Belgium

Belgium is a diverse mix of local governments, languages and population groups. Because of this diversified system, national data are not always available for review. Much of the readily available data was some years out of date and material was difficult to compare.

Some figures worth mentioning about Belgium include a relatively high incidence of breast cancer (48/100,000), with the figures for cervical cancer the lowest of the eight countries reviewed. In relation to young people and sexually transmitted infections, Belgium was third lowest of the countries reviewed for chlamydia, and the lowest for gonorrhea in 15-19 year olds (1/100,000) (1996). There appears to be a high incidence of young girls engaging in health controlling behaviour. Figures on diet and weight control show regional differences: 37.1% of 11 year olds, 47.4% of 13 year olds, and 54.8% of 15 year olds in the Flemish population control their weight, although this drops dramatically amongst the French speaking population (16.6, 16.9, and 24.7% respectively). The problem of data being obtained from unrepresentative focus groups was a recurring theme of research on women's health in Belgium.

The following was submitted by Els Messelis, Higher Institute for Family Sciences.

Introduction

From *Belgium, a federal state:* http://www.bruxelles.irisnet.be/en/region/region_de_bruxelles-capitale/belgique_etat_federal.shtml
The state structure of Belgium has had a certain effect on the development of the health sector. Unity in diversity is inevitably complicated. This is true for Belgium and for Europe as a whole. The challenge is to make diversity an asset while at the same time preventing and settling conflicts.

During the past 25 years, Belgium has established federal structures in which decision-making powers have been divided among:

- the State,
- the three Regions (the Brussels-Capital Region, the Flemish Region and the Walloon Region),

- the three language communities (the French-speaking Community, the Flemish Community and the German-speaking Community).

- In addition, there are ten Provinces and 589 Communes.

The territory of the Brussels-Capital Region is bilingual, French and Dutch. That of the Flemish Region is Dutch speaking. The Walloon Region, meanwhile, includes French-speaking territories and the German-speaking cantons. The French-speaking and Flemish Communities in the Brussels Region have their own areas of competence in regard to persons and institutions. At national level the legislative bodies are the House of Representatives and the Senate; in each Region and Community, the parliament is known as the Council. Executive bodies such as the State, the Regions and the Communities each have their own Government, with Ministers and, where appropriate, Secretaries of State. (CIA World Factbook, 2006)

One widely accepted definition of health is that of the World Health Organization (WHO). It states that 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1946). This holistic definition is taken into account when describing the health of (older) women and young girls in Belgium.

Women's' health

Belgium counts over 10 million citizens, with the following age structure:

- 0-14 years: 16.7% (male 883,254/female 846,099)
- 15-64 years: 65.9% (male 3,450,879/female 3,389,565)
- 65 years and older: 17.4% (male 746,569/female 1,062,701) (2006)

The population growth is 0.13%, the birth rate is 10.38 births/1,000 population, and the death rate is 10.27/1,000 population. The gender ratio is:

- At birth: 1.04 male(s)/female
- Under 15 years: 1.04 males/female
- 15-64 years: 1.02 males/female
- 65 years and over: 0.7 males/female
- Total population: 0.96 males/female (2006)

The infant mortality rate is:

- Total: 4.62 deaths/1,000 live births
- Male: 5.2 deaths/1,000 live births
- Female 4.01 deaths/1,000 live births (2006)

The life expectancy at birth is:

- Male: 75.59 years
- Female: 82.09 years (2006)

The total fertility rate is 1.64 children born/woman (2006)

After the Netherlands, Belgium was the second European country to legalise euthanasia in 2002. In the first year two hundred people died in this manner. Since then rates have steadily risen. In 2005 deaths reported as such reached 360 (http://www.lifesite.net/ldn/2006/feb/06020707.html).

Teenage pregnancy rates are on the rise. In 2003 there was a 4% increase in teenage pregnancy rates, as compared to 2002. It was also found that between a quarter and a third of pregnant teenage girls had planned their pregnancy. 'Jeunesse et Sexualité' (Youth and Sexuality), a non-profit organisation, noted that many of the girls becoming pregnant have difficulties in school or at home and view their pregnancy as a part of growing up or as a way to start a new life for themselves. Despite the rise in teenage pregnancies, abortion rates have not changed. *(Belgium News, Expatica.com , accessed at: http://www.pregnancy-info.net/in_the_news1.html).*

Data is available on the history of abortion rates in Belgium, compiled by Wm. Robert Johnston (last updated 10 May 2006) (Accessed at: http://www.johnstonsarchive.net/policy/abortion/ab-belgium.html).

Historical abortion statistics, Belgium

Year	live births	abortions, legal	abortions, abroad	miscarriages	abortion ratio	abortion %
1965	155,496			2,131		
1966	151,096			2,022		
1967	146,193			1,860		
1968	141,984			1,730		
1969	141,799		150	1,737	1	0.1
1970	142,168		600	1,616	4	0.4
1971	141,527		2,073	1,580	15	1.4
1972	136,304		2,500	1,471	18	1.8
1973	129,424		1,462	1,392	11	1.1
1974	123,674		600	1,276	5	0.5
1975	119,693		12,000	1,227	100	9.1
1976	121,034		400	1,088	3	0.3
1977	121,852		300	1,083	2	0.2
1978	122,592		300	1,035	2	0.2
1979	123,825		200	979	2	0.2
1980	124,398		200	990	2	0.2
1981	123,792		200	891	2	0.2
1982	120,241		100	853	1	0.1
1983	117,145		100	839	1	0.1
1984	115,651		100	789	1	0.1
1985	114,092		(5,000)	714	44	4.2
1986	117,114			746		
1987	117,334		100	706	1	0.1
1988	119,779			676		
1989	120,904			715		
1990	123,776		(3,500)	682	28	2.7
1991	125,924			648		
1992	124,774	22,262	(2,800)	651	201	16.7
1993	120,848	10,380	(2,500)	597	107	9.6
1994	116,513	10,737	(2,300)	507	112	10.0
1995	115,638	11,243	(2,200)	580	116	10.4
1996	116,208	12,628	14,600	508	232	18.9
1997	115,864	26,788	(1,800)	492	247	19.8
1998	114,276	11,999	(1,500)	513	118	10.6

1999	113,469	12,734	(1,500)	515	125	11.1
2000	116,284	13,762	(1,400)	457	131	11.6
2001	115,592	14,775	(1,300)	387	139	12.2
2002	114,014	14,791	21		130	11.5
2003		15,595	22			
2004			8			
2005			8			
Year	**live births**	**abortions, legal**	**abortions, abroad**	**miscarriages**	**abortion ratio**	**abortion**

In Belgium (2004), 75% of the sexual active women between 15 and 49 years old had used methods of contraception in the 12 months previous to the investigation. The percentage of sexually active women who used methods of contraception decreases steadily with the age. Methods are used by 84% for girls of 15-19, and it decreases steadily to 63% for women between 45 and 49 years. The difference between the two age groups (the youngest and the oldest) is significant.

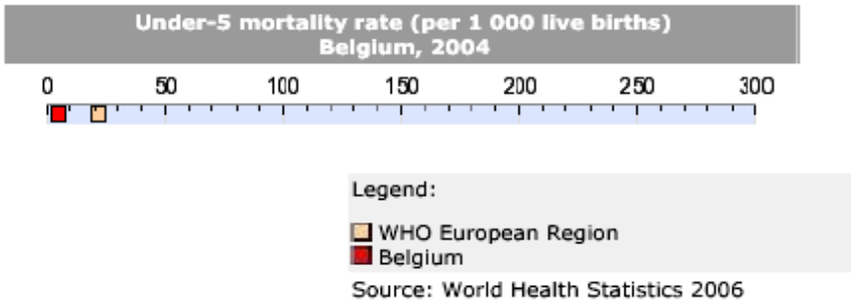
Of the women who used contraceptive methods, 60% chose the pill, 13% an intra uterine device, 8% a barrier method (a diaphragm, a spermicidal substance, a condom) and 12% sterilisation. Other, less frequent, methods were patch or vaginal ring (2.1%), a stick or a puncture pill (0.8%), the morning after pill (0.2%) or another method (periodic abstention, withdrawal) (1.9%).

Birth control is used across Belgium by sexually active women. Three quarters of women use a method to avoid an undesirable pregnancy. The average age of the first pregnancy is 28 years (in the 1970s it was 24 years). The increase in the average age of the first pregnancy is an indication of the tendency in women (and men), to concentrate on the development of a professional career before they start thinking about having children. In this respect it is not surprising that 4 out of 5 women – before the age of 30 say that they use contraception. Between 30-34 years, the percentage decreases (to 72%). The use of contraceptives therefore serves to delay pregnancy. Nevertheless it is alarming that 16% of the young, but sexually active girls, indicate that they don't use a method to avoid a (unwanted?) pregnancy.

Mortality rates in Belgium (*World health Statistics, 2006*):

Summary	Year	Males	Females	Both sexes
Population (millions)	2005	5	5	10
Life expectancy (years)	2004	75	81	78
Under-5 mortality (per 1 000 live births)	2004	5	4	5
Adult mortality (per 1 000)	2004	122	65	
Maternal mortality (per 100 000 live births)	2000		10	

Source: World Health Statistics 2006



Leading causes of death for men and women (different age groups):

Belangrijkste doodsoorzaak naar leeftijd (%) Vlaams Gewest 2002

	Mannen	Vrouwen
< 1 jaar	Perinatale verwikkelingen (35%)	Perinatale verwikkelingen (41%)
1 - 4 jaar	Ongevallen privé-sfeer (16%)	Ongevallen privé-sfeer (20%)
5 - 9 jaar	Vervoersongevallen (9%)	Vervoersongevallen (17%)
10 - 14 jaar	Vervoersongevallen (14%)	Vervoersongevallen (39%)
15 - 19 jaar	Vervoersongevallen (50%)	Vervoersongevallen (31%)
20 - 24 jaar	Vervoersongevallen (50%)	Vervoersongevallen (38%)
25 - 29 jaar	Vervoersongevallen (41%)	Zelfdoding (29%)
30 - 34 jaar	Zelfdoding (34%)	Vervoersongevallen (14%)
35 - 39 jaar	Zelfdoding (29%)	Borstkanker (15%)
40 - 44 jaar	Zelfdoding (22%)	Borstkanker (13%)
45 - 49 jaar	Zelfdoding (13%)	Borstkanker (16%)
50 - 54 jaar	Longkanker (13%)	Borstkanker (19%)
55 - 59 jaar	Longkanker (17%)	Borstkanker (16%)
60 - 64 jaar	Longkanker (17%)	Borstkanker (15%)
65 - 69 jaar	Longkanker (18%)	Borstkanker (11%)
70 - 74 jaar	Ischemische hartziekten (15%)	Ischemische hartziekten (13%)
75 - 79 jaar	Ischemische hartziekten (15%)	Ischemische hartziekten (13%)
80 - 84 jaar	Ischemische hartziekten (15%)	Cerebrovasculaire ziekten (13%)
>= 85 jaar	Ischemische hartziekten (13%)	Hartinsufficiëntie (12%)

Bron : MVG administratie gezondheidszorg

Specific health policies for women

There is no separate body coordinating the activities of the different institutions that has responsibility for the development of state policy in women's health, or for monitoring its implementation. Nor is there a separate Minister, Department or other sort of governmental structure that is specifically devoted to women and health issues.

Since 2004, the National Council of Women in Belgium has been putting together an inventory of all health policies that affect women (Genderwetswijzer Gezondheid, 2004). The report includes policy documents which concern contraception, cancer, breastfeeding, cholesterol, gynaecology, menopause, osteoporosis, patient rights, pregnancy, etc., etc.

- *The State*

The Federal Ministry of Social Affairs and Health: (www.rudydemotte.be); Rijksinstituut voor Ziekte- en Invaliditeitsverzekering (R.I.Z.I.V.) or INAMI (l'Institut national d'assurance maladie invalidité)
Various websites with interesting information on health:
www.gezondheidsgids.be; www.e-gezondheid.be;
www.gezondheid.be;
http://www.iph.fgov.be/epidemio/epinl/crospnl/hisnl/table04.htm;
http://www.wvc.vlaanderen.be/gezondheidsindicatoren/ .

- *The Three Regions*

The Flemish Region

A substantial number of governmental institutions are very much involved in policies and activities relevant to the field of health in the Flemish region:

The Flemish Ministry of Welfare, Health and Family (www.ingevervotte.be); Vlaams Instituut voor Gezondheidspromotie (V.I.G.; www.vig.be); Het Lokaal Gezondheidsoverleg (Logo's; www.provant.be or www.vig.be); Ondersteuningscel Logo's vzw (www.ondersteuningscellogos.be); Sensoa (www.sensoa.be); Vereniging voor Alcohol- en andere Drugsproblemen (V.A.D.; www.vgc.be). Mutualiteiten (www.riziv.be).

- *The Brussels Capital Region*

A number of governmental institutions are involved in policies and activities relevant to the field of health in the Brussels Capital Region: such as: Brussel Gezonde stad; Administratie Vlaamse Gemeenschapscommissie, Lokaal Gezondheidsoverleg Brussel (www.vgc.be).

- *The Walloon Region*

No current information is available at the moment.

The main objectives in health are included in *Global, Inclusive Policy*. Nevertheless, it is sometimes necessary that women in Belgium should be an object of particular concern and protection by all state organs and public institutions related to their health. A substantial number of legal procedures and specific policies have been designed to address women and health issues.

Women are usually subject to research initiatives in relation to diseases typical for the female population such as osteoporosis, breast and cervical cancer.

Three primary issues and how they apply to women

- *Breast Cancer*

(http://www.tegenkanker.net/rubriek.asp?rubid=117)

Breast cancer is the most prevalent oncologic disease for Belgian women. Oncological diseases, and especially breast and cervical cancer, are considered a major priority of the national health policy. There are many legislative and regulative documents dealing with the management of these diseases. Many health professionals are involved in the prevention, early detection, treatment and rehabilitation after breast cancer. One out of ten women in Belgium gets the disease before they reach the age of 75. One out of three women does not survive the illness. For this reason, in Flanders, breast cancer screening is organised for women between 50 and 69 years. Every two years they are invited for a free mammography. The age group 50-69 was selected because it appeared that a generalised screening does reduce mortality caused by breast cancer. There has not been sufficient research into the effect of breast cancer outside these age limits.

- *Eating and weight disorders*

  (Bayingana, e.a., 2006)

Weight disorders

In Belgium, the Body Mass index (BMI) is used as an indicator. Over the age of 18, the BMI is a very stable measure. The average value for the Body Mass index for persons of 18 years or older in Belgium is 25.1 - a value which exceeds the under score for overweight (25). On average the inhabitants of Belgium are too fat. This average is significantly higher for men (25.6) than for women (24.7).

Excess weight – an analysis. The discussion of obesity distinguishes between overweight persons (BMI higher than 25) and obese persons (BMI higher than 30). Forty four per cent of the adult population (18 and over) are overweight. This proportion is much larger for men (51%) than for women (38%).

Underweight – an analysis. Approximately 10% of the Belgian population has low weight. Six per cent of these cases are underweight, while 3% of the Belgian population has extreme underweight. After correction for age, it can be determined that the female population especially has problems with (extreme) underweight; 14% in comparison with the male population (5%). Underweight is a bigger problem in the younger age groups, for both men and women, than in other age groups.

Lack of exercise, in combination with drastic changes in eating patterns have resulted in what we can call an epidemic of obesity. Excess weight impacts on blood pressure, etc. in the short term, but the long term impact is much greater. A huge part of the population in Belgium does not recognise weight and eating disorders as a real threat. It is not easy therefore for policy makers to address prevention.

Eating disorders

Eating disorders occur mainly in women: 90-95% of the anorexia nervosa patients are women. Epidemiological studies in Belgium have shown that eating disorders have increased over the last years.

Anorexia nervosa

Predominantly adolescent girls and women between 15-24 years, with a peak around 18 years, suffer from anorexia nervosa (accessed at: www.vlaanderen.be, 06 October 2006).

Bulimia nervosa

It is accepted that 5 out of 100 women in Belgium have bulimia, but there is some doubt about this figure. Among other factors, this relates to the fact that researchers do not always use the same criteria, and frequently set limits at 15-25 years. Older women are frequently excluded because bulimia is considered, just like anorexia nervosa, especially as an adolescent girls' illness. There are no official figures for Flanders, but the number is thought to be approximately 15,000 women. About 1000 new patients recover annually. Bulimia is 3 - 5 times more apparent in urban areas than in rural areas (Johan Vanderlinden, UZ health letter 120, 1-9-2001).

In addition to anorexia nervosa and bulimia nervosa, more and more women and men are suffering from *binge eating disorder* and *Anorexia Athletica disorder*.

More information is available on:

http://www.eetstoornis.be/

http://www.eetexpert.be/

http://www.self-help.be/zelfhulpgroepen/zelfhulpgroepen.htm

http://www.wvc.Flanders.be/gezondsporten/sport/eetstoornissen.htm

http://gezondheid.infoblog.be/eetstoornissen

Specific healthcare policies for young girls

There are no healthcare policies designed particularly for young girls in Belgium. However there is a strong tradition of school healthcare services with a preventive and health promotive orientation (e.g. use of alcohol,

tobacco, etc.) and several centres of expertise, such as the V.I.G. (www.vig.be), Sensoa (www.sensoa.be). This last organisation has stated that they have circulated a considerable amount of information concerning the use of modern methods of contraception (http://www.jongereninformatie.be/xcms/lang__nl-BE/554/default.aspx; http://www.sensoa.be/jong/flash.html).

An example of 'best practice' in women's health

- *Media campaign emphasises the 'Move it or Lose it' theme of World Osteoporosis Day.*

The theme 'Move it or Lose it' was the focus of the Belgian media campaign for World Osteoporosis Day 2005. With the support of WOD patron Sabine Appelmans, (former world class tennis player), the Belgian Association of Osteoporosis Patients, hand in hand with 'the Belgian Bone Club', issued press notices and gave interviews on radio, TV and print media. Dr. Christiane Pouliart of the Belgian Association for Osteoporosis Patients, appearing on radio and major news stations, underlined the benefits of exercise. She noted that tai-chi in particular is beneficial for the elderly. "European studies have shown that women over 80 years of age who practice 15 minutes of tai-chi two times a day reduce their risk of fracture by half."

- *Media campaign emphasises the field of women's healthcare, especially breast cancer.*

The project is called 'boezemvriendinnen' (VIVA SVV) (http://www.boezemvriendinnen.be/boezemvr.htm): breast awareness for women. VIVA-SVV boezemvriendinnen are volunteers who motivate other women to take part in breast cancer screening. Boezemvriendinnen is a project in which women support and encourage each other to take part in breast cancer screening.

Further examples of Belgian initiatives for women's health

- *In Belgium, women live longer than men but they are more often ill…*

The medical world in Belgium is conscious of the health differences between men and women. A great number of medical statistics have been categorised by sex and/or age, although a combination of both is sometimes lacking. However, access to these statistics does not mean that the health care is designed specifically for either men or women even though it has been seen that women live longer than men but, are more often ill.

Gender differences occur in many aspects of health. As an example, we will have a closer look at the results of the MERI project (Geerts & Messelis, 2004).

Since the 1990s we have had good database at our disposal which compiles information about the general health of elderly men and women. Macro-information is available on the general and physical health problems of women, though not always in comparison with men. Data are mainly about menopause, osteoporosis and fractures. Data that relate to causes of death are also available, and these include gender comparison. Heart-related and vascular problems, as well as cancer, are the most important causes of death for both sexes. Men die most often from lung cancer and women from breast cancer. Within the oldest category (75+), the most frequent cancers are prostate for men and colon/rectum for women.

When it comes to serious health problems and the consequent disabilities they can generate, men are affected more frequently than women. Women are more often confronted with various 'lighter' physical ailments and disorders.

Data are also available with regard to chronic complaints. We have information on prevalence and, to a lesser extent, longitudinal data at our disposal which relate to chronic complaints and discomforts (such as high blood pressure, etc.). Almost half of those aged 65 and over have to deal with chronic ailments. Within these data there is no mention of methodical gender differentiation within the various age groups. Some data reveal that these problems affect women of 65+ much more than men, as they appear to suffer more from physical constraints. There are no data available to overtly contradict these gender-differences.

We hardly deal with research material that inquires into illness within an individual span of life and the coping processes used to address illness. However, we do have data available about health perceptions, which differentiate between age and gender. These differentiations are highly relevant. The older the people concerned, the less positive their perception and, in general, men are more content than women. Many gender-bound differences of health perception are related to the difference in life expectancy: women tend to live longer than men. This means they have to cope more often with experiences of loss (situations that are often very stressful), and that they - in absolute figures - have to deal with age-related illnesses much more frequently. This is especially the case when one looks at data in regard to mental disorders.

The prevalence of dementia increases greatly after the age of 85. The findings on whether or not women are at a greater risk of developing dementia are contradictory. Some research shows that women stand a smaller chance of developing dementia, whereas other statistics show that proportionately they are afflicted with it much more often.

The occurrence of psychological issues, sleeping disorders, and anxiety problems increases with age, and are therefore more frequent among women. There are few data available that differentiate methodically between age and gender. When the distinction is made, however, the conclusion is the same: women suffer more from psychological problems than men, even when age differences are taken into account.

The pattern for suicide is different. Several sources indicate that the number of suicide attempts decreases with age, and even though women attempt to end their lives more often than men, men die more often as a result of suicide. Alongside objective and subjective factors relating to the health of women and men, it is also important to gather information about health behaviour. There are data available about medical consumption, or more specifically, about how often doctors are consulted. Generally speaking, the elderly appear to consume more than young adults. The findings show that there is a tendency among to women consume more than men, regardless of age group. Within the different age groups the distinction according to gender is rarely made.

We did not find much information about the use of medication; generally speaking, however, we could deduce from existing material that women take more medicines than men. These findings are often linked to differences found in terms of psycho-social problems. Another indicator in terms of health behaviour is what we call ‘healthy lifestyle’. When it comes to preventative health behaviour, most information focussing on women, as well pre-emptive actions undertaken by women, has to do with breast and cervical cancer. Generally speaking, preventative action is taken less by women over 60, even in terms of breast examinations and pap smears.

With regard to domestic care, we have access to data that are specifically differentiated according to age: the older the age category, the higher the degree of dependency, and therefore the need for domestic care. There are several extensive databases available but these do not distinguish gender within the differing age groups. Several pieces of

data address the question of what older people are able to cope with. In other words, to what extent can they help themselves? A few observations:

1. there is a wide array of information available on this subject;
2. however, sometimes there is a lack of a methodical gender analysis of the results;
3. there is little method when it comes to making this concept ('the ability to help oneself') operational. This makes a comparison of the research data rather difficult.

The existing trend has been confirmed by recent research into standards of living. In general terms, elderly people show a strong ability to help themselves, although depending on the activities, 10-40% of people aged 75 and over need care at home.

The gender-differences found relate mostly to the fact that women score less when it comes to features of mobility. If one looks at a wide range of domestic tasks and chores, they are less able to help themselves than men of a same age. In comparison to men, women take better care of themselves and their own health. In view of women's life expectancy they do rely on institutional care more often than men. In 2001, 80% of the people aged 95 and over were living in a residential home. This translates into a predominance of women, as they represent four fifths of this age group. We have data at our disposal about the use of day care centres, clinics, psychiatric institutions, and residential homes. Two restrictions are important in this respect:

- there are many more facilities for older people for which we have no methodical registration data yet;
- in all the information about 'institutional care' we found no data that methodically combined a differentiation in terms of age with one in terms of gender.

Conclusion drawn from the MERI project (Geerts & Messelis, 2004):

There is not enough *useful* data available on many aspects of older women's situation in Belgium. On certain topics we hardly have any information, or the information we do have is not differentiated according to age or gender.

Regardless of the above, one cannot deny that there has been a positive evolution in terms of the amount of information available, but there are still many gaps in our knowledge. Our analysis showed that certain themes are well-documented, such as older woman's employment situation. Other themes, such as the ability to help oneself, are also reported on sufficiently, but it is still difficult to obtain a general picture from the information available. There were several subjects in this study for which it was not easy to gather information. If we could derive the situation of older women in our society from the data, there were still inconsistencies and shortcomings; little attention has been given to diversity within the group in terms of age, ethnic origins, etc. Generally speaking, we can say that older women are still too invisible in the data, and even if they are rendered visible as a group, not enough attention is drawn to the diversity within. We not only need a higher quantity of figures, we also need data of a different quality.

Furthermore, it is important that the existing data can be compared, as this is after all the essence of scientific development. A lot remains to be done in this respect as well. It seems vital to us that the existing figures are more carefully attuned to each other, so that not only their scientific use but also their social value increases. The ageing of the population is a huge social challenge for Belgium. The demand for more research, and a research institute etc. has been voiced at several levels in recent years. It seems therefore very important to us, particularly in view of the feminisation of this ageing population, that attention is systematically given to gender-specific research and

statistics. This is also important in the context of equal opportunities policies. The feminisation of the ageing population is a crucial factor in social terms: it is consequently very important that the process can be underpinned scientifically. We need scientific means with which we can reveal and measure the treatment of and discrimination against women objectively. Equal opportunities policies must be based on a better awareness of reality. This is why gender statistics must be compiled methodically, taking account of age differences as well. Gender data must be compiled and developed for older people too, so that government policy for this group of women can be systematically set on the basis of the information drawn (Geerts & Messelis, 2004).

Main Reference:

Highlights of Health in Belgium (http://www.euro.who.int/document/e88544.pdf)
http://www.bruxelles.irisnet.be/en/region/region_de_bruxelles-capitale/belgique_etat_federal.shtml
http://www.umsl.edu/services/govdocs/wofact2006/ (CIA World Factbook, 2006)
http://www.lifesite.net/ldn/2006/feb/06020707.html
http://www.pregnancy-info.net/in_the_news1.html
http://www.johnstonsarchive.net/policy/abortion/ab-belgium.html
http://www.who.int/whosis/whostat2006/en/index.html (World health Statistics, 2006)
http://www.rudydemotte.be
http://www.gezondheidsgids.be
http://www.e-gezondheid.be
http://www.gezondheid.be
http://www.iph.fgov.be/epidemio/epinl/crospnl/hisnl/table04.htm
http://www.wvc.vlaanderen.be/gezondheidsindicatoren/
http://www.ingevervotte.be
http://www.vig.be
http://www.provant.be
http://www.ondersteuningscellogos.be
http://www.sensoa.be
http://www.vgc.be
http://www.riziv.be
http://www.tegenkanker.net/rubriek.asp?rubid=117
http://www.vlaanderen.be
http://www.eetstoornis.be/
http://www.eetexpert.be/
http://www.self-help.be/zelfhulpgroepen/zelfhulpgroepen.htm
http://www.wvc.Flanders.be/gezondsporten/sport/eetstoornissen.htm
http://gezondheid.infoblog.be/eetstoornissen
http://www.jongereninformatie.be/xcms/lang__nl-BE/554/default.aspx
http://www.sensoa.be/jong/flash.html
http://www.boezemvriendinnen.be/boezemvr.htm
http//www.own-europe.org (Geerts, C. & Messelis, E. (2004). Living conditions of women 50+ in Belgium, MERI project, Vrije Universiteit Brussel)

http://www.iph.fgov.be/epidemio/epinl/crospnl/hisnl/table04.htm (Bayingana K, Demarest S, Gisle L, Hesse E, Miermans PJ, Tafforeau J, Van der Heyden J. (2006). Gezondheidsenquête door middel van Interview, België, 2004. Afdeling Epidemiologie, 2006; Brussel. Wetenschappelijk Instituut Volksgezondheid**,**