

# City Health Profiles

A review of progress



WORLD HEALTH ORGANIZATION  
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# **City health profiles**

*A review of progress*

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### **Target 14: settings for health promotion**

*By the year 2000, all settings of social life and activity, such as the city, school, workplace, neighbourhood and home, should provide greater opportunities for promoting health.*

### **ABSTRACT**

*City health profiles – a review of progress* overviews health profiles by reviewing the literature, looking at some common queries about the process of producing profiles and summarizing the review of the profiles produced by cities participating in the WHO Healthy Cities project. The book explores the different processes through which profiles can describe and address inequity at a local level with examples. A chapter reviews how information on lifestyles can be included in health profiles. The last chapter examines community health profiles and what they mean. It also includes examples of some methods used to develop them and how these profiles were used.

### **Keywords**

URBAN HEALTH

HEALTHY CITIES

HEALTH STATUS INDICATORS

HEALTH SURVEYS

HEALTH PROMOTION

LIFESTYLE

CONSUMER PARTICIPATION

EUROPE

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## ***Preface***

City health profiles have become an important tool in the work of creating healthy cities. They have been produced in many different forms, reflecting the varied needs and different approaches of cities. Some cities have used existing models of public health reports, some have been developed based on collaboration between community and technical perspectives and some have focused on specific groups within the population.

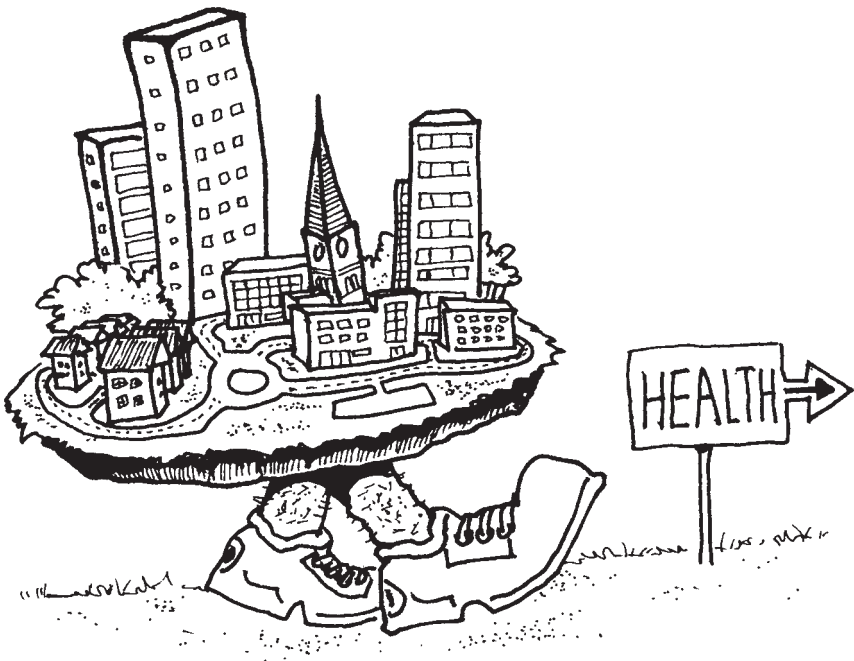
This document draws on the experience of healthy cities in developing and using health profiles and includes contributions from members of the WHO Healthy Cities Project Technical Working Group on City Health Profiles and Indicators. Premila Webster provides an overview of city health profiles produced by cities participating in the WHO Healthy Cities network, assessing their strengths and weaknesses using a standard format. In Chapter 2, John Acres discusses how measures of inequality can be used in profiles to promote change. Chapter 3, by Niels Kristian Rasmussen, reviews how information on lifestyles can be included in health profiles. In the final chapter, Catherine Doyle describes how communities have been actively involved in developing profiles and assessing community health needs.

The WHO Healthy Cities project will continue to develop and use health profiles during the third phase of the project (1998–2002). The project seeks to support cities in acting to improve the health of their residents. This document provides information that can assist cities either in producing their first health profile or in updating their profile. There is more experience on making and using health profiles to create healthy cities as a whole than is recorded here, and we expect that this experience will continue to be exchanged at meetings and through direct contact between cities.

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## Chapter 1



### ***City health profiles – an overview***





## ***What is a city health profile?***

A city health profile is a public health report that brings together key pieces of information on health and its determinants in the city and interprets and analyses the information. The main function of the profile is to stimulate action that will improve health. The WHO Healthy Cities Project Technical Working Group on City Health Profiles and Indicators (1) defined city health profiles as reports that “identify in writing and graphs health problems and their potential solutions in a specific city”. This city health profile can then form the basis of a city health plan that sets out strategies and programmes of intervention to improve the health of the city population (2).

## ***How can city health profiles influence health policy?***

Informing the public, policy-makers and politicians about health and its determinants in their city is the key to ensuring that all relevant groups in the city truly understand the ideas, problems and issues with which they are dealing. The city health profile is an ideal way of bringing together a wide range of health information to acquaint various groups with current health challenges. It may be useful to consider public health reports as “a visible manifestation of the public health function” (3). The role of city health profiles in influencing health policy includes:

- interesting, informing and educating the public, health professionals, politicians and policy-makers and stimulating them to action;
- acting as a source of epidemiological information about the locality;
- identifying health problems, high-risk groups and unmet needs;
- being a critical component of health planning – indicating health priorities, the preferred resource allocation and the direction of service development; and
- providing a focus for intersectoral action.

## ***Questions commonly asked about profiles***

### **How often should the profile be updated?**

Profiles describe health and its determinants, and these are not static. Profiles are a continuous process that should be used both to reflect the present state and to monitor progress in the future. If profiles are fulfilling their role as tools in improving health, a series of profiles will be needed both to monitor change and improvement in the public health and to identify new challenges that may prevent the achievement of good health.

One question often asked is whether there is a magic formula that determines the optimum interval of time between profiles. The timing of the profiles depends on the

cycle the cities set for themselves. For example, if the city has planned a five-year cycle for developing the profile, making recommendations and evolving plans based on the profiles followed by monitoring any progress, then the profile would probably have to be updated to fit in with this cycle. In this situation the profiles probably should be updated after 3–5 years. Some profiles have their data available in an electronic format. In these cases, it would not be too difficult or expensive to update data when new data become available. There is no simple answer, but profiles are a continuous process, and the best people to decide how often and in what format and at what cost a profile should be updated are those who are closely involved in this planning process.

### **Can subprofiles replace a city health profile?**

Many cities have developed subprofiles that examine a community or a theme in great depth. Examples of subprofiles developed include profiles on women or on children's health in specific deprived areas. Although cities may consider it vital to develop community profiles or thematic profiles to highlight specific areas of need or explore certain areas in depth (and this may be an important process to undertake following specific findings in the profile), these profiles cannot replace a comprehensive profile of the city. Subprofiles, although an important part of a city's health profile, do not paint the full picture. Gaining a comprehensive understanding of health and its determinants in a city requires undertaking a complete city health profile.

## ***City health profiles produced by cities in the Healthy Cities project network***

Several of the cities in the Healthy City project network have produced city health profiles. As expected, the profiles produced had a wide range and variety. In 1995 the city health profiles completed by the project cities were reviewed. The purpose of this review was to present a snapshot of profiles and to determine how comprehensive they were and their impact.

### **Method**

Twenty-one profiles from 15 countries were reviewed. The methods used to review the profiles included:

- a structured, systematic content review by two independent reviewers; and
- semistructured telephone interviews to obtain additional information, including data on what impact the profiles had on health policy.

The framework for the content review was based on the guidance provided by *City health profiles – how to report on health in your city (1)*. The areas covered in the review included:

- demography
- health status
- socioeconomic conditions
- environment
- inequalities
- infrastructure
- public health policies and services
- recommendations
- presentation.

## Improving public health reports

The long-standing problem of public health reports is that they depend on measures of death and illness rather than of health (3–6). Although these traditional measures still have a place in the reports, they should also include information about lifestyles, the physical, social and economic environment and an assessment of the health status of the population (3–8). Some sources (3,4,8–13) have stressed that existing sources of information, such as commercial information on purchasing, alcohol, smoking and dietary preferences, are relevant to health and should be considered for inclusion in the public health reports. Including local studies could also enhance the local relevance of the report (3,4,9,13). Studies (3,4,8,9,11,12) have also addressed the importance of presenting and interpreting data in a scientifically robust way.

Several studies (3,4,8,11,14,15) have suggested that public health reports should describe, as appropriate, the health services available to the population. Some studies (4,9,16,17) have also expressed the opinion that the reports should refer to existing health policy. One article (4) mentioned that the working group of eminent European public health physicians and statisticians “was disturbed to find so little agreement on the definitions of quite basic parameters of health and disease”.

*City health profiles: how to report on health in your city (1)* addressed several of these issues and concerns. The WHO Healthy Cities Project Technical Working Group on City Health Profiles and Indicators produced this document following wide consultations with the primary users to ensure that the guidance was practical and appropriate. The text was completed after all the members of the WHO Healthy Cities project network were consulted at a technical symposium held in Poznan, Poland in September 1994 (18). This document was an important milestone in the evolution of comprehensive health profiles that describe health and its determinants rather than disease and death.

## Results

The results showed that the areas covered comprehensively were demography, mortality and the environment. Socioeconomic conditions were fairly well covered. The topic of lifestyles was absent from approximately one quarter of the profiles and inequalities from a third. Data on infrastructure were available in only half the profiles. Forty-two per cent of the profiles did not mention any public health policies. Only one fifth of the profiles made any recommendations, and even fewer mentioned any targets. One of the best features was the skilful use of graphs and pictures to make the profiles more user friendly and intelligible.

The ultimate aim of developing profiles is to improve the health of the local population. Nevertheless, measuring this outcome is difficult, especially in the short term, and ascribing cause and effect is even more difficult. Various proxy measures such as media coverage and well attended public meetings were used to assess the impact of the profiles. All cities that had produced profiles were able to disseminate their work satisfactorily. Most cities had managed to get the mass media interested in the contents of their profiles and had received good mass media coverage. Several cities had formally launched their profiles at public meetings to inform the public and policy-makers of the city health profile and had received a satisfactory response, with meetings being well attended. Some cities had had their recommendations endorsed by the local political body. Plans were produced in accordance with the recommendations of the profiles in a few cities, and occasionally some of the plans were implemented, though in most cases it was too early to examine these areas.

## **Benefits of city health profiles**

All cities interviewed felt that profiles were a vital planning instrument providing important baseline information that would not otherwise be available. They felt that city health profiles had integrated data from different sources in a way that had not been done previously. This had given them the opportunity and leverage to motivate politicians to address areas of need by providing information based on robust data. The production of city health profiles involved several players at different levels and disciplines. Cities felt that this gave them the opportunity to use city health profiles as instruments to stimulate and develop alliances.

## ***Profiles – what next?***

City health profiles are expected to provide the evidence and credibility for serious efforts to promote health at a local level. They are meant to be the basis for setting priorities for health and be an integral part of local decision-making and the strategic planning process. It is not sufficient to produce glossy reports on the problems faced by communities; what is vital is to use the information to campaign on behalf of the community, involving people in their own local initiatives to improve health. This requires that the profile-plan cycle be completed. Profiles gather the intelligence, which should be used to inform strategies to improve health. Profiles must therefore feed into plans, and the city health plan must reflect the information gathered in a city health profile. This is necessary to realize the true potential of city health profiles. City health profiles are therefore not an end in themselves but an important element in the process of improving health and thus moving closer to the reality of a healthy city.

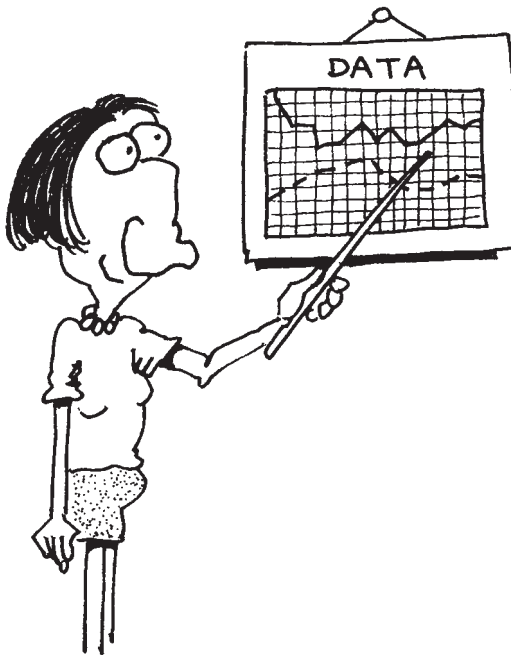
## **Summary**

- The prime objective of a city health profile is to stimulate action to improve people's health.
- City health profiles should act as a source of epidemiological information about the locality.
- Although city health profiles should still include traditional measures of death and illness, they should also include information about lifestyles, the physical, social and economic environment and should assess the health status of the population.
- The population described in the city health profile should be able to identify with it.
- City health profiles should provide a focus for intersectoral action.
- City health profiles will only achieve their true potential if they inform and feed into plans.

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***Using city health profiles  
to help reduce inequity in health***





European regional health for all target 1: “By the year 2000, the differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups.”

## Introduction

The European regional targets for health for all were based on the significant variation in health both between countries and within countries when they were first agreed in 1984. The purpose of target 1 is to focus on reducing these differences.

WHO formed a small Equity in Health Unit to take this forward, and its programme was later combined with the work of the Country Health Policy Unit in 1989. They produced various discussion papers (1-4) to develop policy, and in 1994 the WHO Regional Committee for Europe decided to focus its technical discussions on equity and ethics in health.

The Healthy Cities project is a powerful vehicle for introducing changes to reduce inequity in health.

## City health profiles and change

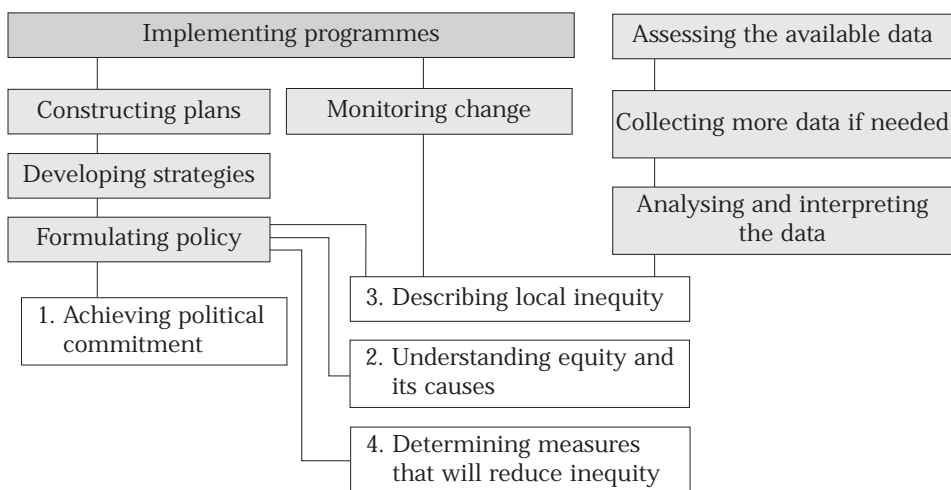
The purpose of the city health profile is to help the city introduce programmes that will reduce the differences in health that can be changed.

The profile is an important lever for change. Nevertheless, it is only one of several components needed to produce change. These include

- informed political commitment;
- understanding of the causes of inequity;
- knowledge of measures (policies, strategies, plans and programmes) that will reduce inequity;
- information to be able to decide which problems to address; and
- a planned way of choosing the issues to be addressed, introducing changes, seeing them through, monitoring them and reviewing plans.

These are linked as shown in Fig. 1.

Fig. 1. Change using city health profiles



If a city wants change, it is important to ensure that all these components are in place.

# What the profile might include to support the equity agenda

## Understanding the causes of inequity

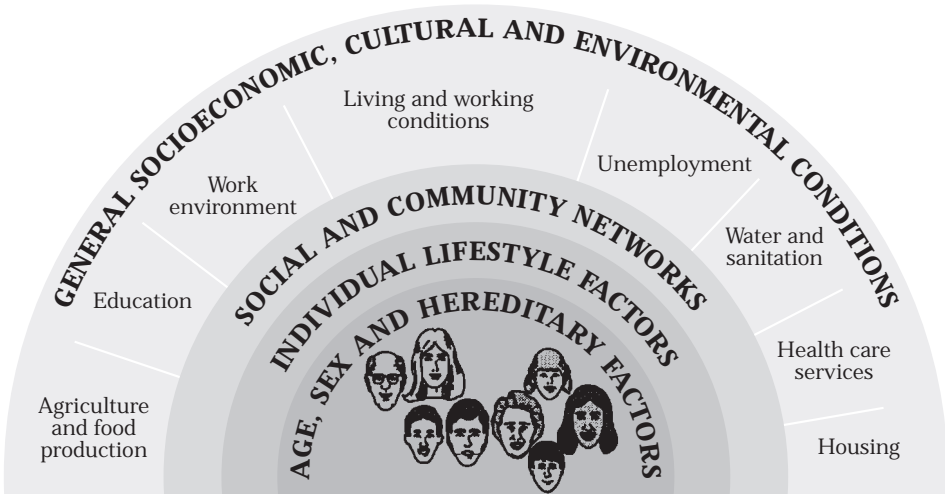
### How do differences in people's health arise?

Differences in health arise from differences in the factors that influence health.

Dahlgren & Whitehead (2) have illustrated these (Fig. 2), which can be summarized as

- age, sex and hereditary factors
- individual lifestyle factors
- social and community influences
- living and working conditions
- general socioeconomic, cultural and environmental conditions.

Fig. 2. Differences in health



Source: Dahlgren & Whitehead (2)

### What is inequity in health?

Some factors causing differences in health are unavoidable and some are not. For example, differences in genetic make-up (including gender) and in age are associated with differences in health, and these factors cannot be avoided. Sometimes differences arise as a result of very risky voluntary activities such as certain sports. Sometimes temporary differences arise as a result of health improvement measures adopted more often by one group of the population before another. Most people would not regard these differences as inequity in health.

WHO uses equity and inequity to refer to “differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust”. “Equity is...concerned with creating equal opportunities for health and with bringing health differentials down to the lowest possible.” (1). Policies that aim to achieve this cover:

- health-damaging behaviour where the degree of choice of lifestyle is severely restricted;
- exposure to unhealthy and stressful living and working conditions;
- inadequate access to essential health and other public services; and
- situations in which health-related social mobility tends to make sick people lose socioeconomic status.

## **Technical advice on collecting data on socioeconomic inequalities in health from Kunst & Mackenbach (3)**

- Socioeconomic inequalities in health can be defined as differences in the prevalence or incidence of health problems between individual people of higher and lower socioeconomic status.
- The core of every monitoring system should be regular health interview surveys and a mortality registry. Several indicators of self-reported morbidity should be included in the health interview survey to cover various aspects of health.
- Whenever possible, socioeconomic status should be measured by three indicators: occupational status, level of education and income level.
- A wide variety of measures can be used to summarize the magnitude of socioeconomic inequalities in health. Both relative and absolute differences in inequity should be considered.

### **Achieving political commitment**

A profile that focuses solely on inequity and is rich in information and explanation would be ideal. Nevertheless, even cities with no information about inequity can place equity on the agenda. With or without supporting local information, the following will help gain political commitment:

- engaging the politicians in the process early on;
- devoting a section of the report to equity;
- ensuring that equity is identified in the table of contents;
- highlighting the European regional health for all target 1 on equity;
- describing the challenges associated with inequity;
- pointing out the need for information to describe the local situation; and
- recommending a work plan on equity and the production of a report within a specified time period.

This will help to gain acceptance of equity as an issue and to prepare the basis for a coherent approach later.

### **Describing local inequity**

#### **Describing health**

*City health profiles – how to report on health in your city* (5) explains how to describe the health of people in a city. The profile describes who has what health problems. The information required to highlight inequity is the same and includes:

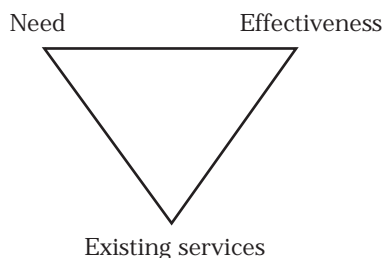
- measures of health and ill health (mortality, morbidity and disability);
- environmental factors related to health;
- lifestyle-damaging and health-promoting behaviour;
- uptake of preventive services; and
- health and welfare services.

Information should be provided in a way that helps the city to target resources towards those in greater need. To do this, the information needs to be linked to:

- smaller geographical areas within the city (so that communities needing particular support can be identified); and
- population groups known to be vulnerable, such as ethnic minorities and people with low income.

If this is done, the health of different population groups can be compared and inequity can be identified. Collecting baseline information will also enable the change resulting from intervention programmes to be measured over time (see box).

Fig. 3. Three types of helpful information



### Choosing priority problems

Many factors affect the choice of priorities, especially assessment about what can be achieved in the local area and the views of local people. Nevertheless, three types of information are helpful in deciding where most benefit is likely to be gained from an investment of resources (Fig. 3).

- need – an assessment of the extent and importance of the inequity and where it is;
- effectiveness – knowledge of types of intervention that are effective (and therefore useful) in reducing inequity and how much they cost; and
- existing services – how many resources are currently devoted to addressing inequity and where there might be shortfalls.

### Intervention to reduce inequity: policies, strategies, plans and programmes

#### Planning

Intervention to reduce inequity needs to be grounded in the available evidence of effectiveness. Implementing intervention in a planned way requires movement from policy to a strategy, plans and programmes of implementation.

Programmes need to be monitored to measure the changes brought about and decide what needs to be changed to ensure that the programme is achieving its objective.

New interventions should be evaluated and published such that others can learn both about good practice and new approaches that work.

#### Intervention a city needs to include to reduce inequity

Approaches that are used to reduce inequity in health can broadly be divided into four different levels (6). These are measures that

- strengthen individuals
- strengthen communities
- improve access to essential facilities and services
- encourage macroeconomic and cultural change.

A city programme to address inequity is likely to require initiatives at all four levels. Gepkins & Gunning-Shepers (7) and Benzeval et al. (6) provide details of the research on the effectiveness of interventions to reduce inequity.

#### Measures to strengthen individuals

Broadly, measures to strengthen individuals can give rise to initiatives that focus on:

- individual behaviour
- individual empowerment.

*Individual behaviour:* An example of this type of focus is simply disseminating information to individuals. Disseminating information by itself, however, increases inequity, as a larger number of advantaged people act on the information than do disadvantaged people. There is more chance of reducing inequity if information is supplemented by personal support or structural changes that help make behavioural

## **Examples of what project cities have done to reduce inequity in health**

### **The city health profile**

Glasgow used a whole healthy city report to focus on inequalities in health and described a model of health explaining the factors that lead to health and to inequity in health.

### **Measures of health**

A general index of health can be useful in showing an overall measure of health or ill health. Not all cities can do this, but:

- Dublin and Liverpool used the standardized mortality ratio;
- Maribor used infant mortality; and
- Łódź used average life expectancy.

These measures are more often used for defined geographical areas. When this is done, the results can be compared with the overall results for the city or the country as a whole.

Dublin, Liverpool and Glasgow provided information that enabled them to show the health measures in districts of the city and thus target resources to small geographical areas.

### **Environmental factors related to health**

Various aspects of the physical environment have been used, including

- information on water, sewerage and noise (Łódź);
- air and water quality data (Sumperk, Czech Republic);
- views on air quality and noise (Padua); and
- unemployment, type of housing, perceptions of health and irritating influences (Sumperk).

Inner Nørrebro (a district of Copenhagen) used quality of life measures obtained from a local survey.

### **Measures of deprivation**

An overall measure can be used to show the geographical areas likely to be in greater need. Various indicators can be selected to indicate an overall measure of deprivation, including:

- residential density (crowding) to reflect economic status used (Jerusalem);
- crowding (Łódź);
- neighbourhood type (Glasgow and Dublin); and
- an index of social conditions or deprivation: unemployment, children in households with low income, overcrowded dwellings, dwellings lacking basic amenities, households with no car and children in unsuitable accommodation such as high-rise flats (Liverpool).

### **Health-damaging and health-promoting behaviour**

Surveys normally need to be carried out to gather this type of information. Łódź, however, gathered information on smoking and drug misuse, and Amadora collected information on membership of sports clubs and cultural associations. Some have used the uptake of preventive services and the availability of health and welfare services.

change easier and if the advice given is sensitive to the difficult circumstances in which many people live (6,7).

Examples where this combination of approaches have been used include:

- antenatal care (8)
- smoking reduction programmes (9,10)
- childhood accidents (11–13)
- breastfeeding (14)
- nutrition in childhood (15)
- cervical and breast screening (16).

*Individual empowerment.* Intervention to promote individual empowerment builds the self-confidence and skills of people who are in danger of being overwhelmed by their disadvantaged life circumstances so that they have a better chance of maintaining their health and wellbeing regardless of the external health hazards they encounter. Such intervention might include stress management services, social support and counselling. One of the outcomes of programmes is that the vulnerable people use more services and the services can be improved. There is good evidence on the benefits of social support approaches to the health of mothers and children. Examples include:

- enhanced programmes of home visits for expectant mothers (18)
- postnatal depression (19)
- community schemes for mothers (20).

### **Strengthening communities**

There is growing evidence that having strong social networks and cohesion benefits health. The term social capital is used to reflect this. Policies at this level are aimed at strengthening the way disrupted and deprived communities function collectively for mutual support and benefit.

The principal elements for success in building social capital seem to be (21):

- assessment of local needs, especially where local people are involved in the research process itself;
- agencies working together and identifying mechanisms for maintaining dialogue, contact and commitment;
- representation for local people: the greater the level of involvement, the larger the impact;
- training and support for volunteers, peer educators and local networks, which ensures maximum benefit from community-based action;
- local committees: durable structures that aid planning and decision-making are vital for successful partnerships – they support the sharing of power and responsibility for change, ensure relevance and give local people a way to voice approval or dissent;
- political visibility: many local authorities, for example, have health subcommittee and healthy city groups;
- reorientation of resource allocation in the direction of community development and social regeneration schemes;
- increased flexibility in the way organizations work;
- policy development and implementation that links local and national interests and is reinforced from the top down, so that resources are redistributed; and
- working across sectors and professional and lay boundaries.

Examples of programmes that can help to strengthen communities include the following.

*Community development.* Community development increases the ability of marginalized communities to work together to identify and take action on priorities

the communities themselves define as important. An example of this is the Granton community development project in Scotland (22).

*Community regeneration.* Community regeneration strategies focus on multiply deprived areas with typically 10 000 to 20 000 residents. Their aim is to improve social conditions at the same time as stimulating the local economy, to provide more employment opportunities and tackle defects in the physical environment.

### **Improving access to essential facilities and services**

*The whole population.* This includes providing the prerequisites for health. It addresses the physical environment and disease prevention, health protection and health and welfare services. It includes adequate housing, sanitation, clean water, uncontaminated food, education, employment and a safe and healthy workplace. Achieving these for everyone is an essential step in achieving equity. Structural approaches such as supplementing salt with iodine and water with fluoride can be powerful ways of reducing certain types of inequity.

*Approaches focused on settings.* When a city has achieved the basic prerequisites for health for all its residents, then the city health profile should move on to address specific aspects of inequity. A settings approach may be particularly valuable here, and the health profile may want to draw attention to the well established Healthy Schools, Health Promoting Hospitals and Healthy Workplace initiatives. Other approaches include

- community environments, including crime and the fear of crime and the availability of recreational facilities;
- education, including focusing on how to overcome the educational disadvantages associated with growing up in poverty through such measures as child care, early education and intervention packages for children falling behind: Head Start (23) has been shown to be effective in doing this; and
- work: because so many people spend substantial time at work, the workplace is a valuable setting for policies to address inequity in health, which can be applied equally to all members of staff, and improving health can become part of the organizational culture.

Some cities may need to emphasize reducing the physical threats to health from the working environment.

In well developed workplaces the emphasis may now be less on the physical environment at work and more on the mental effects of work on health. The focus may be more on a combination of individually based programmes, such as stress management; improving communication and human relations with more opportunity for personal control over work decisions; organizational changes in working practices; and changing the market conditions. The international labour report of 1992 (24) found that the risk of stress at work can be reduced by taking this type of approach.

*Access to health services.* For some cities a key equity challenge may be ensuring the availability of basic health services for all. For cities where this has been achieved, then the equity focus may be more equal access to health services for equal need. Principles adopted here might include (6):

- ensuring that resources are distributed between local areas in proportion to their relative needs: for example, by a formula that takes account of the different health care needs of different areas;
- responding appropriately to the health care needs of different social groups: for example, for immunization, screening, family planning and the uptake of treatment services by different social groups; and



- taking the lead to encourage a wider and more strategic approach to developing healthy public policies.

### **Macroeconomic and cultural change**

Among industrialized countries, those with a more equitable income distribution have a more equitable distribution of health than do countries with a more inequitable income distribution. Countries with increasing income disparity have a widening disparity in mortality (25).

Some of the key requirements at this level for preventing inequities in health are (6):

- income maintenance policies that provide adequate financial support for people who fall into poverty;
- education and training policies that help prevent poverty in the long term; and
- more equitable taxation and income distribution policies.

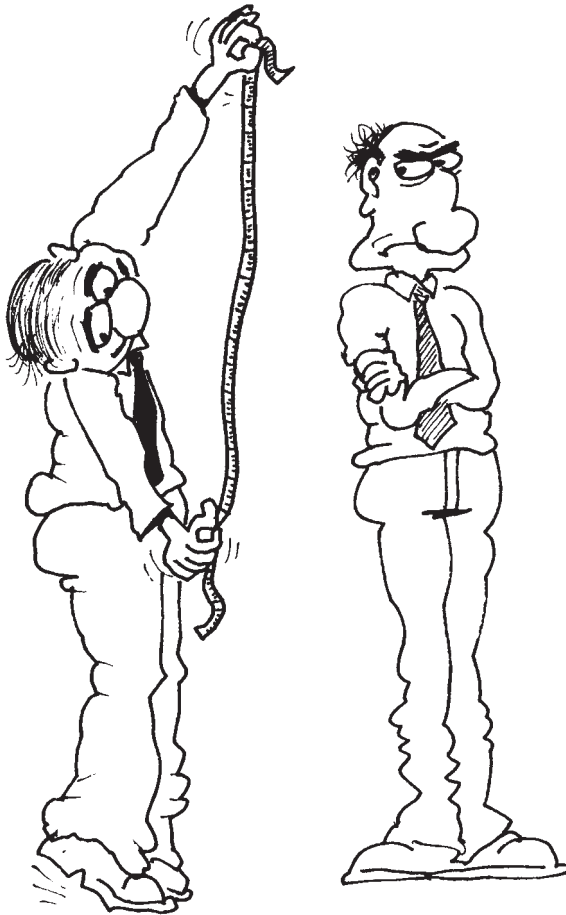
## **Conclusion**

Substantial research describes inequity in health. Coordinated action is now needed within cities to reduce this inequity. The city health profile can be a powerful lever for change to bring this about.

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***Lifestyles in health profiles***



## ***Lifestyles affect health***

Lifestyles have very important effects on the disease patterns and health status of the countries of Europe. The largest groups of causes of premature deaths, cancer and cardiovascular diseases, mostly result from unhealthy lifestyles. Underlying differences in lifestyle also cause a large proportion of the differences in health status between regions, between urban and rural areas and between socioeconomic classes and other social categories.

## ***WHO's strategy for health for all in Europe includes lifestyles***

Lifestyle is a very important component of WHO's European regional strategy for health for all. In addition to developments in prevention, treatment, care and rehabilitation and improving the environment, changes in lifestyles are required to achieve the 38 targets for health for all. Five of the targets are related to various aspects of lifestyle:

- healthy public policy: intersectoral policies should support the promotion of healthy lifestyles, and systems should ensure public participation in policy-making and implementation;
- settings for health promotion: all settings of social life and activity, such as the city, school, workplace, neighbourhood and home, should provide greater opportunities for promoting health;
- health competence: accessible and effective education and training in health promotion should be available in order to improve public and professional competence;
- healthy living: there should be continuous efforts to promote and support healthy patterns of living; and
- tobacco, alcohol and psychoactive drugs: consumption should be reduced significantly through policies and programmes.

These targets were chosen because experience and scientific knowledge show that people's lifestyles in general and healthy lifestyles in particular only indirectly and only together with many other factors depend on whether people have or acquire knowledge about healthy and unhealthy lifestyles. The targets reflect the fact that lifestyle encompasses more than such negative and very tangible components as smoking and alcohol use.

The dictionary defines lifestyle as: "the way in which an individual or a group lives". Thus, lifestyles are much more than the total factors related to health, illness and disease. Health professionals, health promoters and others have tended to equate lifestyles, health habits, health behaviour and other similar names for health-related behaviour. Nevertheless, the concept of lifestyles is much broader than the concept of

health behaviour. Lifestyles cover many other aspects of people's daily lives and behaviour than those that affect health.

Many factors and mechanisms contribute to shaping lifestyles in general and health-related lifestyles. Examples include the socialization during childhood of health habits, peer pressure among friends and in work groups, the perceived risks inherent in certain types of behaviour and the pleasure and joy of habits although they might adversely affect health. All these factors and many more have an important role in forming lifestyles.

This chapter does not exhaustively explain and present theories and hypotheses related to lifestyles. Factors at the levels of individual psychology and biology, social and group psychology, social structure and economics and social culture have to be included simultaneously in understanding and explaining lifestyles. Consequently, intervention and health promotion activities should be directed towards all these levels and towards the sectors and spheres of life that do not focus narrowly on health.

## ***Types of data on lifestyles needed in a health profile***

Health profiles serve several purposes in improving health in cities and in guiding health promotion work. First, they describe the baseline and challenges for the work: what is the magnitude of the various health challenges? Which ones should be given highest priority? Where in the city or community and among which groups are the health challenges to be taken up most prevalent? How can the health challenges be described so that they become visible to the politicians and the citizens and can be used in political debate and decision-making?

Second, regularly conducted health profiles can serve as a measure for evaluation: were the targets achieved? What supported the success of the work and what were the obstacles and the causes of failures?

The debate on whether health profiles should use quantitative or qualitative data has been heated. Distinguishing between quantitative and qualitative data is very difficult. All data are qualitatively distinct. In some cases huge quantities of data are collected and subjected to statistical calculation, and the results are presented in graphs, tables and figures. In other cases a few data are collected and interpreted by various nonstatistical methods.

Some people understand the message inherent in the tables, graphs or figures and therefore like and advocate quantitative methods. Other people better understand the messages of qualitative methods. Both approaches are necessary in understanding, planning and evaluating health promotion.

Quantitative data are required to estimate the magnitude of problems (How many people smoke?), to set priorities (deciding among disease-preventing measures that could increase overall life expectancy by different amounts) and to evaluate whether targets have been achieved (such as increasing the percentage of nonsmokers among adults to 80%).

Qualitative data are necessary to understand many of the crucial processes that shape lifestyle patterns (How is peer pressure exerted and perceived? What are the norms for alcohol use?) and to understand why some people are reluctant to support health promotion actions. Qualitative methods and data are also needed in the stages of developing a questionnaire for a health profile. If researchers cannot understand what the questionnaire means to the target subjects, they cannot understand the data derived.

## ***Available data on lifestyles***

Very few data on lifestyles are collected routinely for public statistics and are thereby available for profile purposes. Usually only sales figures or taxation figures on tobacco and alcohol are available, and mostly only at the national level. Quantitative data on lifestyles therefore have to be collected through questionnaire or interview surveys of samples of the population.

The instruments used to collect data very seldom allow direct comparison between different surveys. If the questions are not worded identically, different responses are produced that do not necessarily reflect real differences. When different cultures are compared, even attempts to word the questionnaire identically in different languages might not suffice for obtaining comparability. If data cannot be compared with each other or a reference point they have no meaning. Surveys for health profiles must therefore use questionnaires that allow survey results to be compared.

The statisticians or researchers developing a questionnaire often find themselves in a dilemma. Most existing questionnaires can be legitimately criticized, as they have been developed through a series of compromises balancing many different opinions. A specific questionnaire can produce biased results. The ambitious researcher can therefore be tempted to develop a new questionnaire that will become the standard for all questionnaires. Nevertheless, this quest might produce a unique questionnaire that does not allow comparison with anything. A questionnaire that does not reach 100% quality and validity gains if it has comparability. The WHO Regional Office for Europe has reviewed national health interview surveys (1), which can form a useful basis for local lifestyle surveys.

## ***Lifestyle indicators in health profiles***

The lifestyle indicators to be included must be considered carefully. They should indicate serious causes of health problems, such as smoking, alcohol consumption or other risk-taking behaviour, or serious results of such behaviour, such as lung cancer or diseases of the circulatory system. The indicators should reflect themes in which measurable changes can be anticipated and possibly changes resulting from health promotion activities and health policy. The ultimate explicit or implicit objective of most public health policies is to reduce mortality and thereby increase life expectancy. Nevertheless, measuring such changes and claiming with certainty and irrefutable evidence that the changes have been caused by a specific health promotion activity, much less by a city's status as a "healthy city", are usually difficult if not impossible. The further in time a cause is separated from its hypothetical effect, the more difficult it is to claim evidence for a causal relationship, especially in observational studies (ones that are not experimental with random allocation of intervention).

Researchers must therefore carefully consider which indicators can best indicate success. Measuring public participation in health promotion programmes and activities is often a realistic ambition. Indicators of public awareness and knowledge of health hazards and contemplation of change in habits can also be chosen. The assumption is that awareness and knowledge sooner or later will change people's behaviour and subsequently their health.

The success of an antismoking campaign does not need to be evaluated based on the incidence of lung cancer: a decline in the prevalence of smoking suffices. Likewise, it could be argued that growing awareness of the health hazards of smoking, the establishment of nonsmoking norms and cultures and social pressure will eventually reduce the prevalence of smoking. A short-term evaluation should therefore focus on changes in knowledge and attitudes rather than on behaviour.



## ***How have health profiles dealt with lifestyles?***

Eleven recent city health profiles (2–12) were analysed and evaluated concerning lifestyles. Two evaluation criteria were used:

- Did the profiles contain data on lifestyles? If so, how did the profiles define lifestyles? Were lifestyles narrowly defined as risk factors or risk behaviour without considering the intentions or motivations behind the behaviour? Were lifestyles defined broadly as coping with living conditions and with health risks and problems?
- How did the presentation of data on lifestyles fulfil the objectives of a health profile?
  - measuring the magnitude of health problems
  - providing input to discussion on health policy and to setting priorities, objectives and targets
  - evaluating efforts, programmes and policies
  - making health challenges and potential visible to the public.

Half the profiles provided data on at least one of the following: smoking habits, alcohol consumption, dietary habits and physical activity. A few profiles featured data on such lifestyle aspects as sexual health and behaviour and drug use. The main reason these data were included seemed to be that the city already had these data and not because it reflected the importance of these aspects of lifestyle on health compared with other areas.

Very few profiles defined lifestyle in its broad sense, including data on public attitudes towards changing lifestyle or contemplating change. Most of the presentations of lifestyle data gave data for the whole city or data according to age and gender or city district. Very few profiles presented data according to social groups or classes, thereby missing the opportunity to influence the priority-setting ideas of how ambitious the targets relating to lifestyles for the whole population can be. Class differences in health and lifestyles not only illustrate social inequity or unjust social differences; they also illustrate achievable targets for health policy. If some social classes have a life expectancy of 80 years, a target for the whole population of 80 years can be achieved. If some social classes have a smoking prevalence rate of 20%, it is realistic to aim for this rate in the total population.

Most profiles did not incorporate lifestyles very well or to a degree that the profiles can support health policy-making, planning and evaluation. There are many reasonable explanations for this. Data on lifestyles are usually only available through special surveys, and conducting them requires special expertise, experience and a lot of resources from the city.

## ***Comparability of the lifestyle aspects of city health profiles***

A health profile should primarily serve local purposes and present information to a local audience. But experience shows that the value and meaning of statistics on health and other factors improves when local figures can be compared with national ones or ones from other cities. The data on smoking could be compared for some of the health profiles reviewed (Table 1). The data were taken directly from the profile reports and are only approximate in some cases, as figures have been estimated from graphs. Five of the profiles provided data on smoking that were comparable to a satisfactory level, as the basic survey data and questionnaires used were similar. Table 1 illustrates that the presentation and breakdown of the data present further problems

for comparison even if the basic data are comparable.

The overall smoking prevalence in Eindhoven is 38%, whereas it is 40% in Dublin and approximately 30% in Sumperk. The health profile for inner Nørrebro (2) does not provide the overall prevalence for Copenhagen, and the overall prevalence for Leiria is not available.

The data from Eindhoven were distributed according to age groups and according to gender, and the results for Copenhagen were distributed according to an age-by-gender matrix. The data from Dublin were distributed according to gender in districts with high or low mortality. In both Copenhagen and Eindhoven smoking is more prevalent among men than among women, but in Copenhagen it is more prevalent among women than men in the youngest age groups. In Dublin smoking is more prevalent among women than among men.

The profiles leave numerous questions unanswered that could only have been answered if all cities had used the same presentation format.

Table 1. Smoking prevalence rates reported in various city health profiles (2–4,9,10)

City and population group	All ages	Age groups			
		14–24 years <sup>a</sup>	25–44 years	45–64 years <sup>b</sup>	≥65 years <sup>b</sup>
<b>Eindhoven</b>					
Total	38%	33%	44%	38%	24%
Men	40%				
Women	35%				
<b>Leiria<sup>a</sup></b>		35%			
<b>Sumperk</b>	about 30%				
<b>Copenhagen<sup>b</sup></b>					
City of Copenhagen					
Men		28%	40%	53%	40%
Women		32%	41%	44%	25%
Inner Nørrebro (district)					
Men		30%	46%	60%	37%
Women		34%	44%	44%	20%
<b>Dublin</b>					
Total	40%				
District with high mortality					
Men	50%				
Women	52%				
District with low mortality					
Men	27%				
Women	30%				

<sup>a</sup>The age group for Leiria was 15–19 years.

<sup>b</sup>The two oldest age groups for Copenhagen were 45–66 years and ≥67 years.

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***Community health profiles***



## ***Introduction***

The health and wellbeing of any population requires a holistic approach that includes the involvement of many agencies and gives ownership to the communities involved. The traditional notion of top-down delivery of health care is no longer acceptable to central governments, who are seeking greater value for money. The increasing return to the principles of public health signifies that a purely medical approach to health cannot by itself resolve the many health problems in increasingly complex cities. Government health strategy documents increasingly recognize the importance of the views of the people receiving services in needs-based service delivery and espouse the involvement of individuals and communities as a key objective in the future delivery of health services (1):

To give people an effective voice in the shaping of the health services there needs to be a move away from one-off consultation towards ongoing involvement of local people...

Action on health issues at the community level has increased greatly in recent years, and local communities are now demanding a greater role in service provision and delivery. New partnerships are emerging to plan and deliver services based on local area needs. The Healthy Cities movement provides a focus for such partnerships.

## ***Community involvement in health***

### **Community development and health**

Community development seeks to enable individuals and communities to grow and change according to their own needs and priorities. Applied to health, this means encouraging people to define their own health needs and seek their own solutions. Community development achieves empowerment through participation. Community development can also aim to develop an awareness and understanding of the issues and the structural causes of social and health problems. Farrant (2) speaks of community development as applied to health as:

...redressing inequalities in health by facilitating collective responses to community defined health needs and enabling powerless and disadvantaged groups to have an effective voice in quality decisions that effect their lives and health.

The core features of community development are (3):

- people identifying what is relevant to them;
- collective action to influence or control change;
- the development of skills, knowledge and confidence;
- the sharing of power;
- the creation of structures for genuine participation; and
- raising awareness and confronting discrimination.

The key elements of this practice are equity, community participation and empowerment of local communities.

### **Community participation in health**

Discussions concerning the involvement of communities use a variety of terms such as community consultation and sometimes participation, which can be individual or collective. In reality, community participation in health can range from a questionnaire being delivered through people's doors and the results never becoming known and acted upon to local people being involved in all stages of the process of developing policy and exerting control over the outcome. Wallerstein (4) highlights the role of empowerment as a health-enhancing strategy. She sees empowerment as meaning "people assuming control and mastery over their lives in the context of the social and political environment. They participate in the democratic life of their community for social change". The concept of empowerment is one of the key strategies employed by the Healthy Cities movement (5).

Local communities have a formal mechanism for being involved in assessing their health needs through their participation in community health profiles.

### ***What is a community health profile?***

A city health profile includes information on the health and disease status of its inhabitants. A community health profile is a subprofile or microcosm of this. City health profiles use health indicators to define the population's health in individual cities and to present information on the lifestyles, environmental and social factors that affect the health of a city's residents (6). A community health profile is a social, environmental and economic description of a specific area that is used to inform local decision-making.

The community profile model facilitates a more detailed data collection of health-related information within communities or subgroups within communities, such as women or travellers. Using the socioeconomic profile as background information, a community profile examines and describes qualitative issues. In addition to people's perceptions of their own health needs, it will usually consider people's own initiatives towards maintaining and improving their health, and especially suggestions about health promotion initiatives – their own as well as those of the local authorities and health agencies. Hence, community profiling is a technique for involving local people in analysing their community needs and surveying the resources within a community with a view to using the information to construct new solutions.

### ***Some examples of community profiles***

#### **Belfast**

Belfast has a very successful history of carrying out community profiles. The Moyard community profile was carried out in 1986 and the Blackstaff project in 1991. Building on the experiences of both of these profiles, the Shankill Health Profile was carried out in 1996.

North and West Belfast has long been recognized as an area of extreme social disadvantage and deprivation (7). A report on relative deprivation in Northern Ireland using information from the 1991 census (8) reinforced the deprivation status and confirmed that within a cluster of Protestant wards, the Shankill area, the level of deprivation and disadvantage had in fact worsened. The Shankill Women's Centre and several other community representatives requested the Health Service to undertake a

health needs assessment of the area in collaboration with the community. *A health profile of the Greater Shankill Area (9)* quantified the extent of social and material deprivation locally.

The Shankill health profile had three major components:

- collection of relevant data to identify the health needs of the community;
- the development of health promotion strategies to meet these health needs; and
- the involvement and participation of the local community in the entire process.

The aim was to develop a suitable model to undertake a community health profile and to design an interagency action plan for a Healthy Shankill.

## **Method**

The area consists of 15 000 households within 17 identical community districts. A random sample was drawn from the electoral register. In total 1885 households were contacted by 27 interviewers. Of these, a number of addresses were uncontactable or untraceable, leaving a contactable number of 1637. Following an intensive interviewing period of 14 weeks, 1025 households were interviewed, giving an overall response rate of 63%.

Extensive community consultation took place in the preliminary stages to ensure that the survey instruments used were appropriate to the perceived needs of the community, and local residents were recruited and trained as interviewers. While the research questionnaire was being designed, the project was publicized extensively.

The report was intended to be a practical descriptive response to be used by the community in identifying and setting priorities for its own needs. It contained a mixture of interview-based information and sociodemographic indicators derived from census data.

The areas covered were:

- education
- economic activity
- financial situation
- traditional health indicators and self-perception of health
- lifestyle
- social determinants
- carers
- lone elderly people
- single parents.

The SF-36 Health Survey was used to assess self-perception of health. Validation was completed by the University of Ulster.

## **Process**

The Steering Group had insisted that local residents be recruited as interviewers, as it was hoped that they would be more acceptable to the local community members than professional interviewers unknown to the local community. This proved to be the case. The use of local residents also ensured that they could inform the researcher and coordinator of the appropriateness of the data collection instruments during the training period and piloting phase of the survey.

## **Outcome**

An information morning was held as soon as the preliminary results of the data analysis became available, and the results of the workshops held on that day provided an action plan. A framework for the delivery of the recommendation of the report was provided by setting up a Liaison Health Committee whose membership was made up of statutory, voluntary and community representatives.



A health profile of the Greater Shankill Area (9) provided a detailed assessment of need and was carried out in a cooperative spirit. It quantified the extent of social and material deprivation locally. It developed a mechanism to enable detailed information to be collected at the neighbourhood level that can also be compared with the results from larger-scale social surveys.

## **Glasgow**

The poor health of many of the citizens of Glasgow has been recognized for a number of years. Glasgow has the highest overall death rate in Scotland, 11% above the Scottish average generally and 20% above the Scottish rate for people under 65. Sixty-five percent of the postcode areas in Scotland designated as deprived are in Glasgow. Within Glasgow there are marked inequalities in health between communities. The 1991 census showed that Glasgow had more social deprivation than any city in the United Kingdom and that deprivation was increasing and concentrated in areas of public sector housing.

The Glasgow Healthy City Project (10) drew up an outline for a pilot community health profile and provided funding for a research student to carry it out in the Gorbals/Oatlands area. The results of the pilot survey acted as the catalyst for the community to obtain widespread support and funding to carry out a full participatory community health profile in the area.

## **Copenhagen**

The Healthy Cities Project in association with the Danish Institute for Clinical Epidemiology carried out a community profile of a random sample of residents in the inner Nørrebro district (11). The aim of the inner Nørrebro profile was to provide information for local health-promoting activities in inner Nørrebro and to facilitate improved dialogue between the local district and the City of Copenhagen about plans for health-promoting activities. The results of this survey were supplemented by information from official statistics.

Inner Nørrebro is a small area of about 2 km<sup>2</sup> with a high population density and about 29 000 residents, 6% of the population of the City of Copenhagen. Inner Nørrebro has a higher proportion of inhabitants aged 16–32 years than does the City of Copenhagen as a whole, with few children and elderly people and a higher proportion of residents who are not Danish citizens. The unemployment rate is higher than that of the City of Copenhagen as a whole. Most of the residents live close together in very small flats. Forty-four per cent of the buildings date from before 1900 and more than one third of the dwellings are smaller than 60 m<sup>2</sup>. Inner Nørrebro has few recreational areas and sports facilities. Heavy traffic is also a major problem.

## **Method**

A questionnaire survey of 1800 randomly selected inhabitants over 18 years was carried out.

People's perceptions of their state of health were sought. Did they feel well enough to do what they felt like doing? Did they suffer from stress in their everyday life or did they have any current or chronic diseases? The responses were compared with results for the entire City of Copenhagen.

## **Results**

There were 755 replies to the survey, or a response rate of 42%. The biggest differences between the residents of inner Nørrebro and Copenhagen as a whole were as follows.

- Middle-aged men suffered from stress considerably more than middle-aged women and more than other people in Copenhagen.

- Men in inner Nørrebro aged 45–66 years consumed much more alcohol than a similar group in the rest of Copenhagen.
- Loneliness was cited as a particular problem, as one third of the population living in inner Nørrebro are single.
- Only 9% of parents in inner Nørrebro recognized that it is important for their children to wear a safety helmet when cycling.
- Inhabitants were more exposed to air pollution from motor vehicle transport than the inhabitants in Copenhagen generally.
- Only 25% felt there were sufficient opportunities for leisure activities.

The biggest influences on health in inner Nørrebro were the old and still partly inferior housing as well as busy traffic. Interestingly, although almost everybody in inner Nørrebro lives in a tenement block, people in inner Nørrebro were as satisfied with their dwellings as people in Copenhagen as a whole. People felt that the local authorities could contribute by reducing the inconveniences caused by traffic. They suggested laying out parks, reducing direct pollution of common areas, increasing facilities for sports and improving housing conditions.

### **Outcome**

Only a few children live in the district, and most of those responding do not regard this as a satisfactory area for children. Many people are deeply lonely and suffered from stress and a comparatively poor state of health, and many are unemployed. These results were important in determining which health promotion initiatives should be taken. In Nørrebro this means that health promotion initiatives must be directed towards boosting employment and strengthening social networks. Efforts must also be made to suppress unhealthy personal behaviour, the most conspicuous type being excessive alcohol consumption.

### **Gothenburg**

A summary profile on the overall health status of the residents of the City of Gothenburg has been prepared annually in recent years. This report has been based on various aspects of health, including increasing vulnerability, unemployment, changes in social policies, lack of adult support among young people, risky behaviour among young people, data on ill health, birth rates and mortality, tobacco smoking and accidents, infectious diseases and the utilization of health care as well as the results obtained using the SF-36 Health Survey for that year.

The executive board of the City of Gothenburg decided in 1997 to establish public health programmes in each district, which would be operated locally by the 21 district councils between 1998 and 2000. To support this work, special resources have been set aside. A working model for the local work is based on five stages:

- the establishment of a local public health council
- the production of a local public health profile and analysis
- the production of a local public health programme
- the implementation of the programme
- evaluation and follow-up.

The local public health profile is based on three cornerstones: registry data, assessment of needs by the community and self-assessed health. Everyone who is involved professionally with public health in the city district, including schools, health care, the police force, the church, voluntary organizations and recreational leaders, is asked to describe their needs and wishes related to various activities. Between 1300 and 2000 city residents are selected at random and asked to complete the SF-36 Health Survey relating to health and wellbeing.

The local health plans will be drawn up based on the local public health profiles and the local needs, but the City's general public health programme and its priority strategies will also be integrated into these local programmes.

Before the end of 1998, all 21 district councils in Gothenburg will have set up local health councils and started work on their health profiles.

## **Dublin**

### **Women's health profile in Clondalkin: health and quality of life**

The networks of the Healthy Cities Project was used to carry out the *Health and quality of life (12)* survey by the Women's Action Group in Neilstown, Clondalkin. North Clondalkin has an estimated population of about 6300 (1991 census). In Neilstown 80% of dwellings are provided by the local authority. In January 1993, Neilstown Junior School provided an adult learning course entitled "Towards a better quality of life" under the umbrella of the Healthy Cities Project, and the group of women who created this report attended. Arising out of an enthusiastic response to issues raised at the course, the women decided to conduct a health survey in their area as their contribution towards achieving health for all. Their main objective was to be the voice of the community in dialogue with statutory and voluntary bodies in increasing awareness of health issues, highlighting areas of concern and making recommendations for necessary changes in the area.

The project had three main strands:

- that health needs should be seen in a broader context than medical services alone;
- that the community must determine and analyse its own health needs as planned for the requirements of the residents in health promotion, disease prevention and cure and rehabilitation; and
- an equal commitment to the goal of a better quality of life, sought from external statutory and government bodies.

Nine local women developed the report; it was not intended to be an academic analysis but rather a way of showing how dialogue between community and statutory bodies might benefit the area and society on a wider scale.

The Department of Public Health in the Health Board provided professional assistance in questionnaire development, analysis and reporting. Before embarking on the task, the authors completed an intensive course on group dynamics organized by the Community Action Network. This enabled them to identify their strengths and weaknesses as a group and kept their energy and enthusiasm high and the aim focused.

*Method.* All the questionnaires were administered in the interviewees' homes. The electoral register was used to pick households for the survey. Every tenth household, beginning from a random point in the register, was chosen. The survey tried three knocks per household: if no one was available at the first call, the people conducting the surveys returned twice more at different times and on different days. If there was still no answer they proceeded to the house next door on the right. A pilot survey of 50 households was carried out before the survey itself. The areas covered by the questionnaire were:

- household details
- availability of local facilities
- crime and drugs
- teenagers
- education and employment
- child care
- local support groups

- personal health
- involvement in local activities.

*Results.* The response rate was approximately 88%. Just over three quarters of the respondents were married women and almost 20% were from single-parent families. Ninety-two per cent of the respondents described themselves as being happy to live in the area despite the key findings identified:

- lack of basic amenities (less than 40% households had a family car and only 60% had a telephone);
- lack of community facilities such as a supermarket, playground, bank, post office and leisure facilities;
- crime: 78% said crime was a problem in the area and 33% had had a family member affected by crime;
- drugs: 57% of the respondents thought that the area had a particular problem with drugs, and 85% thought more should be done to deal with the drug problem;
- teenage pregnancy;
- very high levels of smoking (55% of the women interviewed were current smokers, which is more than twice the national average of 27%); and
- lack of participation in local activities because of apathy.

*Outcome.* The group recognized that their area was seriously deprived but that it also had a highly motivated young and energetic community. They recognized the need to improve self-esteem in the area and that the community itself must contribute to any solutions.

### **Assessment of health needs in Tallaght**

Tallaght is a new area of Dublin (population 67 000 in 1996) with a high proportion of children, teenagers, young families and local authority housing. The Tallaght Community Health Project (13) trained local residents (all women) to conduct and analyse a community health survey in 1995 and 1996. Health Board staff, public health nurses and mental health staff and the Department of Community Health at Trinity College provided assistance. The results highlighted some of the main challenges for the community as being:

- the need for a refuge and community response for the victims of domestic violence;
- the need for a 24-hour emergency centre providing high-quality counselling;
- the need for help to reduce smoking;
- the need for a customer information service with leaflets and videos;
- the need for a female general practitioner;
- the need for more time at antenatal visits; and
- the need for services suitable for people with physical and sensory disability.

The group was asked to rank their needs in order of priority. Many of the issues did not involve significant expenditure but required a different way of working by some health and social care providers. The Health Board committed to formalizing the relationship and to addressing the identified issues systematically.

A full-time community work post dedicated to networking and resourcing community involvement in the locality was created. The worker works with local community groups to develop proposals for improving existing services and for developing new services where necessary. Then they work to bring together local groups with the relevant health services management to push for changes they have identified as priorities. The work seeks to involve groups who are marginalized and creates alliances with supportive managers and with general practitioners.

## ***Advantages of community profiles***

Community profiles in which official statistics, both demographic and health indicators, are supplemented by interview-based survey data provide an important baseline for future dialogue about the health and social circumstances of the people in a district.

The process of conducting a profile encourages debate and raises awareness among community members about factors that influence the positive aspects of health. It provides a mechanism for statutory agencies to develop a community participation strategy and for interagency cooperation.

Crowley (personal communication) has summarized these and other advantages of community profiles.

- They provide better information on local health care needs; the process facilitates more coherent and effective delivery of health care.
- They facilitate a more democratic approach to health needs assessment in keeping with central government policies.
- They facilitate understanding by local residents that services have limitations and resources are finite.
- They result in empowerment of local communities.
- A bottom-up approach is more sustainable than an imposed structure of consultation.

## ***Weaknesses of community profiles***

The idea of working together is simple in theory: asking members of the community to identify their health needs and involving them in finding practical solutions makes sense for all concerned, but in practice it can present real challenges. Nevertheless, this can be overcome through commitment and building trust in the process, enabling resources to be used efficiently and effectively. Community profiling will not yield its full potential impact towards strategic change unless the statutory authorities make a full commitment. Crowley (personal communication) outlines some of the weaknesses of community profiling:

- local people may lack information about the factors affecting their health;
- the responses may be dominated by more articulate people;
- they are very costly to conduct;
- sustaining community involvement is difficult in the face of other pressing concerns;
- they are of little value as a one-off process unless ongoing models for community involvement in assessment of their health needs is sustained; and
- health services have had a marginal impact on the root causes of ill health in deprived areas.

## ***Opportunities***

A healthy community has:

- wide community participation
- broad intersectoral involvement
- local government commitment
- healthy public policy.

Providing information on local health needs should result in a healthy community

because:

- alliances can be formed between local health workers and the community to act as a powerful lobby for resources;
- services for marginalized and socially excluded people can be improved;
- the community can be empowered;
- resources can be coordinated better;
- health professionals can better understand health problems; and
- the relationships between local people and health professionals can improve.

## ***Threats***

Community groups may disagree with one another or with health professionals about priorities.

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