. The aim is to lend importance to innovative projects, from various points of view:

- Scientific: scientific research can still lead to many advances of benefit to health, such as the development of new farming techniques that improve the nutritional quality of the product or the development of new specific and sensitive screening tests, etc.

- Social: social innovation is described by the UNIPSO association of social-profit organisations as "all innovative and original initiatives that provide a new response to the basic needs of the population, emerging or inadequately met, in terms of education, social action, culture and employment. These initiatives are taken on a territorial basis and in collaboration with local players (users, public authorities, businesses, etc.). They may be technological or non-technological, concern a product, a service or improve the operationalisation of existing social-profit projects by means of a new process (working practice, organisational method, etc.) provided that they reinforce its social aim. This innovation is social as regards its activity, its process and its aim. Finally, it is also transformationist as it prompts the behavioural changes needed to take on the big social challenges".78

• technological: use of information and communication technologies (ICT) through e-health, social networks or technological applications, etc.

• territorial: innovation can be associated with a territory for the projects that advocate sustainable development and the preservation of living conditions, for example, which improves the quality of life and increases the well-being of the inhabitants.

• Today, a project is relevant compared with current issues when it also works with a view to the future.
II. Themed strategic objectives:

The priority focuses of action in public health for Wallonia were chosen on the basis of the importance of the health issue (prevalence/incidence), its severity (in terms of mortality/morbidity), the possibilities of eradicating or reducing it by prevention and health promotion.

Five themed strategic axes were adopted:

1. The promotion of lifestyles beneficial to health:
   - promotion of a healthy diet
   - physical activity
   - the fight against sedentariness
   - the fight against smoking.
   The objective is to reduce risk factors common to several priority health issues such as obesity, cancer, vascular diseases and type 2 diabetes.

2. The promotion of good mental health and general well-being which also includes confidence, self-esteem and the development of life skills:
   - education in affective and sexual life (EVRAS)
   - the prevention of the addictive use of alcohol and other psychoactive substances
   - the prevention of suicide
   - prevention of violence and emerging health issues;

3. The prevention of chronic diseases. As has already been explained, the definition of chronic diseases put forward by the WHO is fairly broad and there is no consensus about its definition and the list of diseases to be included in the register (cf. page 34). However, in the context of this Plan, the three most frequent, most serious chronic pathologies for which preventive action is possible have been selected. These are:
   - vascular diseases
   - type 2 diabetes
   - respiratory diseases
   - cancers.

4. The prevention of infectious diseases:
   - their primary prevention (vaccination when recommended)
5. The prevention of accidents and the promotion of safety:
   - falls among elderly people.

Other health topics may be added to this list over time, depending on emerging public health issues.

This Plan is to be deployed in the long term, until 2030.

The explanatory sheets set out below clarify each topic adopted. In each case, they contain summarised observations, impact on health and well-being and the general objective pursued.

They are not intended to be exhaustive and each topic will be reviewed in depth when the second part of the plan is drafted with the definition of measurable general and specific objectives, operational objectives and actions.
1) Promotion of lifestyles and living conditions beneficial to health

Food axis, including excessive alcohol consumption, physical activity and sedentariness

- Diet and physical activity are major determinants in several diseases: obesity, cardiac and cerebrovascular diseases, cancers, digestive and respiratory diseases as well as mental health, in particular self image, sleep. They are also decisive for the improvement of well-being.
- The WHO recommends at least 30 minutes of moderate physical activity per day for adults and 60 minutes for young people.
- Physical activity is essential at the various stages of life: in young children, it contributes in particular not only to the development of their bodies, but also to the way they situate themselves and are able to enter into relationships. In young people and adults, it contributes to the construction of self image, maintaining the energy and corpulence balance, mental health, the prevention of chronic diseases and cancer. In elderly people, it helps maintain their autonomy (capacity to move around and reduction in falls) and reduce the risk of cognitive disorders.
- Sedentariness and in particular spending excessively long periods sitting down is also harmful to health at all ages: phenomenon of carrycots/sleep/life for young children, seated activities at school, computer-based work or leisure activities, television as the sole leisure activity for those living alone, etc. The excessive use of screens is substantially increasing the problems of sedentariness.
### Observations

<table>
<thead>
<tr>
<th>There are too many obese or overweight people, linked to socio-economic inequalities:</th>
<th>Daily consumption of sugary soft drinks:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population of Wallonia: 50% are overweight or obese</td>
<td>15 to 34 years: over 45%</td>
</tr>
<tr>
<td>Walloon pupils in 6th year primary school who are overweight or obese</td>
<td>Daily consumption of sweet or savoury snacks:</td>
</tr>
<tr>
<td>Hainaut: 39%</td>
<td>Children: 62%</td>
</tr>
<tr>
<td>Walloon Brabant: 21%</td>
<td>15 to 24 years: 52%</td>
</tr>
<tr>
<td>75 years and over: 32%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A minority of the Walloon population do sufficient physical activity (at least 30 minutes per day) to protect their health:</th>
<th>A minority eat the recommended five portions of fruit and vegetables per day:</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 years and over:</td>
<td>Children aged 6 to 14 years:</td>
</tr>
<tr>
<td>Men: 44%</td>
<td>Girls: over 10%</td>
</tr>
<tr>
<td>Women: 19%</td>
<td>Boys: under 10%</td>
</tr>
<tr>
<td>75 years and over: 10%</td>
<td>Adults:</td>
</tr>
<tr>
<td>15 to 74 years: less than 20%</td>
<td></td>
</tr>
<tr>
<td>75 and over: less than 10%</td>
<td></td>
</tr>
</tbody>
</table>

### Impact on health and well-being

<table>
<thead>
<tr>
<th>Mortality in 2013:</th>
<th>Alteration of self image</th>
</tr>
</thead>
<tbody>
<tr>
<td>Circulatory system:</td>
<td>Mood disorders</td>
</tr>
<tr>
<td>Men 30.1% and Women 26.4%</td>
<td>Sleep disorders</td>
</tr>
<tr>
<td>Malignant tumours:</td>
<td>Sedentariness</td>
</tr>
<tr>
<td>Men 21.1% and Women 27.4%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Morbidity in 2013:</th>
<th>Maintaining the autonomy of elderly people</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Wallonia, 107,968 people were treated for diabetes in 2013</td>
<td>Corporal and relational development of young people</td>
</tr>
<tr>
<td>The lack of physical activity is said to be responsible for 3% of DALYs (Disability Adjusted Life Years – the sum of the years of life lost before the age of 65 or years of life in poor health)</td>
<td>Maintaining the energy balance and corpulence</td>
</tr>
</tbody>
</table>

### General objectives

- To improve behaviour beneficial to health with regard to diet in the entire Walloon population
- To stabilise and then reduce the number of people suffering from obesity and excess weight, with a particular focus on children
- To reduce the prevalence of denutrition, in particular among the elderly
- To increase regular physical activity among children and adults
Fight against smoking

✓ Smoking is falling in the general population but it has increased significantly among women: their mortality due to lung cancer is rising steadily. In addition, smoking (active and passive) increases the risk of breast cancer.

✓ Passive smoking is particularly harmful for children. They breathe in substances that are more harmful for them than for adults. In addition, passive smoking increases the risks of sudden infant death, slow intrauterine growth and miscarriages.

✓ Passive smoking increases the risk of certain cancers such as lung cancer, breast cancer and brain tumours.

Observations

<table>
<thead>
<tr>
<th>25% of people in Wallonia smoke:</th>
<th>The percentage of heavy smokers (over 20 cigarettes per day) is falling overall: from 12% of the population in 2004 to 8% in 2013.</th>
</tr>
</thead>
<tbody>
<tr>
<td>22% daily smokers</td>
<td>In Wallonia, the more educated the population, the less they smoke:</td>
</tr>
<tr>
<td>3% occasional smokers</td>
<td>- 25% of people with at best a primary school diploma smoke</td>
</tr>
<tr>
<td></td>
<td>- 13% of people with a diploma of higher education</td>
</tr>
<tr>
<td></td>
<td>Among those with the lowest income, twice as many people smoke as among those with the highest income (34% compared with 17%).</td>
</tr>
</tbody>
</table>

Impact on health and well-being

| Smoking is a major cause of cancer, respiratory diseases and cardiac or cerebrovascular diseases. | If they do not stop smoking, half of tobacco users will die further to a disease due to smoking. One quarter of these persistent smokers will die between the ages of 35 and 69 years. BUT stopping smoking at the age of 50 reduces this risk by two and stopping at the age of 30 eliminates it almost entirely. |

General objective

- To reduce the proportion of smokers in the general population
2) Promotion of mental health

Promotion of well-being and good mental health

- According to the WHO, "mental well-being is an essential component of the definition of health".
- "Good mental health enables individuals to be fulfilled, to overcome the normal tensions of life, to perform productive work and contribute to the life of their community."
- However, good mental health is not a static state: it is a balance that can fluctuate over the course of a lifetime depending on internal events (illness, for instance) and external events (social relations, economic situation and environment in the broad sense).
- Mental health, like physical health, is the foundation of an individual’s well-being and the proper functioning of a community.
- Promoting good mental health and preventing mental health disorders is also a way of preventing other problems such as suicide and the harmful use of psychoactive substances.

Observations:

<table>
<thead>
<tr>
<th>In Wallonia, 35% of the population experience psychological difficulties</th>
<th>Depressive disorders among the adult population:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men → 13%</td>
<td>Women → 20%</td>
</tr>
<tr>
<td>Anxiety disorders among the adult population:</td>
<td></td>
</tr>
<tr>
<td>Men → 9%</td>
<td>Women → 14%</td>
</tr>
<tr>
<td>Graduates: 10%</td>
<td>Less well educated: 15%</td>
</tr>
<tr>
<td>Psychological disorders (mainly depression) among the over 65s: 50%</td>
<td></td>
</tr>
</tbody>
</table>

| In the Walloon Region, 35% of women and 27% of men experience problems sleeping. Among women aged 15 to 44 years, the prevalence of sleep disorders is around 31 to 32%, but it approaches 38 to 40% from the age of 45. Eating disorders are frequent and concern women more often than men (13% and 9% respectively). |

Impact on health and well-being

Mental health disorders are linked to a higher risk of physical problems (although the relationship between the two is not always properly understood). They are also linked to a reduction of several years in life expectancy.

General objective

- To promote well-being and prevent mental disorders
Prevention of the abuse of alcohol and other psychoactive substances, cannabis, heroine, psychotropic substances, etc.

- **Alcohol**
  Alcohol is the drug most commonly taken in Belgium and the one with the highest social cost, whether it is drunk additively, chronically or occasionally.

- **The other psychoactive substances also involve risks for physical or mental health that vary depending on the substance**

- **Polyconsumption**
  The consumption of several substances will increase the risks of each substance: for example, alcohol will increase the effects of other drugs, in particular the risks of a fatal overdose.

- **Addiction**
  Addiction, characterised by a daily need for the product and a loss of control over its consumption, will aggravate all the risks linked to the consumption of the substance concerned.

Observations:

| Alcohol is unquestionably the psychoactive substance most consumed and which causes the most damage: - death linked to alcohol among the under-65s:  ➔ 5% of premature deaths among women  ➔ 7% of premature deaths among men. | In Belgium, **82% of the population aged 15 years and over have consumed alcoholic drinks in the previous 12 months.**  
5% of the population have already experienced an episode of binge drinking (consumption of six alcoholic drinks in two hours, in search of the effect) over the past 12 months. This behaviour is more common among young people, as 14% of 15 to 24 year-olds have already experienced such an episode in the past 12 months. |
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In Wallonia, the use of cannabis is usually experimental or occasional: ➔ of the 15% of Walloons who had already taken cannabis in 2013, 60% did not take any more in the previous year. In 2013, 4% of Walloons had taken cannabis in the past 30 days.</td>
<td>Some people take it every day, or almost, and are at risk of addiction: among those who have taken cannabis in the past 30 days, 18% have taken it on at least 20 days. Among frequent users, the socio-educational gradient is very high: significantly more of those with a primary school diploma at most take cannabis almost daily.</td>
</tr>
<tr>
<td>As regards the other psychoactive substances such as heroin, cocaine, amphetamines, ecstasy or other similar substances ➔ 3% of Walloons have already taken them during their life and 0.4% in the past 30 days.</td>
<td>Impact on health and well-being</td>
</tr>
<tr>
<td>The chronic use of <strong>alcohol</strong> is a risk factor in many health problems: cancers, neurological, vascular and digestive pathologies.</td>
<td>In addition, the occasional use of alcohol increases the risk of road accidents or certain acts (aggression, suicide, unwanted and/or unprotected sexual relations). Substantial and daily alcohol consumption can lead to addiction which is particularly serious and difficult to treat.</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>The <strong>other psychoactive substances</strong> also involve risks for physical or mental health which vary depending on the substance: cannabis is carcinogenic and can aggravate certain mental disorders; the consumption of benzodiazepines leads to rapid addiction in a few months that is difficult to fight; the consumption of heroin or cocaine involves a high risk of a fatal overdose, the transmission of serious infections and addiction; the new synthetic drugs are also linked to fatal overdoses.</td>
<td>The consumption of one of these psychoactive substances entails an increased risk of an accident when driving a vehicle.</td>
</tr>
</tbody>
</table>

**General objectives**

- To reduce the harmful use of alcohol in the population as a whole
- To reduce the harmful use of psychoactive substances in the targeted populations, such as cannabis, unwarranted psychotropic substances, etc.
Prevention of suicide

✓ As the WHO points out, "there are effective strategies and interventions to prevent suicide."
✓ Again according to the WHO, "mental disorders (depression, personality disorders, dependence on alcohol or schizophrenia, for example), certain physical diseases such as neurological disorders, cancer and HIV are suicide risk factors."
✓ Promoting good mental health and preventing the use of psychoactive substances are among the actions aimed at preventing suicide.

Observations:

<table>
<thead>
<tr>
<th>In Wallonia, 3% of deaths are due to suicide among men and 1% among women.</th>
<th>Suicide is the leading non-natural cause of death before the age of 65: 7% of premature deaths among women and 10% among men.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Among Walloons aged 25 to 44 years, suicide is the leading cause of mortality among men and the second cause among women.</td>
<td>6% of Walloons are reported to have attempted suicide during the course of their life.</td>
</tr>
<tr>
<td>In 2013, the mortality rate by suicide in Wallonia was 20 deaths per 100,000 inhabitants.</td>
<td>This rate has been falling in Wallonia since the 1990s but remains substantially higher than the average in Belgium, Europe or the neighbouring countries.</td>
</tr>
</tbody>
</table>

Impact on health and well-being

There is no denying that mental health and therefore more broadly the well-being of the individual impacts on acts of suicide.

General objective

- To reduce the number of deaths by suicide per year and to reduce the number of attempted suicides
3) Prevention of chronic diseases

- Chronic diseases are long-term disorders that usually develop slowly (WHO).
- Fighting four major risk factors: smoking, alcohol, inadequate diet and sedentariness, can prevent numerous chronic diseases. Actions need to be focused on health promotion, prevention and early screening.
- To fight chronic diseases effectively, a horizontal integrated approach should be adopted that includes all the levels concerned.
- The social and environmental determinants also play a major role in the development of chronic diseases. There is a real inequality in the weight of these diseases and in prevention and control.
- Chronic diseases affect different age groups, adults and elderly people, rarely children, and the risk of chronic disease increases with age.
- There is no consensus about the list of diseases to be included in the register. In the context of this Plan, the three most frequently occurring, most serious chronic pathologies for which means of action via prevention are possible were chosen. These are **vascular diseases, type 2 diabetes and respiratory diseases**.
- People rarely suffer from a single chronic disease and in fact accumulate multimorbidities.
**Diseases of the circulatory system, type 2 diabetes and respiratory diseases**

<table>
<thead>
<tr>
<th>Observations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular diseases are the leading cause of mortality in Wallonia and respiratory diseases are the third cause.</strong></td>
<td>The prevalence of chronic diseases has been increasing since the epidemiological transition (reduction in mortality due to infectious diseases and increase in morbidity) and the demographic transition (ageing of the population and fall in the birth rate). This increase in prevalence also means a development in the healthcare system with the introduction of treatments that improve survival and the organisation of early screening programmes that improve life expectancy.</td>
</tr>
<tr>
<td>The percentage of people suffering from a chronic disease increases with age. It rises from 10% among young people aged 15 to 24 years to almost half (50%) of the population of elderly people aged 75 years and over.</td>
<td>The relative share of deaths due to cardiovascular diseases has fallen by one third in 25 years while that of deaths due to respiratory diseases has increased.</td>
</tr>
<tr>
<td>Diseases of the circulatory system are the second cause of premature deaths among women (14% of premature deaths) and the third cause among men (18% of premature deaths). In both sexes, the first cause of death in this category is ischemic cardiomyopathy (4% of premature deaths among women and 8% among men).</td>
<td>In terms of years of life lost (YLL), that is the number of life expectancy years lost owing to premature death, ischemic cardiomyopathy ranked first between 1990 and 2013.</td>
</tr>
<tr>
<td>One adult (aged between 20 and 79 years) in 16 suffers from diabetes. However, the prevalence of diabetes is under-estimated as the ISP estimates that one-third of patients suffering from type 2 diabetes in Belgium are unaware of the fact (Belgium -2014). When the level and control of glycaemia are not optimal, diabetes causes many other complications, such as nephropathies, neuropathies and retinopathies, and can also lead to infarction and CVAs.</td>
<td>In Wallonia (2013), 107,968 people are having treatment for diabetes. Out of a total population of 3,563,060 (1 January 2013), this represents approximately 3% of the population.</td>
</tr>
</tbody>
</table>
## Impact on health and well-being

As regards the patient, the consequences are in particular a decline in the quality of life, increased healthcare costs, impoverishment linked to the reduction in or lack of professional income, stress, dependence on those around them, etc.

### General objectives of primary prevention

- The actions taken in the context of the promotion of lifestyles and environments favourable to health enable primary prevention of chronic diseases: these are actions involving diet, physical activity, the fight against smoking and the harmful use of alcohol.

### General objectives of early screening programmes for chronic diseases

- To reduce mortality due to chronic diseases in Wallonia
- To improve the quality of life of people suffering from chronic diseases in Wallonia and reduce the complications (tertiary prevention).
### Prevention of cancer

<table>
<thead>
<tr>
<th>Observations</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancers are the second cause of mortality in Wallonia.</strong></td>
<td>Among children aged 1 to 14 years, malignant tumours account for 20% of deaths and constitute the second cause of mortality after non-natural causes (out of 76 deaths in 2013)</td>
</tr>
<tr>
<td><strong>Among adults aged 25-44 years, the main natural causes of death are malignant tumours which account for 18% of the causes of death (out of 1,012 deaths in Wallonia in 2013)</strong></td>
<td>Among those aged 45-64 years, the main causes of death are malignant tumours (39% of deaths or just over one-third of tumours of the respiratory system (out of 6,020 deaths in Wallonia in 2013)</td>
</tr>
<tr>
<td><strong>Malignant tumours constitute the main cause of death among those aged 65 to 79 years (i.e. 34% of deaths)</strong></td>
<td>In terms of years of life lost (YLL), that is the number of life expectancy years lost owing to a premature death, lung cancer ranked second between 1990 and 2013.</td>
</tr>
<tr>
<td><strong>In 2014, the cancer register recorded 23,459 new cancer diagnoses in Wallonia: 12,119 among men and 11,340 among women.</strong></td>
<td>On the basis of the 2014 figures, 36% of men and 31% of women will suffer from cancer before the age of 75 years.</td>
</tr>
<tr>
<td><strong>Cancer usually increases with age. It mainly affects those aged over 60 years and the new cases most frequently diagnosed in Wallonia are, in order, among men, prostate cancer, lung cancer and colon cancer and among women, breast cancer, lung cancer and colon cancer.</strong></td>
<td>On the other hand, the five-year survival rate among those having suffered cancer has risen sharply in the past few years, which means that for many patients, cancer has become a chronic disease.</td>
</tr>
</tbody>
</table>

### Impact on health and well-being

As regards the invalid, the consequences are in particular a decline in the quality of life, increased healthcare costs, impoverishment linked to the reduction in or lack of professional income, stress, dependence on those around them, etc.

### General objective of primary prevention aiming to reduce the probability of developing cancer

The actions taken in the context of the promotion of lifestyles and environments favourable to health enable primary prevention of chronic diseases: these are actions involving diet, physical activity, the fight against smoking and the harmful use of alcohol as well as the fight against exposure to toxic products and products recognised as being carcinogenic by the IARC. So as with the prevention of respiratory diseases and prevention in the field of mental health, this is where environmental health actions are taken.
To reduce exposure to risk factors, both in individual behaviour and in the environment in the broad sense.

<table>
<thead>
<tr>
<th>General objectives of early screening programmes in the context of the fight against cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening makes possible the presumed identification of a cancer or precancerous lesions by means of tests, examinations or other reliable methods that can be applied quickly. Certain types of cancer can be screened for in a population group that does not yet display any symptoms. This is the case, in particular, for breast, colon and cervical cancer. Detecting cancer at an early stage of its development considerably increases the chances of successful treatment. This relies on screening, but also on educating patients in early diagnosis and ‘warning signs’.</td>
</tr>
<tr>
<td>- To reduce mortality due to cancer in Wallonia</td>
</tr>
<tr>
<td>- To improve the quality of life of people suffering from cancer in Wallonia and to lessen the complications and lighten the treatment by promoting early screening.</td>
</tr>
</tbody>
</table>
4) Prevention of infectious diseases including the vaccination policy

- Infectious diseases can be transmitted in a variety of ways: either directly (from the invalid to the recipient, through the air, sexually, from hand to hand, through the blood) or indirectly (by vectors: animals, insects or media: water, food, soil, etc.) or from mother to child.
- The prevention of infectious diseases by vaccination makes it possible to avoid the apparition of certain infectious diseases which may sometimes have serious complications. There are two reasons for vaccination: protection of the individual and protection of the community. In fact, all vaccination usually prevents individuals from contracting the disease, but also ensures that they do not pass it on to others.

<table>
<thead>
<tr>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Belgium in 2015, <strong>1,001 new cases of HIV</strong> were reported, 14% of whom give their place of residence as Wallonia.</td>
</tr>
<tr>
<td><strong>Increase in the number of cases of certain STDs:</strong> Chlamydia (most frequent in Wallonia): 2002: 163 cases; 2014: 946 cases Gonorrhoea: 2002: 37 cases; 2015: 162 cases Syphilis: 2002:21 cases; 2015: 95 cases</td>
</tr>
<tr>
<td>Nine young people out of ten say that they used a method of protection the first time they had sexual intercourse. Some risk situations for the transmission of HIV remain unknown.</td>
</tr>
<tr>
<td><strong>Tuberculosis is following a downward trend</strong> in Belgium and remains a low-frequency disease. It is still found in large towns and cities and among specific population groups.</td>
</tr>
<tr>
<td>While the trend in controlling infectious diseases that can be prevented by vaccination is improving, certain pathologies such as whooping cough are still found in the population and among the most vulnerable groups.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact on health and well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious diseases can lead to hospitalisation or prolonged absences from work for the patient or his family. Sexually transmitted diseases such as HIV and pathologies such as tuberculosis can engender stigmatisation and rejection. Ignorance in the field of STD leads to risky sexual behaviour, with long-term consequences in the event of HIV infection (lifelong treatment, side effects)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To limit the health risks linked to sexual relations</td>
</tr>
<tr>
<td>- To promote vaccination among the population and specific target groups</td>
</tr>
</tbody>
</table>
- To reduce the health risks linked to infectious diseases and control the spread of these diseases with a view to eradicating them
- To promote better knowledge of infectious diseases
5) Prevention of unintentional traumas and the promotion of safety

Looking at prevention from the point of view of traumas multiplies the intervention strategies by going beyond those that are limited to the identification of persons at risk and the modification of their behaviour. Prevention is thus expanded to modifying the physical environment, legislation and technologies likely to influence the severity of traumas. From this point of view, it is vital to establish consultation between the sectors concerned. Almost three-quarters of the non-natural causes of death are accidents. Moreover, falls constitute a major challenge given the ageing of the population.

Observations:

According to the 2013 health survey, 7% of the population of Belgium say that they have been the victim of an accident requiring medical attention in the 12 months prior to the survey.

In 56% of cases, the accident victims had to be admitted to hospital or another care establishment. This percentage is higher among less educated people (78%) than among those having benefited from higher education (48%).

More men (8%) than women (6%) suffered an accident requiring medical attention. The risk is also higher among young people aged 15 to 24 years (10%) and the elderly aged 75 years and over (9%).

More accidents depending on the type of activities at each stage of life:
- School (6 to 11 years)
- Leisure (15 to 34 years)
- Traffic (25 to 34 years)
- Home (75 years and over)

Non-natural causes of death:
- Among children aged 1 to 14 years: the main cause of death. Of these, almost three-quarters are accidents (of which almost half are road traffic accidents). (Wallonia – 2013)
- Among the 15-24 year-olds: 66% of deaths, most of which are due to road traffic accidents (81%). (Wallonia - 2013)
- Among adults aged 25 to 44 years: 43% of the causes of death (one-quarter due to road traffic accidents). (Wallonia - 2013)
Over the 12-month period prior to the survey, 1% of the population reports having been injured in a road accident, 2% say they have been injured in an accident at home, 2% in an accident during leisure activities, 3% in an accident at work and 1% in an accident at school.

In the 2013 health survey, one person in five (20%) aged 65 years and over – and even one person in four (26%) among the over-75s – say they have fallen at least once during the year prior to the survey.

<table>
<thead>
<tr>
<th>Impact on health and well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact of falls on elderly people:</td>
</tr>
<tr>
<td>Approximately one fall in ten results in a hip fracture or other serious injuries that lead to a functional decline or even death. Recovery after a fall in elderly people often depends on their previous state. The functional condition before the fall is therefore a decisive factor in the functional condition after the fall.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To reduce the mortality, morbidity and severity of trauma</td>
</tr>
<tr>
<td>- To reduce the proportion of the population aged over 65 years who suffer a fall during the year</td>
</tr>
<tr>
<td>- To reduce the proportion of the general population who have an accident (irrespective of its origin) requiring treatment.</td>
</tr>
</tbody>
</table>
D. Actions for Wallonia: operationalisation and implementation of the Plan

During the course of 2017, the various themed strategic axes will be broken down in operational terms in order to be converted into concrete actions, specific targets expressed in figures, follow-up indicators, placed on a time line with a specific allocated budget.

During the operationalisation of the Plan, the next steps will provide:

- **targets expressed in figures for each theme**, staggered on the basis of scientific recommendations;

- **analysis of all stakeholders** for each theme. To do this, the following roles should be identified and clearly defined:
  
  - the various sectors concerned
  - the policy and competent level of power
  - the administration (approvals, observatory, AViQ strategic committee, committees of experts)
  - professionals in health promotion and first-line care
  - beneficiaries and players in living environments (home, MR/MRS, etc.)
  - local authorities and associations;
  - other resources: universities, observatories, local authorities, various services, etc.

- **the definition of the actions to be taken to achieve new objectives**
- **budgets**
- **time planning**
- **the definition of follow-up indicators**.

This set will constitute the second part of the plan which will be put forward to the government at the end of 2017.
At the same time, a decree organising the prevention and health promotion sector is to be drafted and will define the roles and missions of the various players who will be involved in the implementation of this plan.

As regards the management of this plan, this will involve various levels:

- a steering committee consisting of the various offices and administrations concerned, chaired by the Minister responsible for health
- it will be possible to convene groups of experts on an ad hoc basis
- a specific management team, within AViQ, will be given the task of supervising the implementation of the various actions in the plan, the communication of the plan, the administrative and budget follow-up for health competences, ongoing assessment
- it will be possible to set up platforms to organise interactions of the plan with territorial dynamics and consultation with operators in the commercial sector.