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HEALTH EQUITY 2020

HEALTH EQUITY-2020 PROJECT

# REDUCING HEALTH INEQUALITIES PREPARATION FOR REGIONAL ACTION PLANS

## RESULTS OF NEEDS ASSESSMENT AND ACTION PLAN

## KLAIPĖDA DISTRICT, LITHUANIA


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*2015, Gargždai*

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*Klaipėda District Municipality*


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# PART 1 WHAT DOES THE EVIDENCE for your region SAY?

## Phase 1 Carrying out the NEEDS ASSESSMENT

Assessing the magnitude and determinants of socioeconomic health inequalities

### 1.1 Introduction

*It is important to consider the fact that there are differences not only between countries but also within the country. There are visible public health care inequalities between different districts (regions). First of all, it is necessary to evaluate local socio-economic situation and its differences. Situation has to be analyzed at different levels evaluating different socio-economic factors on health in the districts. This will strengthen the structure and impact of developed and implemented strategies on Lithuanian population groups' health.*

*This analysis is prepared in order to:*

*• Show the basic social, health indicator changes, which have impact on public health;*

*• Build up knowledge and awareness that health can affect not only socio-economic situation, but also that socio-economic situation affects health;*

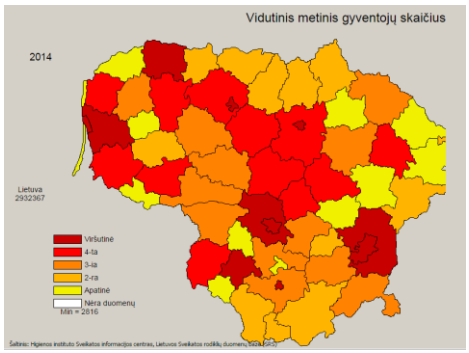
*• To encourage politicians and professionals to discuss about socio-economic factors influence on health and health care and to plan actions.*

*Function health monitoring from 2007 delegated to municipalities by Government with goal - every year to assess health of population at local level, to set priorities for health promotion and health system strategy and development of all municipality, to evaluate changes in health. For this function (monitoring) is responsible Klaipeda District Municipality Public Health Bureau (further – PHB). Every year prepared municipal health profile by PHB and Municipal Administration Health Division is presented to Municipal Council. In municipality, there is now tradition to delegate presentation of Municipal health profile for politicians during Council session by Community Health Board with goal to set priorities for health promotion and to get commitment of politicians to act. Second presentation was done with youth representatives. For Health, profile done in 2014 and 2015 was with focus to health inequalities. We used national routine health data (mortality, morbidity) from Hygiene Institute and data representing demographic, social and economic situation from National Statistic Department. In addition, every three years PHB carry out population surveys on health behaviour. For the Health profile report there also was presented health behaviour survey results with focus on behaviour differences between socio economical groups. Surveys represents adult population from 18 to 64 years old and consist of questions about tobacco, alcohol use, eating habits, physical activity level, mental health and etc. Klaipeda University Public Health Department researchers prepared methodology and questionnaire. For presenting health inequalities in municipality from routine data there was not possible to do it because of no possibility to link mortality or morbidity data with social and economic*

*data at local and event at national level. It was the main reason to focus on data collected from surveys in 2007, 2011 and 2014.*

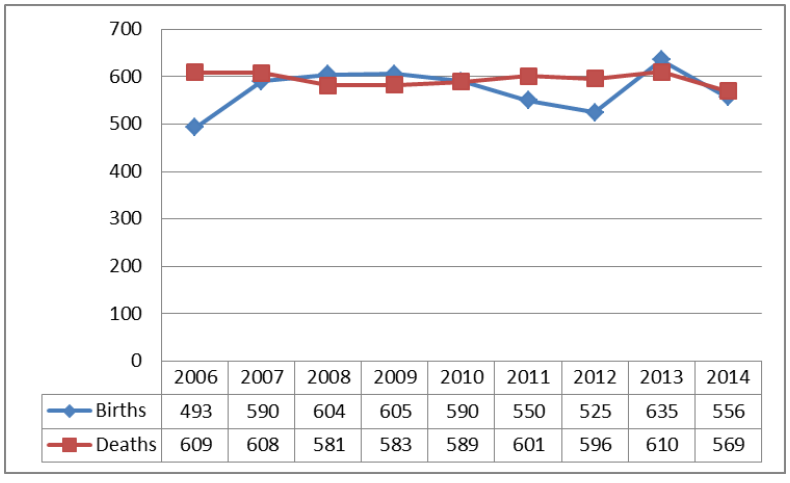
### 1.2 Regional profile

*In Klaipeda District Municipality in 2014 lived 52110 people: males – 25376, females – 26734; in rural area – 35816 people (68,7 percent), in urban area – 16294 people (31,3 percent). Children (0-17 y.) of 20,9 percent of the total population of the region, 65 y. and older – 18,4 percent . 2014 years Klaipėda area was on the top in terms of population density. Average age of population in 2014 was 39 years (males – 37 y., females – 42 y.) (1 picture).*




*1 picture. The distribution of the population density 2014 y.*
*Source: Hygienic Institute for Health Information Center*

*2013 y. in Klaipeda district municipality, compared with 2012 y., the number of births increased from 525 to 635 (an increase of 110 births), was a positive natural increase of the population, but in 2014 y. natural population growth was negative (born – 556, dead - 569) (picture 2).*



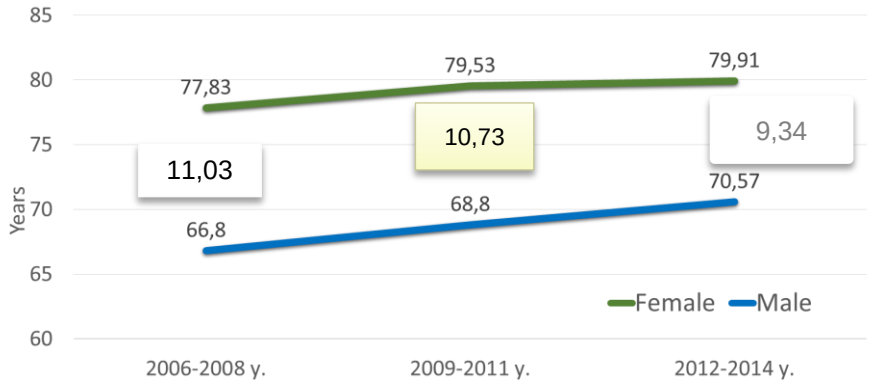

| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|
| Births | 493 | 590 | 604 | 605 | 590 | 550 | 525 | 635 | 556 |
| Deaths | 609 | 608 | 581 | 583 | 589 | 601 | 596 | 610 | 569 |

*2 picture. Changes in deaths and births in Klaipeda District Municipality*
*Source: Lithuanian Statistic department*

### 1.3 Socioeconomic inequalities in health

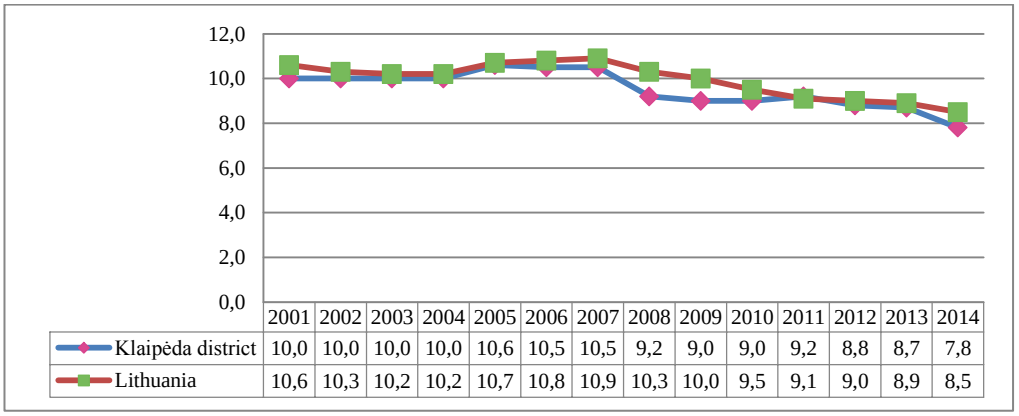
***Mortality and life-expectancy***

*Life-expectancy differences in Klaipeda District ir increasing, and gap between males and females is decreasing and in 2012-2014 y period was 9,34 y (in Lithuania – 10,74 y. in 2014). The goal of Lithuanian Health Program is to reduce gap to 8 y. in 2020.*




*3 picture. Life expectancy at birth, by gender (2006-2014 y.), Klaipėda District*
*Source: Klaipėda District Municipality Public Health Bureau „Klaipeda District Health profile 2014 y.“ Lithuanian Statistic Office.*

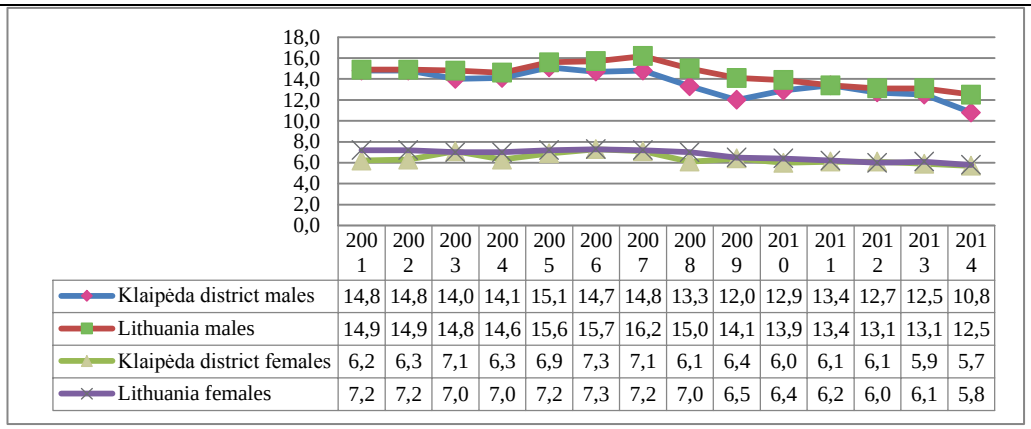
*The analysis of the mortality situation in 2001-2014 y. period, since 2011 to 2014 y. in the region of Klaipeda mortality had decreased 1,4 deaths of 1000 inhabitants. In 2014 y. in Klaipeda district mortality decreased fractionally (1000 inhabitants had 7,8 deaths), compared to 2013 y. – 8,5 deaths (4 picture).*




| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Klaipėda district | 10,0 | 10,0 | 10,0 | 10,0 | 10,6 | 10,5 | 10,5 | 9,2 | 9,0 | 9,0 | 9,2 | 8,8 | 8,7 | 7,8 |
| Lithuania | 10,6 | 10,3 | 10,2 | 10,2 | 10,7 | 10,8 | 10,9 | 10,3 | 10,0 | 9,5 | 9,1 | 9,0 | 8,9 | 8,5 |

*4 picture. Standardized mortality per 1000 inhabitants.*
*Source: Hygienic Institute for Health Information Centre, PHB counting*

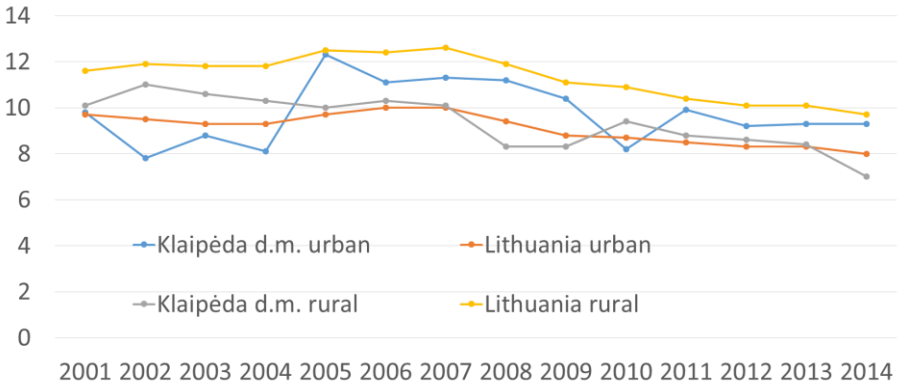
*Comparison with 2013 y., 2014 y. in Klaipeda district and in Lithuania males and females mortality decreased, but males mortality was twice higher than women (2014 y. in Klaipeda district were 10, 8 males deaths and 5,7 females deaths) (5 picture.).*




| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Klaipėda district males | 14,8 | 14,8 | 14,0 | 14,1 | 15,1 | 14,7 | 14,8 | 13,3 | 12,0 | 12,9 | 13,4 | 12,7 | 12,5 | 10,8 |
| Lithuania males | 14,9 | 14,9 | 14,8 | 14,6 | 15,6 | 15,7 | 16,2 | 15,0 | 14,1 | 13,9 | 13,4 | 13,1 | 13,1 | 12,5 |
| Klaipėda district females | 6,2 | 6,3 | 7,1 | 6,3 | 6,9 | 7,3 | 7,1 | 6,1 | 6,4 | 6,0 | 6,1 | 6,1 | 5,9 | 5,7 |
| Lithuania females | 7,2 | 7,2 | 7,0 | 7,0 | 7,2 | 7,3 | 7,2 | 7,0 | 6,5 | 6,4 | 6,2 | 6,0 | 6,1 | 5,8 |

*5 picture. Standardized mortality by gender per 1000 inhabitants.*
*Source: Hygienic Institute for Health Information Centre, PHB counting*

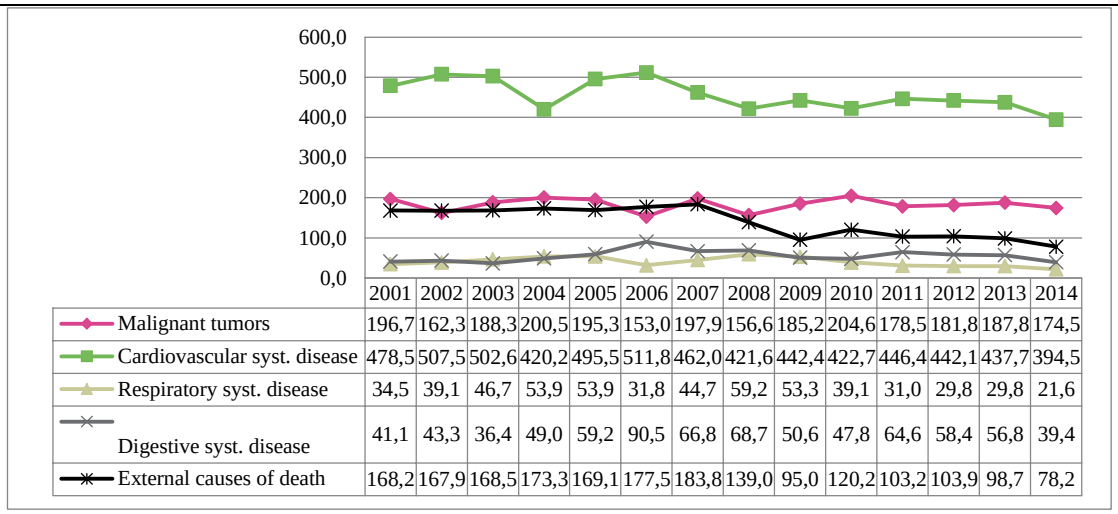
*Mortality rate in Klaipeda district is reducing, but comparing differences in urban and rural area is still big (see picture no. 6)*




*6 picture. Standardized mortality rate differences between urban and rural population, 1000 pop.*
*Source: Hygienic Institute for Health Information Centre, PHB counting*

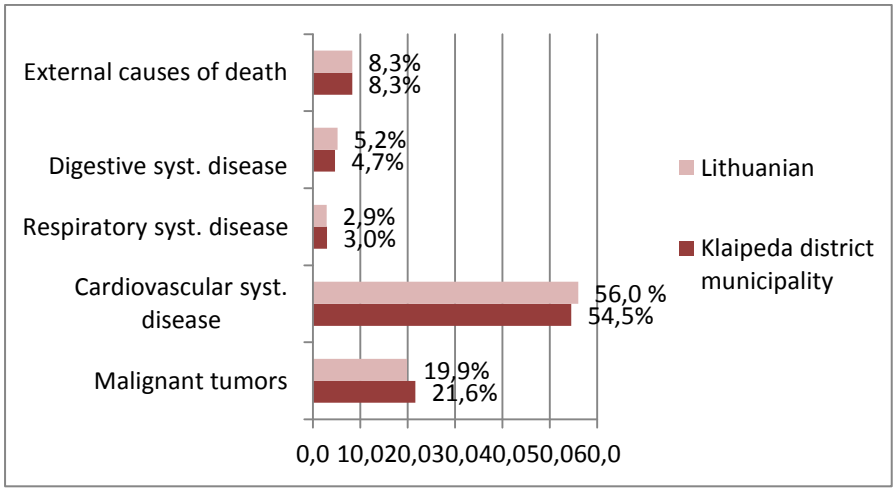
***Health during life***

*The analysis of standardized mortality rate by cause, the main reason of death is cardiovascular system diseases, but from 2011 to 2014 y. in Klaipeda district mortality decreased 51,9 deaths of 100 000 inhabitants. In 2014 in Klaipeda district municipality mostly died from cardiovascular system diseases (56 percent), in the second place- from malignant tumours (19,9 percent), in the third place- from external causes of death (8,3 percent) (6,7 picture).*




| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Malignant tumors | 196,7 | 162,3 | 188,3 | 200,5 | 195,3 | 153,0 | 197,9 | 156,6 | 185,2 | 204,6 | 178,5 | 181,8 | 187,8 | 174,5 |
| Cardiovascular syst. disease | 478,5 | 507,5 | 502,6 | 420,2 | 495,5 | 511,8 | 462,0 | 421,6 | 442,4 | 422,7 | 446,4 | 442,1 | 437,7 | 394,5 |
| Respiratory syst. disease | 34,5 | 39,1 | 46,7 | 53,9 | 53,9 | 31,8 | 44,7 | 59,2 | 53,3 | 39,1 | 31,0 | 29,8 | 29,8 | 21,6 |
| Digestive syst. disease | 41,1 | 43,3 | 36,4 | 49,0 | 59,2 | 90,5 | 66,8 | 68,7 | 50,6 | 47,8 | 64,6 | 58,4 | 56,8 | 39,4 |
| External causes of death | 168,2 | 167,9 | 168,5 | 173,3 | 169,1 | 177,5 | 183,8 | 139,0 | 95,0 | 120,2 | 103,2 | 103,9 | 98,7 | 78,2 |

*6 picture. Standardized mortality by causes of 100 000 inhabitants in Klaipeda district*
*Source: Hygienic Institute for Health Information Centre*

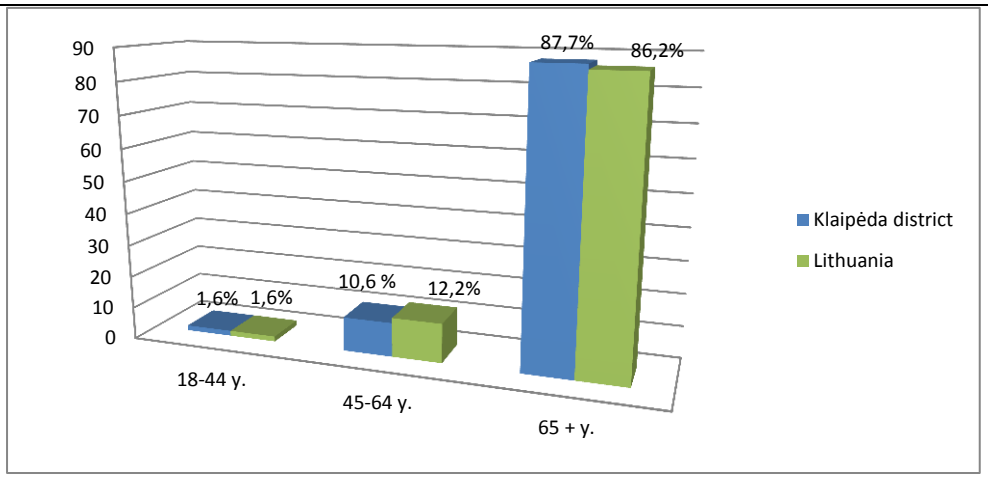



*7 picture. The distribution of deaths by cause in 2014 y. (in percent)*
*Source: Institute of Hygiene death cases and their causes state register, PHB counting*

*The mostly recorded cardiovascular disease - hypertension, in 2014 y. in Klaipeda district were 167,8 persons of 1000 inhabitants with hypertension.*

*In 2014 y. in Klaipeda district males deaths from cardiovascular system diseases were twice higher than women – 516,7 males and 317,5 females deaths (in Lithuanian – 571,6 and 318,6 deaths). In Klaipeda district urban population mortality rate was lower than the rural population (respectively 125 and 185 deaths).*

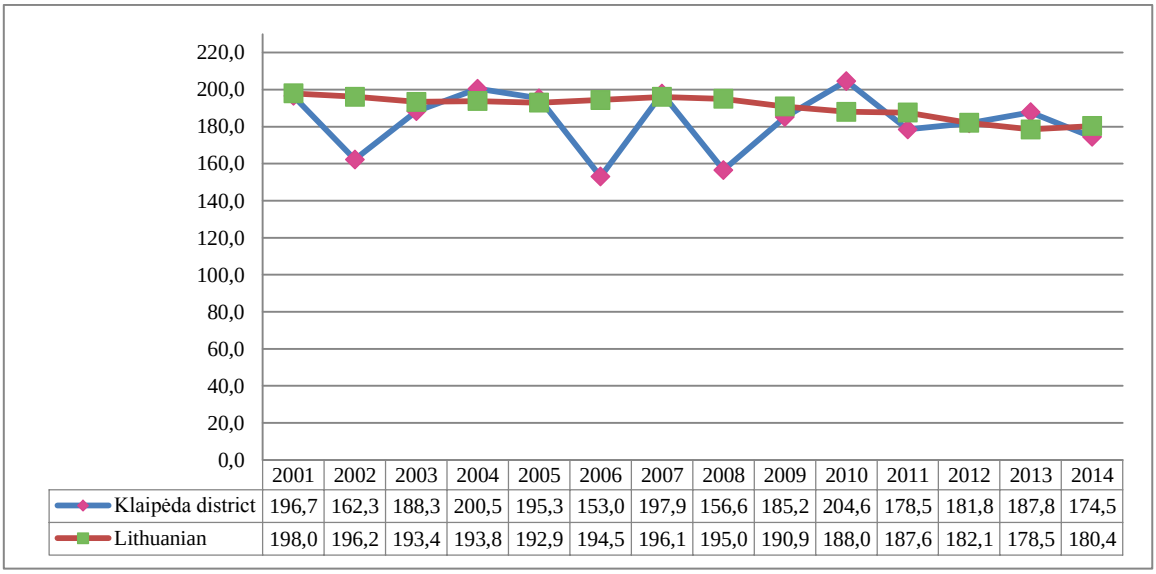
*The mostly died elderly population of the cardiovascular system diseases- in 2014 y. in Klaipeda district 87,7 percent of all deaths from cardiovascular diseases was 65 and older people, in Lithuanian- 86,2 percent (8 picture).*




*8 picture. Deaths from cardiovascular syst. diseases (I00-I99) by age groups in 2014 y. (in percent).*

*Source: Institute of Hygiene death cases and their causes state register, PHB counting*

*Compared to Lithuania, 2010-2014 y. Klaipeda district mortality from cerebrovascular diseases changed unevenly. In 2014 y. cerebrovascular diseases accounted 17,7 percent of all deaths from cardiovascular system diseases, compared to 2013 an increase of 7 percent the number of deaths (9 picture). In Klaipeda district from 55 recorded cerebrovascular diseases, 63,6 percent consisted of a stroke (35 deaths).*




| | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Klaipėda district | 196,7 | 162,3 | 188,3 | 200,5 | 195,3 | 153,0 | 197,9 | 156,6 | 185,2 | 204,6 | 178,5 | 181,8 | 187,8 | 174,5 |
| Lithuanian | 198,0 | 196,2 | 193,4 | 193,8 | 192,9 | 194,5 | 196,1 | 195,0 | 190,9 | 188,0 | 187,6 | 182,1 | 178,5 | 180,4 |

*9 picture. Standardized mortality from cerebrovascular diseases (I60-I69) of 100000 inhabitants.*

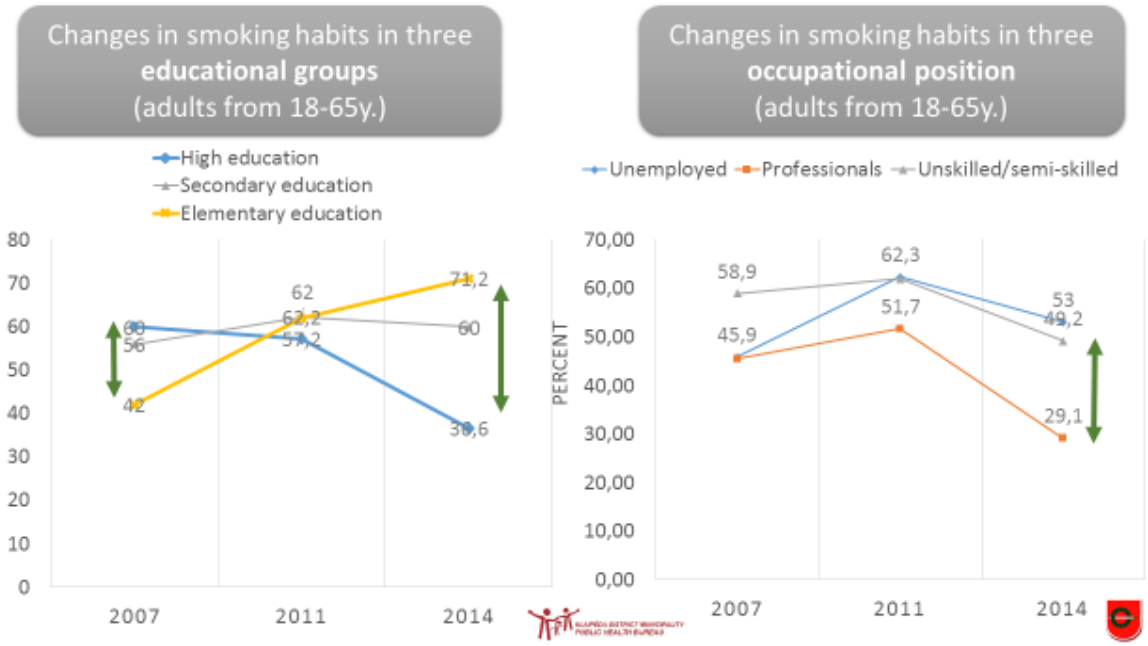
*Source: Hygienic Institute for Health Information Centre*

### 1.4 Socioeconomic inequalities in health determinants

***Health behaviours***

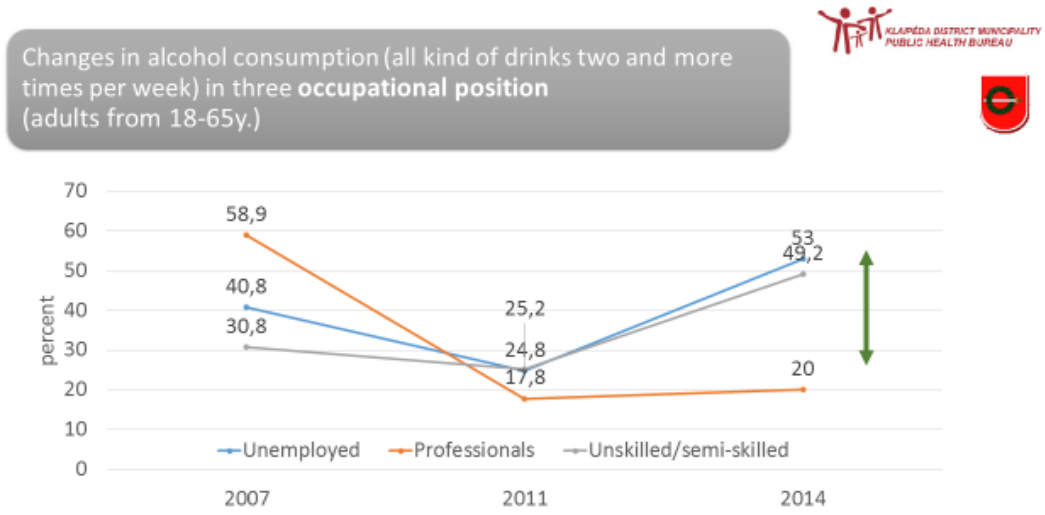
*Smoking.*

*Every day tobacco users in 2014 y. was 48 percent, less smoking habit had rural population than urban population (respectively 33,5 and 60 percent.) and females comparing with males (respectively 38.1 and 60 percent.). Mostly smokes 55 to 64 years age-old persons. The analysis of distributions by education showed that most of the tobacco users was with primary / basic education with the people and their smoking has increased. Comparing the data shows that the least tobacco users was between population with university degree. 2014. survey data, the population of divorced and widows who smoke is 53,3 per cent., unmarried / unmarried population – 40,5 per cent., and married / married or living out of wedlock – 47,4 percent. More tobacco users was between hard workers (agricultural and forestry activities, jobs in manufacturing, construction, etc.) and the unemployed (including students, housewives, pensioners). The gap between population with different education level and occupational position increased during last 9 years.*




*Alcohol consumption*

*According to the survey, alcohol consumption has increased in Klaipeda region. Men consume any alcohol more often than women do. The urban population alcohol consumption in 2014 compared to 2011 increased and the consuming rate was higher than in the rural population. Analyzing 2014 survey responses by age groups showed that every second resident of Klaipeda district and 24 age old any alcoholic beverage consumed two or more times a week. The lowest consuming alcoholic beverages under the age was 35-44 years age population. Survey showed that even 75,3 percent of people with primary / secondary education drink two or more times a week. Unmarried part of population and unemployed use alcohol more comparing with other part of respondents.*




*Physical inactivity*

*During the study, we asked residents of Klaipeda District about their physical activity during their leisure time (the norm was at least 30 min.). Every second resident of the district of Klaipeda exercise at least 4 times a week, and this percentage is increased. Men exercise more than women do. Classified by age group - mainly young people who are up to 24 years old and 55-64 years old respondents were more active. Klaipeda district residents with higher and primary / secondary education, compared with other part of population, exercise frequency increased. Divorced or widowed population (s) part sports less than residents who lives with partners or are still unmarried. Unemployed (including students, housewives, pensioners) exercise more often than employed residents of Klaipeda District.*

*Diet*

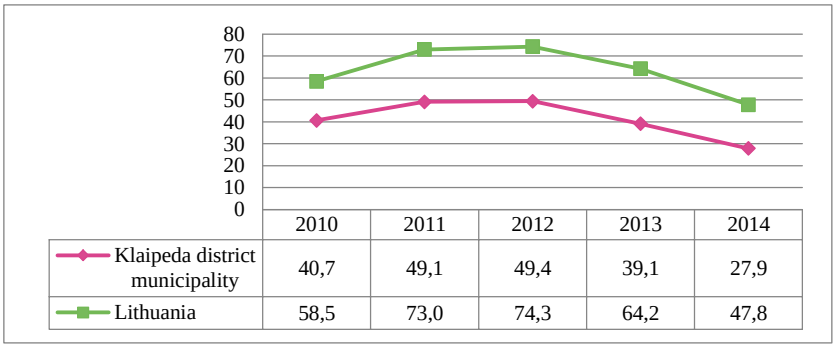
*Women more often than males consume fresh vegetables. Other types (cooked, canned, frozen) of vegetables, more eat urban than rural residents do. More fresh vegetables, eats persons with secondary education. Fresh vegetables are more often used in Klaipeda district residents employed than unemployed are. During 7 years increased fresh vegetable consumption gap between residents who lives with other partners and alone. Consumption of fresh vegetables gap decreased between urban and rural population, but increased in consumption of other vegetables types (from 7,8 percent to 12,7 percent difference).*

***Working & living conditions***

*2011 y. Klaipeda district municipality people, who had accommodation with hot water to be 13192 inhabitants, with the toilet with wastewater- 13405; with bath or shower - 13776, with plumbing- 15979, with an electricity - 17770, with sewerage- 15929 inhabitants.*

*Since 2012 to 2014 y. in Klaipeda district municipality and in Lithuanian decreased the number of people who received social benefits (respectively decreased 21,5 and*

*26,5 people of 1000 inhabitants). In 2014 y. in Klaipeda district municipality, social benefits recipients number was 1,7 times lower than in Lithuanian ( 27,9 and 47,8 recipients) (10 picture).*




| | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|
| Klaipeda district municipality | 40,7 | 49,1 | 49,4 | 39,1 | 27,9 |
| Lithuania | 58,5 | 73,0 | 74,3 | 64,2 | 47,8 |

*10 picture. Social benefits recipients' number of 1000 inhabitants*
*Source: Lithuanian Statistic department, PHB counting*

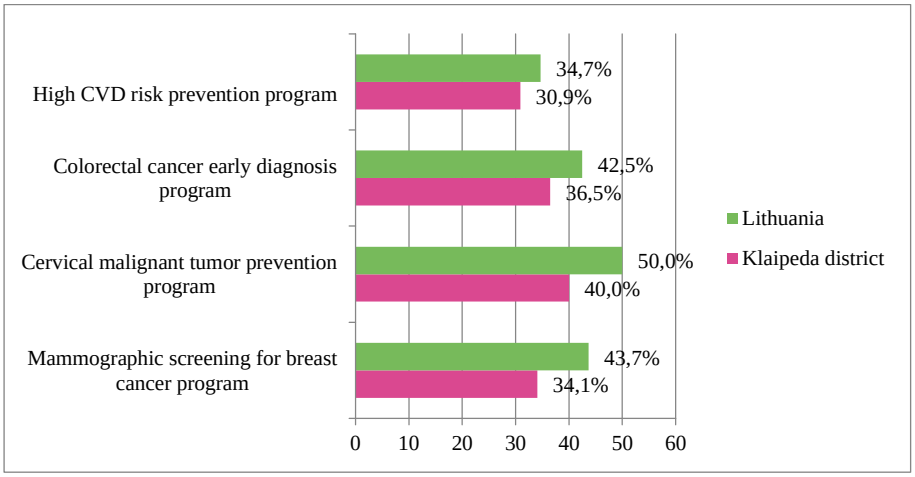
*In 2014 y. in Klaipeda district, pupils, who received free nutrition were 1,6 times lower than in Lithuanian (156,9 and 253,8 pupils of 1000 inhabitants). In 2014 y., comparing with 2010 y., in Klaipeda district municipality the number pupils, who received free nutrition decreased to 958 pupils, in Lithuanian- 53928 pupils.*

### *Access and use of health services*

*In 2014 y. in Klaipeda district 394113 inhabitants visited doctors, preventive visits to compose 13,5 per cent of all visits to the doctor. Visits to first level services providing doctors composed 4,1 times per capita, visits to the II/III level services providing doctors- 0,8 times per capita, visits to dentists- 0,76 times per capita.*

### *Access and use of health services*

*In 2014 y. in Klaipeda district and in Lithuania, half of inhabitants participated in cervical malignancy preventive program (respectively 40 and 50 percent.) (14 picture).*




*14 picture. Participation in prevention programs in 2014. (in percent).*

*Source: Hygienic Institute for Health Information Centre*

*In 2014 y. in Klaipeda district 12,5 percent children (6-14 years) participated in sealants teeth safety program and in Lithuania- 20,9 percent. In 2014 y. in Klaipeda district 95,8 percent of 1 year old children were vaccinated from diphtheria, tetanus, pertussis, polio, Haemophilus influenza B, in Lithuania- 92,9 percent.*

### 1.5 Economic consequences of health inequalities

***Labour related indicators***

*In 2014 y. in Klaipeda district of long-term unemployment rate was 2,3 times lower than in Lithuania (respectively 1,32 and 3,08). 2015 y. on 1 January in Klaipeda district was 438 long-term unemployed, in Lithuania- 52932.*

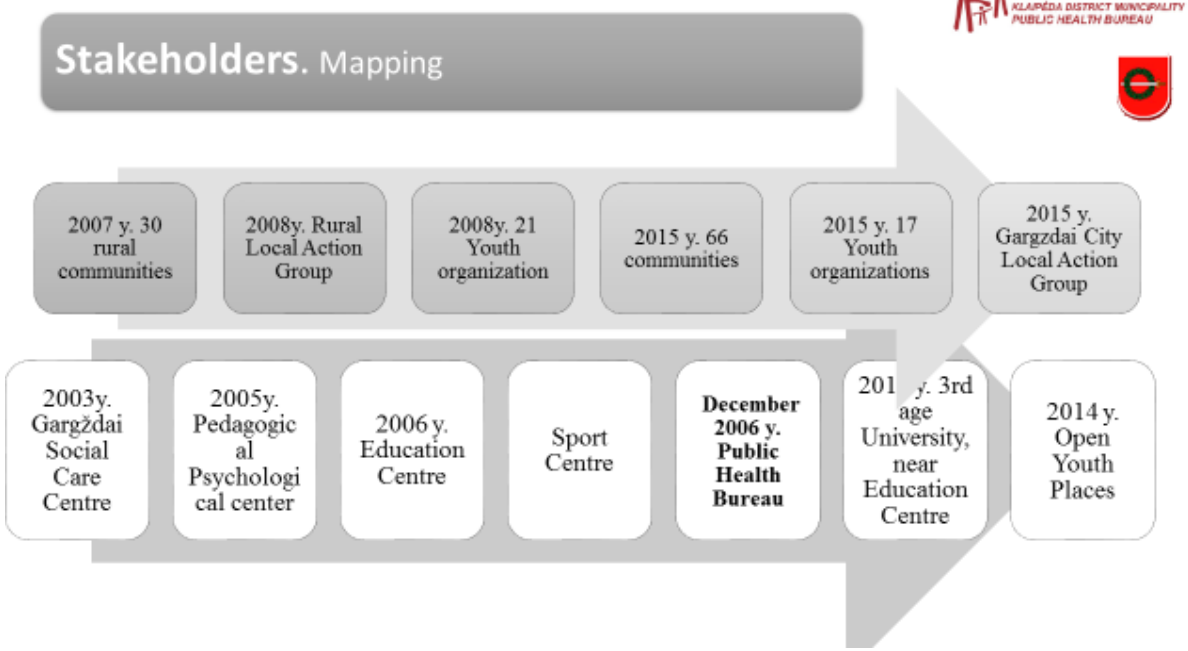
***Direct costs related indicators***

*No data at local level*

## Phase 2 Conducting a CAPACITY ASSESSMENT

**Introduction**

*Capacity audit in Klaipeda district done during two phases:*
*1. Mapping stakeholders (2014 y.)*
*2. Capacity assessment (June 2015)*
*Mapping of stakeholders and their functions done with purpose to understand - how many institutions are in municipality, what functions they do, how they act related to health. Analyse of communities was made with purpose to understand their involvement in decision-making process, capacities to act.*




*In January, 2015 there was organized focus group discussion and invited 14 different stakeholders to talk about health inequality, data collection possibilities. The questions were separated into parts: individual level knowledge, capacity and possibilities to act, organizational level and National level and local level. Focus group done by Klaipeda University Public Health department help.*

**Findings**

*Stakeholders understand that there are differences in health; there is lack of understanding about how to reduce health inequalities, the role of other sectors in reducing disparities in health. Stakeholders wants to know territorial differences in municipality for planning purpose of actions and they need more capacity building sessions (negotiation, advocacy...). Ten percent of communities are active in health promotion field, for other communities priority is wellness of their community and it is related with planed actions to implement.*

## Phase 3 Setting the potential ENTRY POINTS for action

### 1.6 Setting priorities

*[What are the health inequalities that raised concerns in your region? Why?*
*How did you choose a/ between priorities? Explain it by taking into account factors like: impact, changeability, acceptability, resource feasibility.*
*Talk about European regional priority setting! European Structural and Investment Funds are a potential source for funding actions but they also set up the political agenda in terms of developing priorities. Have you managed to relate your priorities set up for your region/country to the European level?]*

*Health monitoring showed that the main health problem in Klaipeda District with which we need to deal is all avoidable diseases. Comparing with other municipalities Klaipeda District municipality is not a priority as territory for national level for bigger investment to solve health problems. Mortality rate in all main diseases is lower than Lithuanian average. Nevertheless, monitoring showed that we have differences of mortality rate between urban and rural area. Harmful habits are reducing, but we have bigger gaps between SES groups in 2014 comparing with 2007 y. Data showed us that we need to focus not just to monitoring changes of main factors prevalence, but also to asses changes of gaps between different SES. For priority setting was very important to asses and integrate goals of National documents. Lithuanian Health program 2014-2025 also was with focus to reduce health inequalities between regions.*

*Also setting priorities were taken into accou*nt in the national action plans on reducing health inequalities, approved in 2015.

### 1.7 Choosing actions

*Choosing actions process was very long and hard. We needed to integrate knowledge, science and integrate actions suggested by national strategy documents. We looked to our local strategy document and saw that in it we have actions reducing the inequalities in socioeconomic position itself (education, income, or wealth in other sectors programs, but we need new actions for improving health determinants prevalent among lower socioeconomic groups (living and working conditions, health behaviours, accessibility to and quality of health care and preventive services). We focused to integrate actions with this strategy (a) a targeted approach; (b) a whole population approach; (c) a life-course perspective; (d) tackling wider social determinants of health.*

### 1.8 Translating actions into regional action plans

*For selecting actions we took in consider how we will reach our target population, which sector can do it, which institution?*

## Phase 4 The IMPACT ASSESSMENT

Assessing the potential impact of actions on health and health inequalities

| **Screening** |
| --- |
| *The actions taken in municipality according monitoring data had good impact to reducing gap between males and females difference in life expectancy, but it raised some inequalities in health behaviour between different SES groups. This planned strategy is with focus to differences to health and actions is selected very precisely according knowledge that is now available. Also regular impact assessment of actions will help us to monitor implementation of actions and it's influence to health inequalities.* |
| **Scoping** |
| Selecting actions we looked to literature reviews, used expert consultation to get |

| |
|---|
| knowledge and to assess how our selected actions can influence differences in life expectancy, smoking, diet, physical activity, alcohol consumption differences between separate population groups. |
| **Decision making** |
| Our experience from two years showed that participatory approach and capacity building of other sectors is very important for planning, implementation and evaluation of strategies or selected actions success. |
| **Monitoring & evaluation** |
| *Our process of integration of action plan is still going on, and the impact assessment carried out successful as it could be during this short time.* |
| |

# PART 2 Action plan to TACKLE HEALTH INEQUALITIES

## Action Plan

### 2.1 General context

| |
|---|
| *Average life expectancy in Klaipeda District Municipality is higher than average of Lithuania, but gap between male and female is still big. Needs assessment showed that prevalence of smoking, alcohol use is reducing, but no changes in nutrition and physical activity level among adult people. Inequality assessment showed that the gap between different SES groups become bigger related to their habits (tobacco, alcohol use, nutrition and physical activity level). It shows that action taken before increased gap between different SES groups and at local level, there is need to take into account these difference. Municipalities has big possibilities to reduce harmful behaviour at local level, by involving local stakeholders and taking action nearest to community. Municipal Council approved four main vertical priorities and stakeholders put on agenda horizontal priorities to reach. Health sector has low number of resources and plays smaller role in creating supporting environment for people to be healthier, the main role is of other sectors, which can reach risk groups (exp. Social sector, education sector) and create environment for more quality life. The plan for strategic goal, to increase average life expectancy and reduce health behaviour gaps in Klaipeda district municipality by implementing HiA policy approach, was developed by group of stakeholders of different sectors and involving communities as advisors. The process took more than 1 year and started from need assessment, presenting data to politicians (approved on May 2015) setting main vertical priorities and getting political "green light" to start discussions with other stakeholders, to plan needed actions to reach municipal goals. We created separate groups to plan, organized meeting with communities and different institutions. The main coordinator of action plan was Community Health Board with help of Klaipeda District municipality Public Health Bureau and Municipal Administration Health Division professionals in health. There was agreement to have separate plan for reducing health inequalities, but* |

*other sectors stakeholders into different programs (exp. will integrate actions into local municipal strategic action plan. Actions for increasing population's physical activity level into sport program of strategic plan). Before suggesting different actions, professionals assessed local strategic plan to know what we already planned, and what we need to strength. In addition, there was need to integrate actions approved in National Lithuanian health program 2014-2025 and take into account what proved on national inequality reduction action plans.*

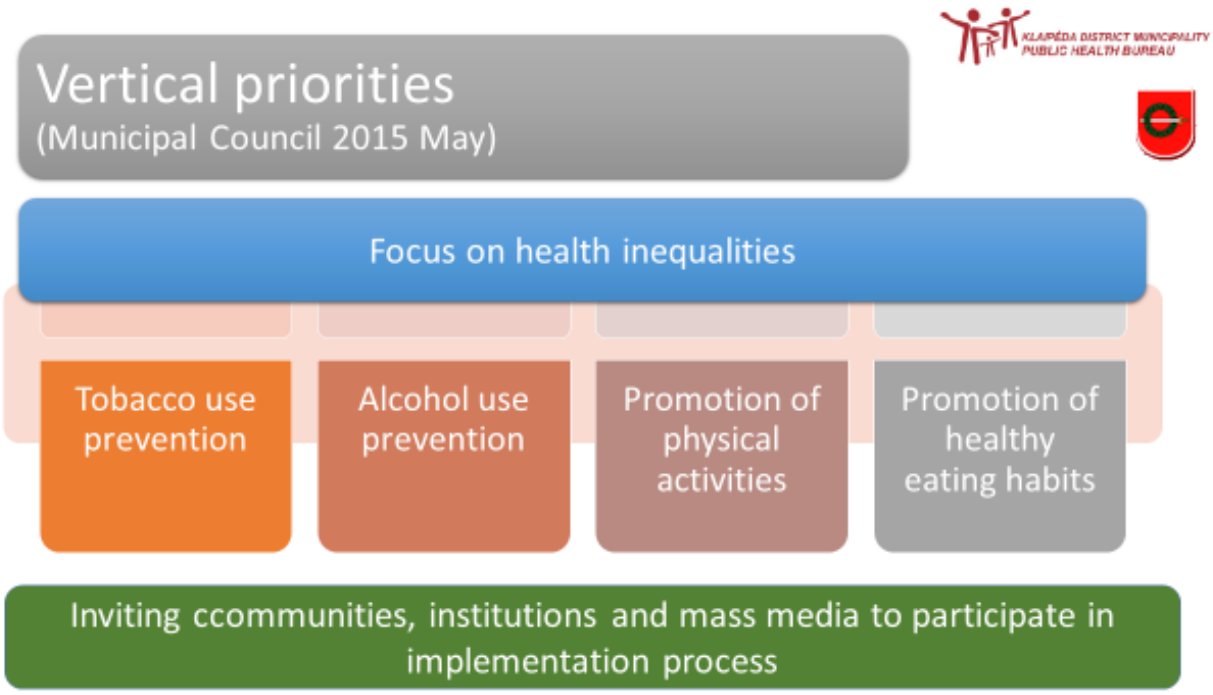
### 2.2 List of partner organisations

1. *Community Health Board – coordinator of action plan*
2. *Drug Prevention and Control Committee*
3. *Klaipeda District Municipality Public Health Bureau*
4. *Divisions of Municipal Administration: Health Care division, Education Division, Culture Division, Strategic Planning and Monitoring Division, Culture Division, License Division, Architecture and Urban Planning Division, Social Care Division*
5. *Politicians*
6. *Communities involved into preparation of plan (13)*
7. *Education Centre*
8. *Social Care centre*
9. *Pedagogical Psychological Centre*
10. *Childs Rights Protection Office*
11. *Open youth centres*
12. *Sport centre*

### 2.3 List of supporting documents

*Socioeconomic health inequalities in Klaipeda District, Lithuania*

### 2.4 Action Plan table




***Main horizontal priorities:***

- *Ensure for all equal opportunities to health promotion*
- *Building capacities for partnership of other sectors and health*
- *Prevention of risk factors, by creating strong social support and environment.*
- *Risk factor prevention with focus on early stage and youth.*
- *Risk factor prevention with focus on vulnerable groups and territories*
- *Integration of public health and primary health care services*
- *Strengthening population health literacy*
- *Strengthening professionals (health and decision makers) health inequality literacy*

***Main goal** - to increase average life expectancy and reduce health behaviour gaps in Klaipeda district municipality by implementing HiA policy approach*

***Aims:***

1. *To reduce health inequalities carrying out health strengthening and healthy lifestyles*
2. *To reduce health inequalities in maintaining / supporting risk groups*
   *To strength other sectors capacities to act for health*

| Actions | Output/ Deliverables | Responsible party | Others to involve to complete action | Timeline | Indicators | Financial resources |
|---|---|---|---|---|---|---|
| Priority area/Objective<br>• Alcohol use prevention | | | | | | |
| *1. To reduce accessibility of alcohol by creating regular social media support* | *Created places for Social media, controlled by Municipality* | *Community Health Board, Drug prevention and Control Committee* | *Klaipeda District Municipality Public Health Bureau Health Care Division* | *2015-2018* | *Effect indicators:<br>1. reduced number of alcohol use<br>2. reduced alcohol use gap between SES groups<br>3. increased health literacy of people and stakeholders* | *Municipal budget* |
| *2. To discuss other solutions allowed by law for local level* | *Reduced number of alcohol sell places* | *Community Health Board, Drug prevention and Control Committee* | *Health Care Division, License Division* | *2016* | | *Municipal budget* |
| *3. To involve community into creating not friendly environment for alcohol use* | *Number of communities accepted actions for free alcohol initiatives* | *Klaipeda District Municipality Public Health Bureau* | *Culture Division, Communities Community Health Board* | *2016-2018* | | *Municipal budget, Local Action groups budget* |
| *4. To integrate alcohol prevention topic into marriage preparation course, 3 age university program, preparation for new born courses and other* | *Number of programs with integrated topic of alcohol prevention* | *Klaipeda District Municipality Public Health Bureau, Education centre* | *Health Care Division, Education Division* | *2015* | | *Municipal budget, Governmental budget, EU funds* |
| *5. To strength social support with integrated health care for families with alcohol use problem in their daily life.* | *Created supporting system* | *Health Care Division* | *Child protection office, Klaipeda District Municipality Public Health Bureau, Social protection Division, Social Care centres* | *2017* | | *Municipal budget, EU funds* |
| *6. To build capacity of family doctors and nurses of short interventions.* | *Number of educated doctors and nurses* | *Health Care Division* | *Primary Health Care Centres, Klaipeda District Municipality Public Health Bureau* | *2016-2018* | | *EU funds* |
| *7. To strength capacity of other sectors in HI topic related to alcohol use prevention* | *Number of educated civil servants, professionals of* | *Klaipeda District Municipality Public Health* | *Community Health Board, Health Care Division* | *2016* | | *Norwegian funds, EU funds, Municipal budget* |

| | | | | | | |
|---|---|---|---|---|---|---|
| | *other sectors, number of involved sectors* | *Bureau* | | | | |
| *8. To educate communities on alcohol prevention topic* | *Number of educated communities* | *Klaipeda District Municipality Public Health Bureau* | *Communities, Community Health Board, Health Care Division* | *2016-2018* | | *EU funds, Gorvemental budget* |
| *9. To create support system for festivals organized of non profit organizations and sport games without alcohol.* | *Festivals organized without alcohol selling places* | *Culture Division* | *Health Care Division* | *2016-2020* | | *Municipal budget* |
| *10. To implement social emotional education programs into the schools.* | *Number of schools implementing social emotional education program* | *Schools* | *Education Centre, Health Care Division* | *Till 2020* | | *Municipal budget, Governmental budget* |
| *11. To create and implement education program for alcohol prevention in kinder gardens.* | *Number of educated parents* | *Schools* | *Health Care Division, Education Division, Klaipeda District Municipality Public Health Bureau* | *2015-2020* | | *Municipal budget, Governmental budget* |
| *12. To create youth friendly services* | *Created system of youth friendly services, created coordinating centre* | *Klaipeda District Municipality Public Health Bureau* | *Health Care Division, Primary Health Care centre, Pedagogical Psychological Centre* | *2015-2019* | | *Norwegian funds, Municipal budget* |
| *13. To create intersectoral consultation system for families from low social economical groups.* | *Created system* | *Social Care Division* | *Child Protection Office, Health Care Division, Klaipeda District Municipality Public Health Bureau* | *2017* | | *Municipal budget* |

| Actions | Output/ Deliverables | Responsible party | Others to involve to complete action | Timeline | Indicators | Financial resources |
|---|---|---|---|---|---|---|
| *Priority area/Objective*<br>• *Tobacco use prevention* | | | | | | |
| *1. To keep and spread non-smoking zones* | *Number of non-smoking zones created* | *Drug prevention committee* | *Health Care Division* | *2016-2018* | *Effect indicators:*<br>*1. reduced number of tobacco use*<br>*2. reduced tobacco use gap between SES groups*<br>*3. increased health literacy of people and stakeholders* | *Municipal budget* |
| *2. To strength, discuss and find methods how to work with families witch use tobacco in their living environment and have children with these habits.* | *Created number of programs and created system* | *Health Care Division* | *Child protection office, Klaipeda District Municipality Public Health Bureau, Social protection Division, Social Care centres* | *2016* | | *EU funds* |
| *3. To support employees to have tobacco free workplace.* | *Employees involved into action* | *Klaipeda District Municipality Public Health Bureau* | *Health Care Division* | *2016-2018* | | *EU funds, Governmental budget* |
| *4. To strength capacities of non health sectors on tobacco use prevention and Health inequalities topic.* | *Number of educated stakeholders* | *Klaipeda District Municipality Public Health Bureau* | *Health Care Division* | *2016* | | *Norwegian budget, EU funds* |
| *5. To motivate persons to use e-health* | *Persons used e-health* | *Klaipeda District Municipality Public Health Bureau* | *Health Care Division* | *2017* | | *EU funds* |
| *6. To create help system for tobacco users* | *Created system* | *Klaipeda District Municipality Public Health Bureau* | *Health Care Division, Primary Health Care centres* | *2016-2020* | | *EU funds, Governmental budget* |
| *7. To integrate PH and PHC services by creating e-health solutions for accessing persons with tobacco use problem.* | *Services provided by integrating PH and PHC actions* | *Primary Health Care centres* | *Klaipeda District Municipality Public Health Bureau, Health Care Division* | *2018-2020* | | *EU funds* |

| Actions | Output/ Deliverables | Responsible party | Others to involve to complete action | Timeline | Indicators | Financial resources |
|---|---|---|---|---|---|---|
| Priority area/Objective<br>Promotion of physical activities | | | | | | |
| *1. To create plan and invest into opened places for physical activities* | *Number of plans created* | *Culture Division (Sport coordinator)* | *Communities, Sport Centre, Education Division* | *Till 2020* | *Effect indicators:*<br>*1. Increased number of physical active persons*<br>*2. Increased physical active person in low SES groups*<br>*3. increased health literacy of people and stakeholders* | *Municipal budget, EU funds* |
| *2. To establish bicycles routs according prepared plan* | *Number of routs established, km* | *Culture Division (Sport coordinator)* | *Architecture and Urban Planning Division* | *Till 2025* | | *EU funds, Municipal budget* |
| *3. To create plan and invest into playgrounds.* | *Created plan and number of established playgrounds* | *Municipal administration temporary action group* | *Architecture and Urban Planning Division, Communities, Sport Centre, Education Division* | *2016-2020* | | *EU funds, Municipal budget* |
| *4. To open closed facilities for communities* | *Municipal control closed FA places opened to community* | *Culture Division (Sport coordinator)* | *Education Division* | *Till 2020* | | *Municipal budget, NGO, private companies budget* |
| *5. To provide free or low cost servicers of physical activities for youth, old people, people from low socio economical group and high risk factor* | *Number of services created, Number of uses.* | *Health Care Division* | *Culture Division (Sport coordinator), , Sport centre, Public Health Bureau, Primary Health Care centre, Social care centre* | *2015-2020* | | *EU funds* |
| *6. To create physical activity map* | *Created map (e-map)* | *Culture Division (Sport coordinator)* | *GIS Division* | *2015* | | *Municipal budget* |

| Actions | Output/ Deliverables | Responsible party | Others to involve to complete action | Timeline | Indicators | Financial resources |
|---|---|---|---|---|---|---|
| Priority area/Objective<br>Promotion of healthy eating habits | | | | | | |
| *1. Every child in school should have access to warm food, fruits and vegetables.* | *Number of schools with access to warm food, delivering fruits and vegetables for every child program* | *Education Division* | *Klaipeda District Municipality Public Health Bureau, schools* | *2015-2016* | *Effect indicators:*<br>*1. Increased number of persons with good eating habits*<br>*2. increased health literacy of people and stakeholders* | *Municipal budget* |
| *2. To strength communities health literacy related to nutrition.* | *Number of communities educated* | *Klaipeda District Municipality Public Health Bureau* | *Communities, Health Care Division* | *2016-2018* | | *EU funds* |
| *3. To integrate healthy eating topic into non formal education programs, initiatives as library without walls, community centers activities* | *Number of programs created and integrated topic* | *Klaipeda District Municipality Public Health Bureau* | *Communities, Health Care Division* | *2017-2018* | | *EU funds* |
| *4. To strength accessibility for population of rural areas and youth to use evidence based resources for information.* | *Number of e-health solutions presented to communities and created internet access.* | *Klaipeda District Municipality Public Health Bureau* | *Health Care Division* | *2016* | | *EU funds, Norwegian funds* |
| *5. To start discussions with farmers and small local companies, local action groups about network „from farm to table“.* | *Plan prepared for cooperation* | *Klaipeda District Municipality Public Health Bureau* | *Communities, Health Care Division, Agriculture Division* | *2019* | | *Municipal budget* |

# PART 3 DEVELOPING THE ACTION PLAN: the process

### 3.1 General overview of the process

*[Please describe the overall process of developing the action plan throughout the HE2020 project. Please define the context.*
*How the process has started? Have you had dealt with the topic of health equity before within your region/country (in a direct or indirect way)? Have you built your work in the project on any earlier regional work/developments related to the inequities field? Have health/health equity/social determinants of health issues had been on the discussion table of policy makers before? How did this have an effect on the general process of developing the Action Plan as part of the project?]*

*Our region had inequality topic on agenda set in 2008-2009 y. But it was with focus more to monitoring health inequalities. The process in this project pushed our region much further and finalized process with having action plan with very concrete recommendation. For that process, it was very important that at the same time at national level there was prepared strategies for reductions of disparities in health.*
*In Municipality the process started from preparing report on health inequalities, Public Health Bureau of Klaipeda District Municipality specialists did it. Second step was – presentation to Municipal Administration Health Division and getting agreement that we need to act, with additional arguments, that in Europe and in Lithuania, this is the main topic in health. Then we get commitment of Division to start the process. We prepared presentation and report for Municipal Council, agreed that Community Health Board will take the role of in project suggested regional action group in municipality. For Municipal Council there was made presentation of report "Klaipėda district municipality Health profile 2015) and was set priorities for health, mentioned in other parts of this document. This was also "green light" to start discussions with other stakeholders in municipality and to prepare action plans. For better process, thanks to project we participated in different workshops and involved other important stakeholders from other sectors responsible persons for policy planning and started to build their capacities and understanding this health inequality topic. Also we did capacity audit of stakeholders, prepared action plan, discussed it with communities and representatives of other sectors. Now we are in process of starting broader discussions in smaller groups with different (66) communities and at least 12 different institutions and 10 different formal created groups in municipality.*
*For this process success one of factors was, that in municipality there is Public Health Bureau and from 2007 we worked intersectoral, all actions done before by Public Health Bureau always was with partners, so we had good network created and good relations before. It helped us to have process more controlled and with big involvement. Also having experience of doing need assessment and tradition (and law) to present health profile report for Municipal Council and tradition to set priorities helped in this project.*

### 3.2 Using an evidence-based approach

*Evidence gathered influenced setting the priorities; choosing actions and interventions. Strategies usually are evidence-based in our region, and always it is enough data to conduct necessary assessments for designing action plans. And we get more and more data comparing with 2007.*

#### A community & intersectoral approach

*For this process success one of factors was, that in municipality there is Public Health Bureau and from 2007 we worked intersectoral, all actions done before by Public Health Bureau always was with partners, so we had good network created and good relations before. It helped us to have process more controlled and with big involvement. Our Region action group – Community Health Board also comparing with 2007 y. is getting stronger and is good selection for the role to play RAG in municipality. This recommendation also was speeded to National level and suggested for other community health boards in municipalities (hope it will be accepted in the future).*

### 3.3 Building Support

*Political support was when Municipal Council proved vertical priorities and gave us "green light" to talk. Second important thing was that Community Health Board members are 3 politicians from Council. Also in first meeting with communities we had 5 politicians form Municipal Council participated in discussions, group work, also in focus group discussion about health policy.*

### 3.4 Typology of the region

*In Lithuania we have two administration levels: national and local level (municipal). Municipalities is an autonomous with high competences in designing policies at local level. Municipality's functions in health promotion (LR local self-government law): primary personal and public health care (establishment of institutions, reorganization, liquidation, maintenance); municipalities' health program development and implementation, support for municipalities population health care; approval of sanitation and hygiene rules and monitoring compliance of them, cleanliness and assurance of order in public places; to municipalities is assigned noise prevention and national noise management implementation; environmental quality improvement and protection; drinking water supply and organization of wastewater management; public health care function implementation in municipality. Institutions responsible for Health Promotion in Municipality: Decision making institution: municipal Council, municipal Council committees (one of them is health care and social affairs), the Mayor, Deputy Mayor (-s). Executive bodies: Municipal administration: Municipal Administration Director, Vice-Chairman (s), administration departments, specialists that do not depend upon administration departments (municipal doctor). Health care service providers. Personal health care services: primary personal health care, secondary health care institutions. Public health care services: Municipal Public*

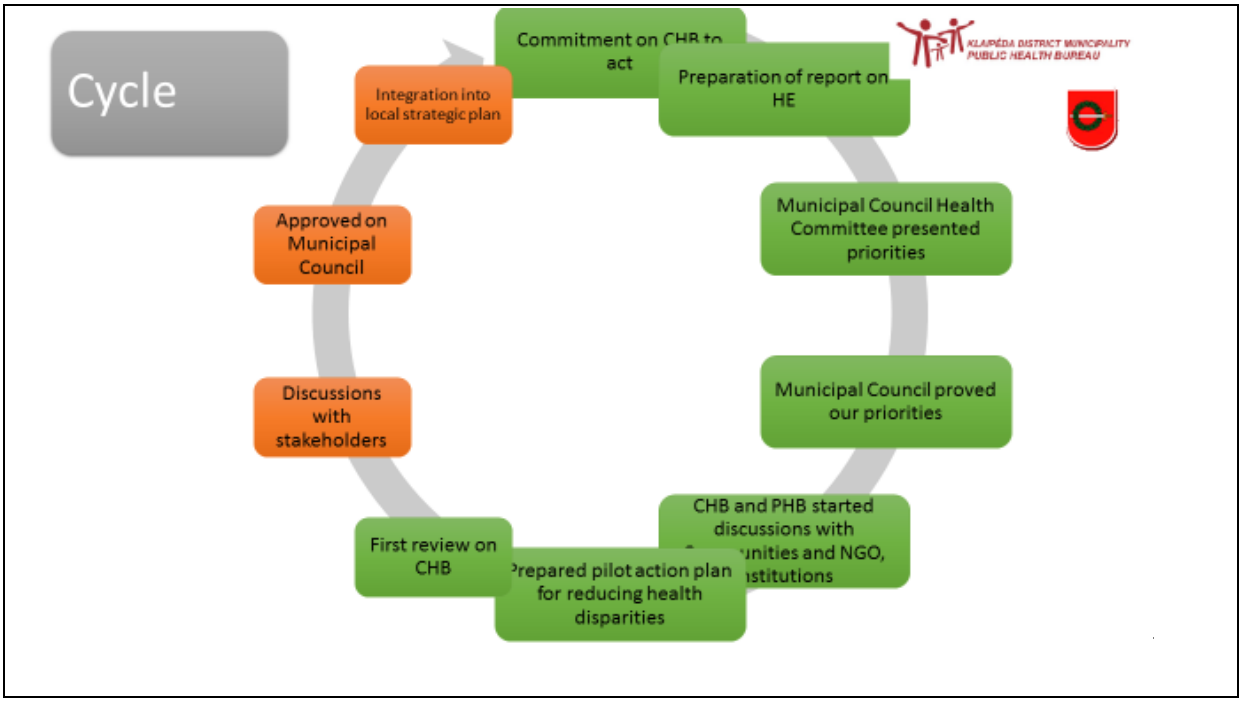
*Health Bureau. Municipality's PHC, public organizations, local communities Advisory institutions: Municipality's Community Health Council, public organizations, local communities. Health care division at Municipal administration (municipal doctor) implements in the municipality state's health policy; Organizes municipality's health program preparation and implementation, organizes state's programs implementation in the municipality; Analyzes population health state changes, provides to Municipal Council conclusions and recommendations; Examines population complaints on health care issues. Municipality's public health bureau carry's out public health monitoring in the district; Organizes children and youth public health care in the district; Organizes resident health training, promotes healthy living, provides information to residents on health issues, participates and initiates health program preparation.*
*Municipality has role to create Municipality Strategic Development Plan – long-term document and short-term document – Municipal Strategic Action Plan. Every sector can have their own strategic plans approved at Municipal Council. Into those plans must be integrated National strategic plans. In Health Sector must be integrated National Lithuanian Health Program 2014-2025.*

### 3.5 Challenges

*To share role and responsibilities*
*Balance between separate plan for sectors (problem) and integrating into local plans of municipality*
*To advocate all communities and to show their importance*
*To use participatory approach and to reach result*
*To „open" other sector for health*
*To share understanding at local level that we need do not need to address not individual needs but to create possibilities for everyone*

### 3.6 Validating the regional Action Plan – Integrated planning

*We took an integrated approach by incorporating specific, health inequality focused action plans into wider regional plan in order to promote and ensure synergies in decision making and funding. It is one of the biggest challenges in this work at this our process stage. In 10th December 2015 in Community Health Board we agreed to have wide discussion about action plan (in February to start with 66 communities, 12 institutions, 10 different groups). Some meeting we plan with other sectors stakeholders that controls sectors strategy at municipal level.*




### 3.7 Financing the Action Plan

*[Our region and institution have enough knowledge about using European Structural and Investment Funds (ESIF) in our country. We participate in different meetings, consultation sessions at national level. Our municipality is not priority region for investments, but we can focus on child health and elderly health topic in our region. Also investments from other sectors health/health equity issues is compatible with them. The influence started much more before in period 2008-2013, when we participated in different consultation meetings and raised our problems for national institutions. In our region usually all planed actions are with funds and we get planed funds earlier or later from planed different funds.*

### 3.8 Benefits for the region, lessons learnt, good practices

*Major achievements of our planning process*
We have agreement on priorities
We set actions
We planned very big sessions of discussions and took real participatory approach at local level.

### 3.9 Cascade learning into other regions

In my country, we shared our knowledge by involving our institutions specialist into one of Lithuanian project, which has goal to prepare recommendations for local level how to reduce inequalities; also, we already made presentations in Hygiene institute about this experience in this project. In addition, we participate in other consultation workshops where we share our experience get in this project.

### 3.10 Annex – Information on the Regional Action Group

Official name of the group: Community Health Board

List of member organisations of the Regional Action Group

*1. Biruta Alšauskienė, Member of Klaipeda District Municipal Council, politician.*
*2. Laima Anužytė-Kilnė, Head of Multifunction centre – school "Slengiai".*
*3. Audronė Balnionienė, Member of Klaipeda District Municipal Council, politician, Head of Health Committee of Municipal Council.*
*4. Voldimara Jasmontaitė, Member of Klaipeda District Municipal Council, politician, doctor of Gargždai Hospital.*
*5. Laima Kaveckienė, Head of Klaipeda district Municipality Administration Health Division.*
*6. Vidmantas Gedvilas, Head of Vėžaičiai Community (NGO)*
*7. Arnoldas Jurgutis, Head of Public Health Department, Health Science Faculty, Klaipeda University, doctor of Paupiai primary health care centre. Head of Community Health Board.*
*8. Viktorija Lygnugarienė, Head of Gargždai Social Care centre*
*9. Šarūnė Petruškevičienė, Head of Dovilai Community (NGO), Head of Non-governmental organization "Social initiative centre Dovilai"*
*10. Donalda Saulė Surplytė - Head of Kisiniai Community (NGO)*
*11. Ineta Lukšonienė - Head of Dauparai Community (NGO)*
*12. Neringa Tarvydienė – Head of Klaipeda District Municipality Public Health Bureau*

*Community Health Board - is an independent coordinating institution of health promotion at the Municipality Council. Functions:*
*- Forms municipality's disease prevention and health promotion policies;*
*- Provides information and suggestions to the municipal Council on improvement of public health care tools' condition in the district;*
*- Organizes meetings, seminars and conferences on relevant public health issues.*
*Head is Arnoldas Jurgutis, Head of Public Health Department, Health Science Faculty, Klaipeda University, doctor of Paupiai primary health care centre. Vice Head – Donalda Saulė Surplytė - Head of Kisiniai Community (NGO). Group formulated on 25th June 2015 by Municipal Council law No.T11-184.*
*CHB consists of 1/3 municipality persons appointed, 1/3 community organizations that protect public health interests, 1/3 of municipality enterprises, institutions and organizations. CHB has rights to get information from Municipality Administration, institutions and organizations that they need for implementation of CHB functions. CHB members' position is none paid. CHB meets more than 4 time per year.*
*Klaipeda District Municipality Administration Health Division is responsible for technical support of CHB.*