Institute of Health and Society IRSS
Institut de Recherche Santé et Société

ACTIVITIES REPORT (2017-2018)
Acknowledgements

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It is a pleasure to present to you the 2017-2018 Activities Report of the Institute of Health and Society (IRSS), an Institute addressing the complex character of health in both individuals and the population, by targeting a number of themes ranging from health economics and international health, to health services research and primary health care.

Each year, Belgians and citizens across the world are confronted with unsettling health diagnoses, either for themselves, or for a relative or friend. Such a diagnosis can be a case of bad luck, yet for a large number of cases, the health problem may have been avoided. Indeed, disease prevention and health promotion are key to improve overall health status of society, where each stakeholder plays a role within a complex system; researchers informs policymakers, whom determine the policy agenda for society and the health system, while individuals are influenced by this system, their environment, their position in society (the circumstances in which people grow, live, work, and age), and their personal health choices. Thus, healthcare systems are inherently complex, consisting of multiple interdependent processes that adapt to changes in the environment and behave in a multifaceted manner. A strong understanding of the entire health system is crucial for achieving health goals at both the societal and individual levels. IRSS members embrace this complexity, considering interactions between people, health determinants (including health systems) and the environment, in their research goals.

The report focusses on a number of societal utilities, such as well-being, quality of life, health-for-all, integrated care, healthcare organisation, optimising patient care, and setting the right priorities. Notably, IRSS holds a unique position, not only within UCLouvain but also within Belgium, allowing us to address these societal utilities, as our members master the analytical tools that allow for a deeper exploration of the intricacies of ill health stemming from a complex set of interacting determinants. These emerging insights allow for evidence-based solutions for healthcare organizations and systems to advance the health of society.

The richness of our Institute lies in diversity, and the multi-levelled manner in which we aspire to achieve this. Firstly, we aim to address diversity in health outcomes and methods. IRSS members have demonstrated expertise in using an array of analytical tools, both qualitative and quantitative, to examine and understand diversity at the health level. Yet, diversity in health is not only a result of complex interactions between determinants, but also results from the ways in which individuals move within the society. Our work at
IRSS influences health policies by providing intersectoral and multidisciplinary investigations, which serve to translate pure clinical outcomes into meaningful solutions for policymakers. Secondly, IRSS embodies diversity in thought, thus respecting the various perspectives of its members in how to approach a health problem. Indeed, IRSS members use such diversity to provide multidisciplinary and data-driven insights to policymakers and the society as a whole.

As with all maturing institutes, IRSS is experiencing crucial changes requiring its members to reflect on how to optimize collaborations, both at a professional and personal level. Such a transformative period may seem daunting at times; however, these challenges are also an opportunity for the Institute to grow. It is in the daily interactions that we can seize each moment to embrace diversity amongst us - be it in terms of age, title, gender, or race. The common wish of all staff members at IRSS is to construct an institute with a positive atmosphere in which each person speaks openly and respectfully. I am therefore confident that the Institute will rise to this challenge by harnessing the wide and rich variety of ideas we all hold. Just as we use diversity to understand health, we can use our own diversity to understand each other.

While growing and maturing, IRSS has never ceased to demonstrate scientific excellence while producing meaningful output, summarized in this report. Such achievements reinforce IRSS’s role in the field of health and society, both in Belgium and abroad. Many bright and eager spirits have joined us in the past two years, which will contribute to the further success of our Institute. IRSS has the sincere ambition to provide them, and all members, a warm, welcoming and inspiring environment to develop their skills for the advancement of health in society.

Reaching scientific excellence is only possible with the full contribution of all. I would like to express my gratitude for the ongoing hard work and dedication of the IRSS staff (scientists, academics and administrative support) in reinforcing the leading role of the Institute in the field of health and societal research.

Niko Speybroeck
President, Institute of Health and Society UCLouvain
Mission and Vision of IRSS

The Research Institute of Health and Society (IRSS) offers multidisciplinary research, targeted at improving both quality of life and health of individuals and the population.

Created in 2010, IRSS has been inspired by the definition of health issued by the World Health Organization: «Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity»

This definition includes physical, mental and social dimensions of health - both in the individual and the general population. The general objective of the Institute is - to develop research activities that envisage improved understanding and measurement of the several dimensions of health, as well as the complex interactions of these dimensions in the individual and the population.

Key-values

- Health is a fundamental right of every human being
- Health is a global concern calling for research surpassing local and national boundaries
- Health research requires the highest principles of scientific conduct, requiring lifelong learning leading to discovery and innovation
IRSS in brief

Scientific ambitions

- Develop an interdisciplinary environment conducive for the generation of top-level academic output
- Achieve relevant results that are useful for society
- Encourage scientific excellence
- Recruit high-level researchers

Research Axes

- Biomedical law and ethics
- Health promotion and therapeutic education
- Epidemiology, socio-epidemiology and biostatistics
- Health services research
  - Mental health system research and psychiatry
  - Primary health care and general medicine
  - Health systems and social networks
- Pedagogy and medical education
- International health
- Ageing
- Health economics
IRSS in numbers

The team*

- **Academic staff**: 35
  (26 ‘affected’ and 9 ‘affiliated’)

- **Scientific Staff**: 54
  (including 26 PhD candidates)

- **Technical and administrative staff**: 17

- **Registered PhD candidates**: 44
  (doctoral school)

- **PhD theses defended**: 64
  theses defended since 2010 of which 12 in the last two years

* As of February, 28 2019
Research activities and funding

Research projects
30

Publications

During the last two years, the Institute has published 293 publications, from which 72% were in international peer- and non-peer-reviewed journals.

Histograms of the number of publications (2010 – 2018) – according to Impact Factor (IF) 1048 articles published in scientific journals from which 850 have an impact factor.

Number of grants by donor (%), 2017-2018

- Fédération Wallonie-Bruxelles: 40%
- FNRS & associated funds: 17%
- Private fundings: 13%
- Regions: 13%
- Federal resources: 17%

Distribution of the budget granted and signed in 2017-2018, by source of fundings (%)

- Fédération Wallonie-Bruxelles: 31%
- FNRS & associated funds: 3%
- Private fundings: 35%
- Regions: 16%
- Federal resources: 4%

Distribution by type of publication, 2017-2018 (%)

- Journal article: 72%
- Conference Paper: 16%
- Dissertation: 5%
- Book: 1%
- Book chapter: 4%

* As of February, 28 2019
Retrospective:
10 Key Dates in the life of IRSS

2010

June 18 / Inauguration of IRSS.

2011

September 29 / CRIV Colloquium: Working day aiming to bring together researchers from different institutes and universities interested in multidisciplinary approaches in the field of aging and its relationship with health.

2012

October 21 / Cycl'IRSS participated in the 24h biking of Louvain-la-Neuve.

2013

November 28 / Second special day for doctoral students, Woluwé (Brussels).

2014

Retrospective:
10 Key Dates in the life of IRSS

2015

March 20 / Doctor Honoris Causa Award attributed to Prof. Johan Mackenbach (physician, professor, and Chairman of the Department of Public Health at the Erasmus University Medical Centre in Rotterdam) by the public health faculty and the Institute for his work on health inequalities.

2016

September 1 / New president of the Institute, Professor Niko Speybroeck.

2017

March 29 / The Institute and Faculty participated together in the Alma 10Km.

2018

October 1 / Dr. Angel Rosas receives the mandate of postdoctoral researcher from FNRS. November 13 / Doctoral day in public health organized on the campus of Sart-Tilman (Liege), in the prestigious setting of the Château de Colonster.
Setting Priorities: Impact of Health Problems
[coordinated by Niko Speybroeck]
More than just the presence/absence of specific health problems, disease burden encompasses a comprehensive quantification of the physical and psychosocial health impact of diseases, conditions, and risk factors. Summary measures of health, such as the Disability-Adjusted Life Year (DALY), have become key metrics for quantifying disease burden (See Box 1). With ageing populations and the growing importance of non-fatal diseases, evidence-based public health policy requires a global overview of population health to set the agenda for public health research and policy priorities.

IRSS has been at the forefront of developing tools to quantify disease burden. It has participated in an international initiative by the WHO Foodborne Disease Burden Epidemiology Reference Group, providing the first estimates of the global burden of foodborne diseases. IRSS also contributed to estimating disability weights, a crucial component of DALY estimations. Furthermore, IRSS scientists developed the zDALY, an indicator allowing the estimation of zoonotic disease burden, hereby highlighting animal-related losses in the many human diseases originating in animals.

In Belgium, the increasing demand for summary measures of population health to support policy development has resulted in new projects, such as the Belgian Burden of Disease Study (see Box 2). IRSS plays an important role in these newly initiated activities. In 2018, IRSS published the first in-depth analysis of Belgian health status trends, comparing Belgium with other countries. IRSS was already the first group to quantify Belgium disease burden of haemophilia, melanoma, and specific congenital and foodborne infections.

**BOX 1 / DISABILITY-ADJUSTED LIFE YEARS (DALYS)** combine mortality (years of life lost from premature death) and morbidity (years of life lived with disability) into a single indicator, permitting a comparative ranking of the burden of various diseases, injuries and risk factors. DALYs measure the health gap, using a life lived in perfect health as baseline, by quantifying it as the number of potentially healthy life years lost due to morbidity, disability and mortality. For example, a disease burden of 100 DALYs per 1000 people-years would imply a yearly loss of 100 healthy life years per 1000 people. Diseases accounting for more DALYs have a higher population health impact.

**BOX 2 / WHAT ARE THE MOST IMPORTANT DISEASES IN BELGIUM?**
Which risk factors contribute most to the disease burden? How is the burden of disease evolving over time, and how does it compare with neighbouring countries? In the context of increasing budgetary constraints, a precise answer to these questions is required to inform policy-making. To respond to this need, the Belgian Institute for Health (Sciensano) has initiated a national burden of disease study, which will generate consistent disease burden estimates.
DALYs and other measures give an indication of the importance of a health problem today; yet these problems are always shifting, and it is therefore essential to try and understand the temporal, as well as spatial, trends. By regularly updating DALY estimates, population health can be monitored and the impact of macro-level policies can be evaluated. IRSS has gained an international reputation by monitoring the impact of disasters on health (see Box 3 & 4).

The need to improve the (lack of) bias and precision of data for DALY estimations encouraged IRSS to work on the optimization of routine data collection. In countries like Peru, the most cost-effective malaria surveillance system is being developed, with the aim to measure progress towards eliminating malaria. IRSS is involved in monitoring adverse drug reactions and resistance to antimalarial drugs in Uganda and the Democratic Republic of the Congo, respectively. In Belgium, IRSS was one of the first to collect information on “post-treatment Lyme disease syndrome”, clarifying some of the controversies surrounding Lyme borreliosis. At the European level, IRSS plays a crucial role in quantifying foodborne health problems, in cooperation with the European Food Safety Authority. In order to improve the rigour of its estimations, advanced Bayesian approaches are used, as illustrated by our work on malaria and mortality during humanitarian crises (see box 3).

BOX 3 / THE CENTRE FOR RESEARCH ON THE EPIDEMIOLOGY OF DISASTERS (CRED) specializes in epidemiological studies exploring the public health impact of natural disasters and conflict on populations. It uses data from the EMDAT Disaster database, which spans 118 years and covers 184 countries, to publish articles and inform research on ways in which natural disasters impact human populations. Patterns of injuries from earthquakes or severe malnutrition, and disease outbreaks following floods reveal important risk factors which help design public health prevention and preparedness programmes. The Centre also works on war-related mortality, developing new methods for estimating death tolls and cause-of-death, such as Bayesian techniques or Lot Quality assurance Sampling. Data and publications can be downloaded from www.cred.be.
IRSS understands that the importance of computing disease burden by subpopulation (e.g. socioeconomic groups) can result in a more detailed perspective on population health. For example, research on HIV in Africa\textsuperscript{14} has led to the quantification of socioeconomic health inequalities, but also to a better understanding of inequalities themselves. Moreover, estimating the disease burden in specific subgroups may pave the way for changes in the organisation of the health care system. For example, research on the number of children treated for complex chronic conditions in the Brussels region, led to advocacy for better access to palliative and respite care services in Belgium.

**BOX 4 / THE IMPACT OF DISASTERS ON HEALTH SYSTEMS.** CRED has conducted several studies recently on the impact of disasters on hospitals and their patient load. A study in the Philippines has looked at the impact of Typhoon Haiyan on two local hospitals. A first published paper assessed how the typhoon influenced the pattern of admissions in these hospitals\textsuperscript{15}. One of our findings was that women were more affected than men, and in particular women giving birth. This is particularly worrisome, as it implies that women give birth under suboptimal conditions. Within another substudy, interviews were conducted with hospital staff, to identify barriers for providing care\textsuperscript{16}. One of the main findings was that (medical) staff find it difficult to focus on their work, while they and their families are at the same victims of the event. Furthermore, CRED carried out a study on hospital admissions due to heatwaves in the Netherlands\textsuperscript{17}. People were mostly admitted because of respiratory and heat-related diseases, in particular the elderly. Also, the impact in terms of admissions of one day with severe heat was comparable to three days of moderate heat, which has important implications for heat-health warning systems. CRED is currently involved in assessing the impact of the 2015 Nepal Earthquake on a tertiary hospital, which is the PhD thesis topic of one of their researchers (Maria Moitinho de Almeida).
Health, Well-being, and Quality of Life
(coordinated by William d’Hoore)
According to the Universal Declaration of Human Rights, “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family…” (Art. 25).

Actualizing this right is not a simple task. Health and well-being are influenced by a wide range of factors and their interactions, including age, gender, genes, local environment, lifestyle, social networks, working conditions, and access to quality healthcare, among others. The complex range of influences on health means that many different interventions and approaches are needed. Consider the struggle against smoking, for example; factors can range from decisions about taxation (tobacco), public spending (education, health promotion) and legislation at a national level (smoking ban), all the way down to the actions of individuals and the support given to each other within their communities. Another example (Box 1) makes the case for sex workers, a group likely to suffer poor well-being due to working conditions, stigma and exclusion.

To realize the fundamental ‘right to health’ for everyone, it is necessary not only to understand the main determinants of health and well-being of the population, but also of the social and economic environment in which health policy or programs are developed and implemented. This is, broadly outlined, the scope of IRSS research in relation to health and well-being.

Simply stated, population health is the health outcomes of a defined group of people, as well as the distribution of health outcomes within the group. While health status can be measured objectively (see the chapter about setting priorities), well-being resists the objectivism definition. Instead, each individual is entitled to define their well-being in their own way. Therefore, a first step before designing interventions to improve well-being is to understand the meaning and dimension of well-being.

BOX 1 / FEMALE SEX WORKERS (SW) FACE A DISPROPORTIONATELY LARGE BURDEN OF SEXUALLY TRANSMITTED INFECTIONS (STIS), INCLUDING HIV. Sex workers are also often exposed to physical and sexual violence, commonly have limited use of health-care services, and face social stigma and marginalization. Structural determinants (contextual factors external to the individual) of SW health and well-being has begun to receive increased attention. In particular, the presence of laws that criminalize buying and selling sex results in unsafe work environments, exacerbating stigma and poverty. This research, in the form of a PhD thesis, aims to understand how local SW policies in six Belgian towns (1) shape SW practices and working conditions, (2) influence SW well-being through the interplay of vulnerabilities, and (3) prompt SW reactions directed to legislative changes and emancipation (Julie Gysen).
sions of well-being. This may have major implications for physician-patient relationships and for therapeutic education. Implications for research include the opportunity to develop specific, as opposed to generic, questionnaires to assess quality of life in specific groups.

For example, in a contribution to research about quality of life in patients with inherited ichthyosis, researchers used qualitative methods to elicit perceptions on factors influencing quality of life. While some factors were identified that negatively affect quality of life (e.g., fear of intimate relationships), some factors positively influenced quality of life (e.g., coping strategies and development of self-efficacy). These findings open perspectives to help the patient “become the same, yet different person” (i.e., supporting patient autonomy).

In the same line of patient autonomy support, the Service universitaire de Promotion de la santé (IRSS/RESO) in partnership with Promo Santé et Médecine générale (asbl) issued a literature review on what is known about and how to implement shared decision-making in general practice.

The era of chronic disease brought quality of life issues to the forefront: when a disease cannot be cured, other facets of patient experience must be used to assess quality and relevance of (health) care. Hence, the term “health-related quality of life” was coined. For example, elderly people were most likely to endure chronic disease, and thus, received much attention from IRSS researchers. An IRSS team developed a typology of case-management interventions using mixed methods based on the observation of 22 projects. Realist evaluation was performed to account

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**BOX 2 / CARING FOR FRAIL OLDER PERSONS AT HOME REPRESENTS A HIGH RISK OF BURDEN FOR INFORMAL CAREGIVERS, PARTICULARLY IN CASES OF DEMENTIA.** Burden is defined as the physical, psychological, emotional, social and financial consequences experienced by caregivers, potentially altering their quality of life. In a cohort study of 79 older spousal caregivers, we tested the hypothesis that the sense of coherence (SOC), a concept proposed by Antonovsky to explain why some people remain healthy in spite of stressful life situations, is associated with lower perceived burden. SOC consists of understanding life events, the ability to manage them, and feeling that life events are meaningful. We observed that a high sense of coherence is associated with a lower caregiver burden. So, addressing factors that support health and well-being, rather than factors that cause disease, could help practitioners in developing empowering dialogues to reinforce caregiver coping strategies (Florence Potier).
for the fact that “case management programs occur in complex and heterogeneous, multi-layered contexts in which they are embedded and with which they interact”. A set of tools were developed to distinguish between types of case management interventions and to evaluate various outputs and outcomes, including quality of life of frail older people. Furthermore, patients are not cared for by healthcare professionals only. Hence, promoting patient well-being also requires understanding the circumstances of and resources needed by informal caregivers. Box 2 illustrates characteristics of patient relatives, which are associated with health in spite of stressful life situations.

Quality of life may also benefit from proper modelling of disease risk, another important avenue of research at IRSS. Risk modelling consists of mathematically combining multiple predictors to estimate the probability of developing disease, conditional on time or age. Risk modelling generally results in what is called “prediction models”. Accurate prediction models rely both on identifying accurate diagnostic tools and providing the opportunity to improve these tools. Benefits of accurate prediction models include protecting quality of life, limiting iatrogenesis, and improving the use of evidence-based medicine for personalized medicine, physician-patient communication and counselling.

Health, well-being and quality of life are commonly used terms underlain with complex concepts. As in other disciplines of medicine, nursing, or psychology, quality of life research at IRSS aims to (1) understand the meaning and relevance of quality of life for individuals or groups, so that people’s voices are considered, (2) identify personal and social factors associated with perceptions of quality of life, and (3) design interventions and policies to improve quality of life.
Health for all
(coordinated by Vincent Lorant)
Traditionally, public health interventions were assessed for their effectiveness in achieving health outcomes. Yet, by the end of the 20th century, public health research has increasingly been interested in how intervention effects were shared across the different groups of society. A key impulse came from the 1993 “Health For All” WHO monitoring framework (Organisation Mondiale de la Santé, 1993) and from the 2008 “Closing the Gap” report (Health & World Health, 2008). In a way, public health is moving towards an overarching concern: making health a resource available to all. The IRSS research activities are modestly contributing to that agenda in three ways: new models to explain inequalities and intersectionality, prioritizing interventions to reduce inequalities, and avoiding double jeopardy.

**New models to analyse inequalities**

Why do our democratic and open societies still display huge and persistent inequalities in health? More than 40 years after the Black report, this issue has anything but disappeared from the epidemiological radar—public health research is in need of new ideas. One avenue investigated by the H2020 SILNE-R project by Pierre-Olivier Robert, Nora Melard and Adeline Grard is to examine how low socio-economic status and smoking (a key contributor to the latter for health inequalities) become co-constructed very early in the lifecycle and at school, due to social interactions and implementation of health protection policies at school. The SILNE-R project also delivered individual feedback to each participating school describing how well they were doing and possible solutions for implementing strategies to promote healthy adolescent health behaviours (see graph 1).

**Dimensions of inequalities and intersectionality**

Health inequalities are the unequal distribution of health and its determinants across groups that stratify our society. Yet, this domain of research is sometimes fragmented across different streams, such as gender, socio-economic status, and ethnicity. Marie Dauvrin, working on the topic of cultural competencies, showed the possibility that research feeds this fragmentation, as socio-economic and ethnic inequalities are rarely considered during the process of interventions. Instead, intersectional approaches provide promising avenues to address inequalities across dimensions of stratification. Other research conducted at IRSS, seeks to elicit the perceptions of and strengthen a “sense of agency” in particularly vulnerable groups, such as women who had undergone female genital mutilation in their country of origin, or women who suffer from parental...
burn-out, putting their children at risk of violence or neglect.\textsuperscript{38}

\textbf{Interventions to address inequalities in child preventive services}

The aging population should not obscure the importance of protecting and enhancing the health of other groups, such as younger generations, whom hold the future of any population. In addition, positive and negative behaviours affecting health are adopted during adolescence, although their affects may only be noticeable much later. In some areas of the world, such as in Africa, access to preventive services remains an important vehicle to reduce inequalities. Yet, the most important driving factors of inequalities in preventive services are not always clear. Using modern decomposition approaches, Carine Van Malderen (see Box 1) dissected wealth inequalities within preventive services to identify important factors for policymakers to consider.

In another perspective, reducing health inequalities may also demand developing group-specific interventions for very vulnerable groups. The project \textit{Drugroom}, for example, aimed at reducing the harm to people using illicit drugs by setting up drug consumption rooms\textsuperscript{39}.

Research conducted at IRSS also seeks to improve the quality of life of children with complex or life-limiting conditions who receive palliative care\textsuperscript{40}. Through an ongoing collaboration with the Fonds Houtman, the research on paediatric palliative care extends to end-of-life decisions and practices in intensive neonatal care\textsuperscript{41}.

\textbf{Avoid double jeopardy}

Policymakers and citizens alike are looking for ways to address the aforementioned inequalities. There is, however, no single answer and thus, the first step is to characterize and understand these factors before interventions can be designed- a strategy the Institute has prioritized. This is a wise approach as any interventions should first be grounded in a strong analytical perspective. Some young IRSS researchers are investigating these factors. For example, it was found that patients with chronic disease, such as those with a severe psychiatric disorder, drift away in their social integration and drop-out from the labour market or community accommodation. Furthermore, patients with a lower

\textbf{BOX 1 / PREVENTIVE SERVICES TO TACKLE WEALTH-INEQUALITIES IN INFANT’HEALTH}

Skilled birth attendance and measles immunization reflect two aspects of a health system. In Kenya, their national coverage gaps are substantial but could be largely improved if the total population had the same coverage as the wealthiest quintile. A decomposition analysis allowed identifying the factors that influence these wealth-related inequalities in order to develop appropriate policy responses. The pro-rich inequalities in both healthcare indicators were mainly due to differences in parents’ educational level, antenatal care attendance, and birth order. Province and ethnic group contributed more to the skilled birth attendance inequality than to the measles immunization inequality. Interestingly, urban/rural residence was associated with a reduction in the pro-rich inequality in measles immunization. This may have been a result of the supplemental immunization activities efforts in reaching geographically disadvantaged households. (Carine Van Malderen)\textsuperscript{37}
socio-economic status may have more difficulties in navigating our complex mental healthcare system, so providing them with better continuity of care is a promising approach (see Box 2).

While research conducted at IRSS is closely linked with medical interventions, there are also non-medical ways to promote patient health, particularly for the most vulnerable. Social support is an essential resource on which the patient may rely to cope with limitations and maintain social participation. An IRSS researcher has designed a tool – Morpheus – that maps patient social support networks and identifies weaknesses within their network, such as the lack of contact between informal carers and professionals, or the lack of information exchange between the patient’s GP and psychiatrist (see Box 3).

Tackling the non-medical determinants of patients’ health is at the heart of a collaborative research project on personalized health care planning conducted in the Brussels region by a research consortium coordinated at IRSS. See http://www.participate.brussels/.

BOX 3 / “MORPHEUS” For severely mentally ill people (SMI) living in the community, social support helps them manage disease, limits the consequences of stressful situations and provides resources for social integration. Yet, clinicians are not always aware of the strengths or weaknesses of a patient’s social network. “Morpheus” is a research project which designed a handy tool for clinicians to describe the users’ social support network and explore the links between the network structure and different outcomes, such as continuity of care and support delivery. (François Wyngaerden)

BOX 2 / CONTINUITY OF CARE FOR ALL? Social integration of patients with chronic and severe psychiatric disorders (SMI) is still suboptimal, in violation with the national and international policy commitments to integrate these patients into the community. The overall aim of this IRSS project is to highlight persisting factors that limit the social integration of SMI patients, despite the recent shift towards community care. One possible explanation for these disparities is that interventions sustaining continuity of care may not be accessible or provided to these patients. (Pierre Smith)
Integrated Care
(coordinated by Jean Macq)
Integrated care at the centre of many health (and social) care reform processes

Access to health (and social) care services is a main determinant affecting individual and population health. Service organization not only influences the quality of services provided (including its capacity to contribute to better individual and population health), but also equitable access and subsequent financial strain put on society. Integrated care is an important criterion of quality services which many countries are aiming towards in the process of transforming their health systems. “Integrated health (-and social-) services are health (-and social-) services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course.” The WHO global strategy also focuses on people-centered and integrated health services. IRSS researchers have studied the process of integrating care in diverse populations, such as people with mental health problems, chronic disease and those in need of long-term care (particularly frail older people). IRSS researchers have also studied benefit packages for care integration and include combinations such as primary and emergency care; nursing care and other services to improve wellbeing at home; social, mental and psychiatric services (see Box 2); and the broader preventative, social and curative services to improve care for people with chronic diseases. Also, IRSS studies the effects of improving care integration on continuity of care; social integration, quality of life and comprehensiveness, and ‘people-centered care’... by using quasi-experimental approaches.

Secondly, ease of care integration will depend on the group of providers involved, such as professionals working within and outside an organisation. Therefore, improving the integration of care will often require an understanding of structural determinants to improve inter-professional and inter-organizational collaboration. This has been studied by some researchers at IRSS, including in the context of the general reform of mental health care in Belgium.

The multiple facets of care integration: target populations, benefit packages, and professional and organisational determinants

The way reforms are implemented to improve care integration differs with each key factor. Firstly, integrating care will be different in function of the target population, benefit packages and expected outcomes. IRSS researchers have studied the process of integrating care in diverse populations, such as people with mental health problems, chronic disease and those in need of long-term care (particularly frail older people). IRSS researchers have also studied benefit packages for care integration and include combinations such as primary and emergency care; nursing care and other services to improve wellbeing at home; social, mental and psychiatric services (see Box 2); and the broader preventative, social and curative services to improve care for people with chronic diseases. Also, IRSS studies the effects of improving care integration on continuity of care; social integration, quality of life and comprehensiveness, and ‘people-centered care’... by using quasi-experimental approaches.

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proaches), and tools for sharing information (electronic health records, shared plans). These are implemented at the “micro” level (focusing on interactions between individuals), at the “meso” level (focusing on interactions between organizations and groups of professionals), or at the “macro” level (focusing on policy dialogue to decide on financing mechanisms, legislation, territorial approaches, etc). Researchers at IRSS have evaluated different interventions, networks and system improvements. These have been studied at the individual patient level with a focus on inter-professional collaboration, and at the community level within the frame of larger reforms in Belgium or elsewhere.

One key question for patients with chronic disease is whether different services should be provided by the same clinician or by different clinicians. In one large international prospective study, IRSS looked at the effect of personal continuity of care compared to functional continuity of care in the domain of mental health and found no difference.

Methodologies to evaluate the reform process and interventions to improve care integration

Finally, evaluating the process of integrating care calls for multiple forms of evaluation, often new in the fields of health services, health systems and policy evaluation. IRSS has been on the forefront of proposing innovative forms of evaluation (see Box 1).

**BOX 1 / PSYCHIATRIC CARE.** Mental health, adult psychiatry and child psychiatry services from UCL are spread over several sites. In 2017, the Psychosomatics of Mont-Godinne continued its research and publications in various aspects integrating personal psychology, care-grooming relationship and biology in areas as diverse as immunology, oncology, psycho-pharmacology, cochlear transplants, quality of life, accessibility to care and return to the work environment.

At the Cliniques Saint-Luc, the Department of Child and Youth Psychiatry has developed specialized areas of expertise such as the diagnosis of autistic disorders and the accompaniment of situations of abuse. On this second axis in particular, we are attentive to participate in the advancement of scientific knowledge by publishing articles in national and international journals on the theme of models of care and treatment of psychotrauma.

Indeed, by definition, infant-juvenile psychiatry encounters not only a young patient but also all of his socio-family environment. As the African proverb owes it, ‘it takes a whole village to raise a child’, likewise, taking care of a child or a teenager asks to integrate in a “partnership envelope” parents and professionals concerned by a young individual in pain.

Overall, the Department participates in an individual family health policy that is part of a general public health concern as we intervene in the current life of the child and adolescent in a perspective of symptomatic improvement as well as implementation of longer-term life plans. (Jean Macq and Emmanuel de Becker)
**Box 2 / Methods**

Most changes for improving care integration can be obtained through complex interventions (i.e., interventions made of multiple components and highly contextual), or even through progressive “tuning” of a care system. Evaluating such changes calls for innovative methods, and researchers at IRSS play a leading role in developing and using such methods, as outlined below:

> **Complex intervention evaluation**: “The case management interventions for frail elderly persons were evaluated at the patient and health system level. A mixed methods approach was used: qualitative methodology focused on the characteristics and conditions for case management intervention implementation through multiple embedded case studies; quantitative methodology evaluated case management intervention effectiveness by population subgroup with specific long-term care needs (defined by Principal Component Analysis prior to cluster analysis) in comparison to a control group receiving “usual care”. The net benefit of clinical outcomes were evaluated using generalized pairwise comparisons and the probability of healthcare service utilization through Hurdle models.”

> **Realist evaluation**: The originality of the approach within the overall evaluation of the Protocol 3 program (aimed at identifying innovative interventions to help frail elderly people live well and longer at home) lay in the use of the realist perspective used in the synthesis of existing literature and the evaluation of existing Protocol 3 projects. Typically, a realist approach starts with an initial (“intuitive”) theory, which is then refined against other evidence. Second, CMOCs (Context-Mechanisms-Outcomes Configurations) are sought to identify underlying mechanisms explaining why a specific outcome was achieved in a specific context. This can be seen as a mid-range theory. Third, candidate mid-range theories are sought in the literature, with experts and researchers to provide an explanatory framework for these CMOCs. Fourth, adjudication between rival theories or the refining of existing theories is carried out through testing with empirical data and iterative consultation of the literature, and with experts.

> **System thinking**, including Agent-Based Modeling (ABM): System thinking is a way of looking at changes in the healthcare system. Rather than “dissecting and analyzing each part of it (as with the classic analytical approach), it looks at the whole system’s function in terms of interacting elements. ABM is one method used in system thinking which uses simulations to study and analyse system dynamics over time. This model is composed of acting agents, decision-making heuristics, and agent interactions within a specific context, capable of influencing and being influenced. Different scenarios of the initial state and rules of interaction (adaptive processes) can be proposed. Subsequently, system dynamics should be interpreted with stakeholders.

> **Quasi-experimental studies** are another promising approach when policies are the main intervention. Two studies illustrate this approach. The COFI study compared two approaches of continuity of care, personal continuity and functional continuity, using a naturalistic design in five countries. The SILNE-R study looked at the implementation of tobacco-control policies in schools (STPs) and attempted to measure the effectiveness of these policies on adolescents smoking behavior by comparing a set 20,000 adolescents from 38 schools across 6 different countries in both 2013 and 2016.

> **Ego-Network analysis**: The appropriate delivery of integrated, personalised care to vulnerable patients with chronic and complex needs require adapting the care pathway to each individual situation. A detailed knowledge about the social support network (SSN) of the patient, i.e. the acquaintances around him/her and their capacity to offer support to the patient, both professionals and relatives, is needed in order to organise adequately the patient’s every day care in the long-term. The project “Egonet”, carried out at the IRSS in collaboration with high schools within the programme «Bridge» of Innoviris, aims to describe, map, and assess the social support networks of patients. The project is conceived as a research and development project of a computer-assisted intervention that is feasible in routine clinical practice. It provides clinicians and patients with a SSN mapping and contributes involving the patient into the description of his/her own social support resources and organisation of his/her own care, including the patient him/herself. Indeed, the patient, as any individual, is hardly aware of the entire set support resources around him/her. The mapping also informs the multiple professional and non-professional actors around the patient about the human resources around him/her. Network mapping and analysis are based on previous research on SSNs using Ego-Network analysis tools and metrics. To this end, an analytic module is foreseen to return notifications to patients and clinicians with a useful information about the aspects of the SSN that deserve attention, in terms of continuity of care, subjective quality of life, and social integration.
Optimising Patient Care
(coordinated by Jean-Marie Degryse)
An important research focus at IRSS is to improve patient care through the development of new diagnostic algorithms, clinical prediction rules and instruments to measure health outcomes on the one hand, and through collaborative and qualitative research projects, that involve clinicians in reflective practices around their care, on the other.

One strategy to improving patient care is through providing insight into the effective prevention, diagnosis, treatment and prognosis of diseases. This is accomplished by filling gaps in clinical practice knowledge with evidence-based solutions that are applicable to both clinical practice and society. **Clinical prediction modelling** is used to develop innovative tools and designs for clinical and epidemiological studies and to facilitate personalised medicine. IRSS research focuses on the specific areas of health status of older persons, the management of multimorbidity patients, and the early diagnosis of obstructive lung diseases (see Box 1 & 2).

**BOX 1 / THE BELFRAIL (BFC80+) study** improved our understanding of the epidemiology and pathophysiology of chronic disease in very old patients. Through a multi-systems approach to assess the dynamic interactions between **health, frailty and disability**, our research team was able to investigate the complex relationship between various physiological systems. Specifically, the study design (a prospective cohort study with follow-up) enabled us to identify a new series of robust and independent risk factors associated with functional, physical and mental decline, as well as time-to-first hospitalization and mortality.

**BOX 2 / THE CRYSTAL STUDY** (a prospective cohort) aimed to identify valid health markers and to develop a risk model for predicting adverse outcomes in a population of community-dwelling older persons (aged 65+) living in the Kolpino district of St. Petersburg, Russia. Overall, the study found that classical risk factors lost predictive power in this population. Based on these findings, the CRYSTAL risk model was developed and older adults were identified as having a higher risk for mortality when two or more of the following components were present: poor physical performance, low muscle mass, poor lung function, or anaemia. The new risk prediction model aims to help patients and physicians make informed decisions about screening, diagnosis and the establishment of a care plan.
**Prediction models** guide health care professionals in their decisions regarding patient disease management. These can include decisions about additional testing and initiating or withholding treatment(s), recommending lifestyle changes, and informing patients of their risk of having (diagnosis) or developing (prognosis) a particular disease or outcome. They are not intended to replace qualitative reasoning of health care professionals, but rather to supplement the decision-making process by providing objectively estimated probabilities. In the current era of personalized and risk-tailored care, such risk prediction models are of increasing interest.

**Clinimetrics** is a methodological discipline with a focus on the quality of measurements in medical research and clinical practice. “Quality” refers to both the quality of the measurement instruments and the performance quality of the measurements. Clinimetrics covers the domains concerned with indexes and rating scales, among others, that are used to describe or measure symptoms, physical signs, and other distinct phenomena in clinical medicine (see Box 3 & 4).

**BOX 3 / THE RESPECT STUDY** (RESearch on the PrEvalence and the diagnosis of COPD and its Tobacco-related etiology) is a prospective, observational, population-based cohort study of subjects aged 35-69 years old from two northwest regions of the Russian Federation. The study was conducted in close collaboration with the North-Western State Medical University in Saint Petersburg and the Northern State Medical University in Akhangelsk. An important outcome of this collaborative research project is new insight into the challenging nature of COPD diagnosis. In a publication in *Nature PJ: Primary Care Respiratory Medicine*, we were able to demonstrate that “a single comprehensive assessment” is not enough to make a final diagnosis; longitudinal follow-up and a serial assessment of lung function and symptoms are needed to make a final diagnosis.
Patient-reported outcomes (PROs) are being increasingly considered as a best method to assess quality of care from a patient-centred perspective. Also in paediatrics, and more specifically for children receiving palliative care, PROs are recognized as a valuable strategy for offering quality personalized care. However, it is recommended to complement this with measuring instruments, thus combining the objective and subjective, and self and proxy outcomes.

At IRSS, we also continue to produce new practical tools, such as a new Comprehensive Geriatric Assessment tool for clinicians (CGA) (see Box 5 & 6). This interactive tool integrates seamlessly with electronic medical records and is the result of a research project run by a group of final-year medical students. A trial is ongoing to clarify if this new comprehensive approach leads to better outcomes for older patients (www.geristeps.org, www.safaries.be).

Research conducted by Isabelle Aujoulat and colleagues looks at ways of co-constructing innovations for supporting patient empowerment through personalized health care planning (http://www.participate.brussels/), with a strong focus on child and adolescent patients’ needs. In parallel, the vulnerability and empowerment of carers, whether informal or professional carers, is also among the research priorities.
BOX 5 / PHARMACOTHERAPY

Polypharmacy and poor compliance among old persons have been associated with poor outcomes. Case-finding of patients at risk may improve strategies for a better treatment adherence\cite{84}.

Executive function play an important role in poor adherence. Use of screening tools for an appropriate prescription during a hospital stay was also reported as an innovative approach to avoid inappropriate drug use\cite{85}.

Interdisciplinary team work including clinical pharmacists is also an important tool that has to be developed in acute geriatric wards\cite{86}.

The new STOPP/START.v2 lists target significantly more cases of inappropriate prescribing associated with preventable drug-related hospital admissions (23\% vs. 40\%, P<0.001). DRA were most frequently associated with PIMs of fall-risk-increasing drugs and PPOs of musculoskeletal and cardiovascular system drugs\cite{87}.

The underuse of anticoagulation in older people with atrial fibrillation was detected in one third of these patients, and decreased AC from the pre-DOAC (37\%) to the post-DOAC era (30\%). AC underuse still concerned 3 out of 10 geriatric AF patients at high risk of stroke\cite{88}.

Rational prescribing in vulnerable very old adults can be challenging for non-specialists in pharmacotherapy in old age\cite{89}. Our analysis in vulnerable very old patients illustrates that CGA-based medication assessment and tailoring leads to further drug modifications in addition to STOPP/START.v2 only\cite{90}.

BOX 4 / THE MOSAIK STUDY (Move to Open Shared Advanced Interventions for Kids with life-limiting conditions) developed an instrument to measure the quality-of-life of children facing life-limiting or-threatening conditions. The study was conducted as a collaborative project among six Belgian paediatric palliative care teams. Part of MOSAIK consisted of a retrospective analysis of Belgian paediatric liaison teams’ (PLT) annual reports from 2010-2014. A second part systematically reviewed the literature on existing instruments used to measures outcomes in paediatric palliative care. The review concluded that no consensus was reached concerning dimensions to be measured and that currently used instruments lacked robust psychometric properties\cite{83}.

Thus, there is need for a new instrument to measure quality-of-life using a multidimensional and family-centred approach. Recently, a new field study was launched to further develop and validate such a tool in co-construction with health care professionals to guarantee optimal implementation into clinical care practice (Marie Friedel)
This study aimed to map the implementation status of CGA-based models of care in general hospitals in Europe. A great variety in the implementation of CGA-based care models was observed among the surveyed EU countries with the uptake being the highest in Belgium, Denmark and Ireland. A supportive legislative framework and a residency training in geriatrics favour the implementation of the geriatric care models.

This scoping review identified that the structure and processes of care provided to geriatric patients by interdisciplinary geriatric consultation teams (IGCTs) are highly heterogeneous. Despite nurses being key members of IGCTs, only limited information on their specific roles and responsibilities within the IGCT was identified. More research in this area is required in order to inform health care policy and to formulate practice oriented recommendations to redesign the IGCT care model and to improve its effectiveness.

In the Emergency Department, early and rapid identification of older people at risk would avoid wasting time and ensure optimal orientation of vulnerable patients. This study tested the predictive ability of SHERPA, a screening tool assessing risk of functional decline (FD). FD prediction with SHERPA was limited, but some predictive factors stay consistent across time and with literature.

Older people in the emergency department (ED) represent a growing population and increasing proportion of the workload in the ED. This study investigated the support for frail older people in the ED, by exploring the collaboration between the geriatric services and the EDs in Belgian hospitals. Collaborations between EDs and geriatric services are emerging in Belgium, but are currently rather limited and not yet sufficiently embedded in the ED care.
Engaging with health actors and policymakers
(coordinated by Sophie Thunus)
The Institute of Health and Society is a scientific and interdisciplinary platform. As part of its work the institute is committed to develop systemic and multi-methods approaches to transitions within health care systems. The following research axes address these transitions at the policy, organisational and individual levels – thus outlining a sociological and comprehensive perspective on health care research and governance.

Health policies – knowing health for making policy
The conception and implementation of contemporary health policies have undergone important transformations. Increasing decentralisation has moved decision-making from the central state to regional and local levels. As a result, an increasing variety of actors, including service users, health professionals and the scientific community are now involved in health policy as they bring together different types of lay and expert knowledge. Furthermore, contemporary health policies are increasingly global and experimental. First, their global nature lies in the development of collaborative networks including primary and secondary care, as well as social, employment and judicial sectors. Second, experimental devices, such as pilot projects, are increasingly blurring the boundaries between policy conception and implementation, as they make room for local adaptations of global health programmes. Thus, the scientific community is now required to evaluate complex and long-term policy processes rather than measuring policy outcomes.

IRSS plays a central part in addressing the specific challenges raised by transformations in contemporary health policies, particularly in the fields of mental health and integrated care for chronic disease. Acknowledging decentralisation, as well as the global and experimental nature of contemporary health policies, contributes to meeting the Institute’s broader objectives of promoting care quality, equity and accessibility. The KCE HSR-52 research (2017-2019), which illustrates this approach, is a mixed-methods analysis of a mental health reform launched in 2010 for the adult population in Belgium; it was followed by the Parcours.Bruxelles research (2018-2019) which pursued this analysis in the Brussels Region while drawing particular focus to vulnerable populations currently facing exceedingly difficult access to mental health care.

Remaking the health care system for people with complex situations
IRSS stays closely attuned to the challenges raised by complex situations, understood as chronic and/or multiple illnesses combined with socio-economic vulnerabilities. The growing number of people facing complex situations has put a financial strain on European healthcare systems, and has compelled these systems to adapt their approach. Indeed, these systems initially developed on the basis of a disease-centred approach, is gradually becoming comprehensive and patient-centered. Organizational adjustments aim to improve care integration, strengthen primary care, stimulate multidisciplinary
work, facilitate communication between healthcare providers, and empower patients as well as their relatives.

Be.Hive\(^{96}\) (starting in 2019) is an interdisciplinary Chair designed to address the challenges that people with complex situations introduce within health systems. Its global aim is to rethink the role and identity of primary care within the French-speaking parts of Belgium. Specifically, its third work package (Pr. Thunus & Kathy Delabye) focuses on the care demands expressed by patients and their relatives. It explores patients’ experiences of complex situations and raises the question of how primary care could be redefined and reorganised in order to meet their social, psychological and medical needs. The research project will question specific dimensions, including multi-disciplinary work at the primary care level; the development of new professional roles supporting collaboration and facilitating transitions between institutions and home environments; and the use of digital tools by people receiving home care.

**Mental health as collective action**

The World Health Organisation’s strategy for mental health in Europe\(^{97}\) has significantly influenced the policy agenda of its member countries. Accordingly, Belgian mental health policy promotes a global and community-based mental health approach for the whole population. For several years, IRSS has been involved in several reform evaluations carried out in Belgium, e.g. the reform of mental health care delivery for adults (Art. 107)\(^ {98,99}\) and the reform towards care access for mentally disordered offenders (For-Care)\(^ {100}\). Despite their comprehensive ambitions, policy measures and scientific research addressing organizational transformations have merely focused on healthcare systems, thus overlooking other spheres of society.

The *Parcours.Bruxelles* research\(^ {101}\) aimed to acknowledge the comprehensive nature of mental health viewed as ‘collective action’; a conception which conveys the significant impact of events and interactions occurring within multiple spheres of society on mental health and on access to care. Accordingly, qualitative methods were designed to include vulnerable populations in the research process, who are facing increased exclusion following previous mental health reforms in Belgium. Results emphasised that interactions between different spheres of society, including housing and employment, are essential to grasp the social and care trajectories of people from various socio-economic backgrounds. Moreover, the research highlighted the positive impact of specific types of services not included in the mental health sector. Open to the public, their notable influence for mental health lies in the process of social inclusion of people with mental health problems within the community through organizing cultural or everyday activities that stimulate social interactions within heterogeneous groups. Finally, *Parcours.Bruxelles*
emphasised that professional and organisational cultures hinder organisational change and access to mental health care for the most vulnerable populations. Recommendations therefore encouraged the development of inter-organisational immersions, likely to accelerate cultural transitions within the mental health system.

The Parcours.Bruxelles research results stimulated the development of a research project offering a processual and systemic approach to mental health and work, a priority issue on the European Commission and the OECD’s policy agendas. This project will aim to trace a network of meetings expanding from the policy arena to civil society and to gather communities of people from diverse socioeconomic backgrounds who are experiencing or have experienced employment-related mental health problems.
Partnership inside and abroad

Institutions étrangères

Academisch Medisch Centrum bij de Univeristeit van Amsterdam (The Netherlands)
Cathie Marsh Institute for Social Research (United Kingdom)
Dhaka Community Hospital Trust (Bangladesh)
Escola Nacional de Saude Publica (Spain)
Institut de Santé et Développement, Université Cheikh Anta Diop (Senegal)
Institute for Psychiatry and Neurology (Poland)
King’s College London (United Kingdom)
Lietuvos Sveikatos Mokslu Universitetas (Lithuania)
Martin-Luther University Halle-Wittenberg (Germany)
Max Planck Institute for Biogeochemistry (Germany)
Ministère Santé Publique (Liban)
Peruvian Society of Infectious and Tropical Diseases (Peru)
Regional Health Direction of Loreto (Peru)
Saint Petersburg University (Russia)
SEEDS Technical Services (India)
Sodertorns Hogsoila (Sweden)
Stichting VU-VUMC, Amsterdam (The Netherlands)
Tampereen Yliopisto (Finland)
Technische Universität Dresden (Germany)
Technische Universität Delft (The Netherlands)
Société Générale de Distribution et de Communication (France)
United Nations International Strategy for Disaster Reduction (Switzerland)
Universität degli Studi di Verona (Italy)
Universidad Complutense de Madrid (Spain)
Universidad Peruana Cayetano Heredia, Instituto de Medicina Tropical Alexander von Humboldt (Peru)
Université catholique de Bukavu (RDC)
Université de Kisangani (RDC)
Université de Kinshasa (RDC)
Université de Lille (France)
Université Paris Diderot (France)
Université polytechnique de Bobo Dioulasso (Burkina Faso)
Universiteit Maastricht (The Netherlands)
University of California (USA)
University of Edinburgh (United Kingdom)
University of Jadavpur, Department of Atmospheric Physics (India)
University of Leeds (United Kingdom)
University of London, Unit of Social and Community Psychiatry of the Queen Mary (United Kingdom)
University of Oviedo (Spain)
World Health Organization (Switzerland)
Institutions in Belgium

Association Parkinson (Namur)
AZ Delta (Brussels)
Centre de Recherche de l’ECAM-CERDECAM (Brussels)
Centre Hospitalier Universitaire (Liège)
Ecole royale militaire (Brussels)
European Network for Smoking and Tobacco Prevention (Brussels)
Haute Ecole Leonard de Vinci (Brussels)
Hogeschool Gent (Ghent)
Institut Paul Lambin (Brussels)
Institute for International Research on Criminal Policy, Ghent University (Ghent)
Institute for Social Drug Research, Ghent University (Ghent)
Institute of Tropical Medicine (Antwerp)
KU Leuven (Leuven)
LUCAS, Katholieke Universiteit Leuven
Organization, Policy and Social Inequalities in Health care, Vrije Universiteit Brussel (Brussels)
Sciensano (Brussels)
Service Public Fédéral, Santé Publique (Brussels)
UCB (Brussels)
Université Libre de Bruxelles (Brussels)
Université de Liège (Liège)
Universiteit Antwerpen (Antwerp)
Mandana Mehta

Since February 2018 I have been working as a researcher on the project PARTICIPATE, Brussels with Professor Isabelle Aujoulat. This a collaborative research action initiative concerned with the personalisation of healthcare plans for those persons living with a chronic condition in Brussels. Currently I am involved in a qualitative study that involves interviewing persons affected by chronic conditions as well as the professionals who accompany them. I am particularly interested in the elements of a person’s life they consider essential to maintaining their health and understanding how this is incorporated into their health care plan, if at all. I also have a focus on the collaborative or “participatory” nature of our project and the impacts of citizen participation to research in health. I am new to Qualitative research methods. I am a medical doctor by training and a couple of years ago I worked at the Centre for Research in the Epidemiology of Disasters with Professor Guha-Sapir. The work I did there utilised quantitative data analysis and thus I am grateful to have returned to the familiar in a way whilst also having the opportunity to develop new skills and competencies. What I appreciate most at IRSS is working with colleagues who share my passion for representing the needs of even the most marginalised and neglected populations in public health and access to health care.
Pierre-Olivier Robert

Social Assistant and Sociologist specialized in public health, I am currently completing my PhD thesis on the ‘denormalization’ of tobacco and health inequalities among young people. The latter is part of a European Horizon 2020 project whose data focuses on the health behaviors of young people in 7 European countries. I participated in various aspects and tasks of these projects such as fundraising, drafting of documents for ethical committees, data collection and dissemination of results to stakeholders in the surveys (SILNE projects). A thesis can not be a ‘self-standing’ project, it takes also benefits of working within a whole team of the institute which allow me to fully develop and reach the aims of my study. Since 6 years, I am also assistant in teaching in “Methodologies quantitative and qualitative”, “Promotion of the health”, “Dynamics of groups” and “Policies of health”. In the next future, I am planning to integrate a high school in the Walloon region to invest in the training of social workers for the future. I also plan to dedicate my time in the field of associations and the health sector of Hainaut helping young people, to strengthen my experience in the field and put into practice the various tools and knowledge acquired throughout my doctorate. My main areas of interest are additions and mental health among young people from 13 to 15 years.

Olivier Schmitz

I joined the institute in 2011 and like most of my socio-anthropologist colleagues, my research is largely based on the use of qualitative methods that are taking an increasingly important place in public health and particularly at the Institute. My research focuses on the areas of organization and delivery of health care to vulnerable populations, and sexuality in the broad sense of the term. I am currently working on various research projects, including the PARTICIPATE project aiming to personalize chronic patient care, but also on a project carried out within intensive neonatal services and, in collaboration with the Belgian Cooperation and Kisangani University, on a field study whose objective is to improve protocols for the treatment of Victims of Sexual Violence in the DRC. In parallel with my research activities, I am also an arborist and forestry operator.
Sophie Thunus

I started my university career as a young researcher on a European project called “Know and Pol” (2009-2014, sixth framework programme for Research and Innovation (RTD)). This project questioned the relationships between knowledge and policy in the health and education sectors. It gave me the opportunity to learn about a multi-level, multi-stakeholder and process approach to the formation and implementation of policy-relevant ideas. This approach prevailed my PhD research. Based on qualitative methods and drawing on a sociological perspective, this research analysed the formation of mental health policies in Belgium and the ongoing implementation of the 107-Reform at the organisational level. It stressed the significant role played by policy and inter-organisational meetings in orienting the reorganisation of mental health care delivery according to a network and community-based model. Post-Doc research, funded by the F.R.S.-FNRS and supervised by Frédéric Schoenaers, University of Liège, and Richard Freeman, University of Edinburgh, consequently consisted in developing a sociological approach to meetings. It resulted in a conception of meetings as social events with specific temporal, interactional and situational properties, which accounts for their contribution to policy and organisational change. I have been Professor of Health Care Services Management at UCLouvain, Faculty of Public Health since September 2017. I have been teaching courses related to the coordination of health care services’ networks, group dynamics, organisation theories and management. Moreover, as a member of the Institute of Health and Society, I have kept on carrying out research on policy and organisational change in the mental health field, but also in the field of health care for chronic patients. My most recent research, Parcours, Bruxelles, carried out with Carole Walker, was a fascinating research which combined qualitative interviews, focus groups and ethnographic meetings to provide an empirically-grounded evaluation of current organisational changes in the mental health system. This research pioneered an inclusive approach to mental health policy evaluation by directly involving people with mental health problems, including the most vulnerable populations, which are increasingly excluded from mental health care.
Alexandria Williams

I have a MSc. in epidemiology and infectious disease from the George Washington University in Washington D.C. and have been living in Brussels since 2015. I started working at the Centre for Research on the Epidemiology of Disasters (an entity of IRSS) in early 2017 and then became research coordinator for IRSS in September 2018. A lot of my experience so far has strengthened my academic writing and editing skills, which I plan to use for a PhD, eventually. Much of my coordinator role involves searching for possible funding opportunities for IRSS, aiding researchers in proposal content and flow development, and planning activities to strengthen the skills of younger researchers. I particularly enjoy interacting with my peers in the weekly writing group and hope to plan more events with them soon! In collaboration with my colleagues, I plan to bring in new funding opportunities that can lead to evidence-based practices, which will advance the health of society. Finally, I hope that my research coordinator role, along with a positive attitude, can bring a collaborative environment to our Institute.

Héline Zabeau

Psychologist and sexologist, I am part of the Institute team since October 2015. It is for me a great discovery as the place bring together human and creative personalities, with various backgrounds and high level of expertise! Currently, I work as a research and teaching assistant in the Faculty of Public Health. My research activities focus in the field of chronic illness and pregnancy. As part of my doctoral thesis, I am conducting a collaborative research to improve support for the specific needs of therapeutic education and psychosocial support for women living with a pre-existing condition. As an assistant in the Faculty of Public Health, I am pleased to supervise courses in health promotion, qualitative methods and education for health and therapeutic patient education. This teaching experience allows me to share my theoretical knowledge and practical skills. Both research and teaching have the art of arousing my curiosity, which is essential for meaningful work.
Bibliography


27. Mello JA, Maq J., Van Durme T., Cés S., Spruytte N., Van


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