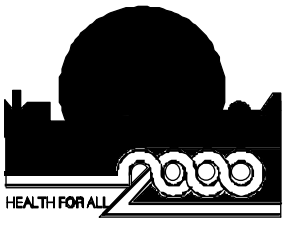
City Health Profiles:
how to report on health in your city



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Text editor: Rosemary Bohr
Desktop publishing: Shirley Harelle
Cover design: Thora Feldam

This booklet provides advice on how to produce a city health profile. A city health profile is a quantitative and qualitative description of the health of citizens and the factors which influence their health. It identifies problems, proposes areas for improvement and stimulates action. All appropriate sectors work together to collect, analyse, interpret and present the information. Guidance is given on the analysis of data, production of the report and the presentation and communication of the report's findings. Detailed suggestions are made for the contents of a city health profile.

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URBAN HEALTH
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The Working Group

Dr Mark MacCarthy, Camden (Chairperson)

Dr June Crown, South-East Institute of Public Health, England (principal technical adviser and responsible for drafting the report)

M Jacques Berthou, Rennes

Dr Ann Marie Connolly, WHO Regional Office for Europe

Dr Patrick Doorley, Dublin

Dr W.G.M. de Haes, Rotterdam

Dr S. Fontanelli, Bologna

Mr Kieran Hickey, Dublin

Dr I.A. Krasilnikoff, St Petersburg

Dr Hans van Oers, Rotterdam

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Foreword

Comprehensive city health profiles represent key products of the Healthy Cities project. They provide the evidence and the credibility for serious efforts to promote health at the local level. They act as the basis for advocacy, the setting of priorities and accountability for health. Profiles are about the health of people and about the conditions in which they live. They are essential tools for change and thus must be an integral part of local decision-making and strategic planning processes. The preparation of profiles creates unique opportunities for intersectoral work and community and media involvement. This booklet is intended to provide guidance and a reference frame to cities, towns and municipalities that belong to the Healthy Cities movement. The WHO Healthy Cities project office is planning a series of follow-up publications covering issues such as: tools for assessing a population's health; innovative examples of and approaches to designing profiles and evaluating the impact of city health profiles.

Technical documents based on commissioned expert input alone are relatively easy to produce, but they may be more academic and lack the practical touch. Books in the Healthy Cities document series are based on thorough consultation and experience through information exchange processes involving a wide range of expertise especially from the primary users. This book was prepared through consultation with a technical working group to ensure that it is a truly practical and appropriate guide for those working in Healthy City projects. The final text was agreed only after consultation with the full WHO Healthy City network at a technical symposium held in Poznan (Poland) in September 1994.

I should like to express my gratitude to Ann Marie Connolly for coordinating the preparation of this booklet, to June Crown

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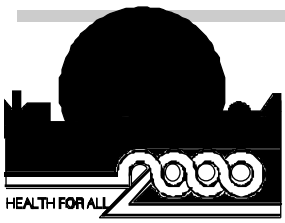
Agis D. Tsouros, MD, PhD
Coordinator Healthy Cities project



Part I

Preparing a City Health Profile

1. Introduction

A city health profile is an invaluable tool for every participant in a Healthy Cities network. It provides a lively, scientifically-based account of health in the city; it can stimulate public interest and political commitment; and it can identify targets for the future and monitor progress towards them.

All WHO Healthy Cities have agreed to produce profiles by the end of 1995. This document aims to help them do this. It draws on the experience of cities which have already prepared profiles as well as the advice of an expert group.

The Healthy Cities network has developed a set of healthy cities indicators which are incorporated into the suggestions for profiles. Indicators and profiles together should help in the development of city health plans, which in turn can lead to a review of the indicators.

Indicators are measures of health and of the factors which influence health. They can provide a basis for comparisons between cities.

Profiles include both indicators and other health-related measures with an analysis of the information. They identify in writing and graphs health problems and their potential solutions in a specific city.

City health plans set out strategies and programmes of intervention to improve health in the city, define targets and timetables for achieving proposed actions and identify monitoring arrangements.

It is important that the preparation of a city health profile is not seen as a burdensome requirement imposed by WHO for member-

ship of the Healthy Cities project. A profile can help cities in many ways: the collaboration which is needed to produce it can help cement alliances for health; the information it contains can highlight health problems and bring partners together to find solutions; and the presentation of the profile can stimulate public and media interest and improve general understanding of health issues.

We realize that participating cities vary widely in the resources they can devote to the preparation of profiles and in the amount and quality of information currently available. This book does not aim to give a prescription or rigid instructions for the preparation of a profile but to put forward suggestions and ideas which will give cities a starting point. To be relevant to a city a profile will always depend on local involvement, interpretation of the data in a way that is sensitive to social and cultural differences, and proposals for change that are credible and feasible.

A good profile describes a city and the factors affecting its citizens' health in a way that they will instantly recognize, and sets out proposals for change that will generate enthusiasm and energy. It should provide a focus for both community involvement and political support.

2. Objectives and purpose

A city's health profile is a quantitative and qualitative description of the health of the citizens and the factors which influence their health. It identifies problems, proposes areas for improvement and stimulates action.

Objectives

A city health profile should:

- summarize health information relevant to the city
- identify health problems in the city
- identify factors that affect health in the city
- identify suggested areas for action to improve health
- act as a stimulus for making health changes in the city
- set targets for achievements related to health
- act as a stimulus for intersectoral action
- identify needs for new data on indicators of health
- inform the public, politicians, professionals and policy-makers about matters that affect health, in an easily understandable form
- make health and its determinants visible
- record the local community's views on health issues in the city.

The main purpose of a city health profile is to stimulate action to improve health by:

- providing accurate, up-to-date, unbiased and independent information about the citizens' health

- providing accurate, up-to-date, unbiased and independent information about the determinants of health in the city
- analysing the information with respect to its impact on health
- identifying courses of action to improve health
- inviting community participation in planning for health
- inspiring all relevant groups to take action to improve health
- setting targets to monitor progress.

All the cities participating in the Healthy Cities movement have committed themselves to improving the health of their citizens. The city health profile is a tool to assist in this work.

Although a city's health profile is usually produced by groups of professionals in the city, its contents should be useful to and endorsed by policy-makers and the public as well as professionals. It should form a valuable channel of communication between politicians, experts and citizens and facilitate open discussion of health problems.

One of the most important instruments in the struggle for health is information, which can be used to secure community interest and political commitment. It can also measure progress in improvement in health. The city health profile is a vital source of information.

The information can only be effective, however, if it is of high quality. Whatever its source, it must be checked for accuracy and be as up-to-date as possible. The group responsible for gathering the information should have high professional standards and ensure that all the data are selected and analysed independently. However well

meaning, the inclusion of biased data from persuasive pressure groups will unbalance the report and detract from its overall impact.

A city's health profile should describe clearly current knowledge of the citizens' health and of the many aspects of the city's life that influence it.

The analysis should lead logically to the identification of possible areas of action, with some indication of relative priorities.

The presentation of the information and the analysis should be compelling, so as to galvanize the population and policy-makers into taking action. The style of the document should be cohesive, encouraging all groups to see the contribution they can make and to facilitate the development of alliances for health across the community.

A city's health profile is not a one-off document. A series of profiles should be planned for publication at regular intervals. Ideally they should be produced annually, especially in larger cities, but where resources are limited a two-year cycle may be more appropriate. Regular publication enables targets for progress to be set, the implementation of recommendations to be monitored, and achievements measured, recorded and celebrated.

If all these aspects can be successfully incorporated, a city's health profile can become a valuable and powerful instrument of its health strategy.

3. Production

Each city will face different problems in producing a health profile. The priority is to make progress and not let the best be the enemy of the good. Ideally you should:

- identify a lead agency to manage the production of the city's health profile
- involve all relevant agencies at an early stage
- identify the available budget and human resources
- identify target audience(s) and decide how many versions of the profile are needed
- set a timetable for production and dissemination
- decide on content and the longer-term programme
- identify existing relevant data sources
- consider the availability of local assistance (schools, universities, voluntary groups)
- include recommendations.

Lead agency

In most cities, the initiative to produce a health profile comes from one agency or department which takes the lead in producing it. This agency should be acknowledged by others in the city as the appropriate group and should take responsibility for coordinating or managing the production of the profile. The Healthy Cities coordinator will often take this role, and will aim to secure political sup-

port for production of the profile as part of the commitment to the Healthy Cities project.

Involvement of relevant agencies

It is important, however, that the profile is not the work of only one agency. At an early stage, contact should be made with other relevant groups in the city, using formal and informal contacts. Collaborators should, wherever possible, include statutory agencies responsible for health services, environmental health, housing, social services and education. Voluntary agencies concerned with health and health-related issues are also valuable partners. A steering group for the project can support the production team. Ideally this would include representatives of formal agencies which can contribute resources or information together with, if possible, one or two enthusiasts chosen for their personal commitment and ability to inspire others.

However, it is sometimes difficult to get going. It may be necessary for the first profile to be produced by only one or two agencies, with others being encouraged to join in in subsequent years. It is better to get started, with high quality information wherever possible and perhaps with some gaps, than to wait until every possible partner is ready to collaborate.

Identify resources

The preparation of a city's health profile takes time, and printing and distribution need money. It is important at an early stage to identify a budget for the project which includes the available financial and human resources, contributions in kind (paper, printing) and sources of income (advertising, sponsorship).

All those contributing resources should be asked to make clear at the outset exactly what they can make available. The production team should work within this and not put pressure on contributors to exceed their capacity. All contributions should be acknowledged in the publication. (However, caution should be exercised about accepting sponsorship from producers of products that are dangerous to health such as tobacco companies.)

Cities should not be deterred by having to produce a profile with limited resources. Some of the best city health profiles have been produced very cheaply.

Target audience

One of the first tasks is to decide on the target audience for the city's health profile. A document which is suitable for health professionals may not be suitable for policy-makers and may be too technical for the general public. It may be necessary to produce a number of versions of the document. For instance, it may be possible to produce a short, accessible version for the public together with a more comprehensive document, fully referenced with statistical information, for professionals. Decisions about the target audience may determine the number of copies needed and may thus be influenced by the budget.

Timetable

The group responsible for production should, at an early stage in the process, set a timetable with agreed dates for interim stages and completion. It is useful to fit the publication of a city's health profile to key organizational points for participating agencies, such as planning or budget-setting cycles. The intention of this is to draw attention to health problems and possible areas of action when the next phase of activity and resource allocation within the city is under discussion.

Content and long-term programme

The participants should agree on the frequency of production of the city's health profile. Ideally these should be produced annually, especially in larger cities, but where resources are limited a two-year cycle may be more appropriate. The first profile is likely to include a comprehensive statistical description of health in the city. If annual profiles are to be published it may not be necessary to reproduce all the statistics each time, especially when there is little change or surveys have not been repeated so that there is no new data. It is, however, worth including annual figures for population and vital statistics if these are not readily available elsewhere, as they provide valuable reference material.

The first profile should try to be as comprehensive as possible and cover a broad range of health problems and issues. Subsequent profiles can focus in depth on a few health issues, which may each be allocated a chapter in the publication. It is helpful to decide on and announce the special topics for the next two to three editions. This has the advantage of reassuring people with an interest that their topic is not forgotten. In addition, the knowledge that a topic is in preparation may generate surveys or offers of relevant information.

Data sources

The formal agencies in the city will have access to the major data sources and national statistics. Much of this information is not collected specifically for health and health care purposes. It is nevertheless of great value in describing the population and the determinants of health. Statistics derived from the use of health services are also valuable, although they have to be interpreted with care since they may reflect access to care and inequitable demand and supply rather than population morbidity and need. Local statutory and voluntary organizations may also have data from surveys and other sources which will enhance the city's health profile. The conclusions drawn from such data must take account of their epidemiological and statistical quality.

Local assistance

Gaps in information or areas where local studies would be valuable may become evident when the work is being planned. Assistance can sometimes be obtained from collaborators such as schools, universities and institutes of higher education or voluntary bodies, which may carry out surveys or other investigations for inclusion in the profile. If properly designed and supervised, with concern for scientific rigour, such projects can greatly enhance the profile, encourage participation and understanding and offer useful educational opportunities.

Recommendations

Finally, review the contents of the city's health profile, decide on priority areas for action and put forward recommendations. These should be firmly based on the evidence that has been pre-

sented, not just the current aim of a persuasive pressure group, and should identify the agency responsible for taking action. It is helpful to propose quantified targets for implementation which can give people a sense of achievement and confidence when they are attained.

not be available. Examples are hospital admissions by selected ICD codes and primary care attendances by cause.

- **Other primary care measures may be valuable, as this is the level where the vast majority of morbidity is managed. The arrangements vary from country to country, so each city should try to develop measures appropriate to its own system.**

- **Statistics from statutory procedures: examples include compulsory admission to hospital because of mental illness or physical infirmity statistics from registration procedures. The main examples are statutory notification of infectious diseases and cancer registration.**

4. Contents

This section should be read in conjunction with Part II

Every city will produce its own individual profile, with contents that reflect the availability of data and the local priority concerns. The first profile should try to be as comprehensive as possible, but it should include in particular those health issues which are of immediate concern or importance to the citizens at that time.

- There is no prescription for a city's health profile: each city will choose its own topics.
- All profiles should include a basic description of the population (number, age structure) and vital statistics (birth and death information).
- Other areas for consideration for inclusion are:
  - health status
  - lifestyles
  - living conditions
  - socioeconomic conditions
  - physical environment
  - inequalities
  - physical and social infrastructure
  - public health services and policies.

The basic demographic and vital statistics are so fundamental to the description of the city that we would expect them to be included in the statistical section of all profiles. They are usually well and universally defined and so form useful indicators for com-

parisons between cities.

Some indicators can only be obtained if considerable resources are available, for example through special surveys, so it may not be possible for all cities to include them.

Some characteristics of the city may change only slowly, so data may sensibly be collected and analysed every three or five years. More frequent surveys would waste resources and perhaps be disheartening to local people because of the small changes recorded.

Cities are not homogeneous: health and its determinants vary across them, and it is useful to obtain some of the statistical data by locality and perhaps to represent it graphically to help pinpoint areas which have special needs. We would expect every city health profile to include some examples in each of the following sections. A more detailed list of possible topics can be found in Part II.

Population

The starting point for the profile must be the size of the city and the demographic description of the population. This information is usually available from national or regional censuses. It can often be broken down by localities, and future trends and projections can be included.

Health status

There is no single indicator of the health of a population. Most of the measures are of death and illness rather than positive health. These are nevertheless useful measures which have the advantage of widespread use over many years. Their advantages and limitations are well known. The main areas to be included are:

(a) ***vital statistics****:* measures of births, deaths by age group and cause, and ratios which allow comparison with other places;

(b) ***measures of morbidity****:* measures of illness in the population, which can be obtained by special epidemiological studies or by indirect measures such as disease registration (notifiable diseases, cancer) or use of health services.

Lifestyles

There is good epidemiological evidence on the influence of lifestyles on the major causes of morbidity and mortality across Europe. Cities should include information on these whenever possible, as they represent areas for local preventive action. They include:

- smoking
- alcohol
- misuse of drugs
- exercise
- diet.

Housing

Adequate housing has long been recognized as an important prerequisite for health. The patterns of tenancy (home ownership, private and public rented housing) vary considerably from country to country, so there will be different data sources which will be well known within the city. Information may be available on:

- the numbers of homeless people in the city
- physical characteristics of housing
- density of occupation.

Socioeconomic conditions

Living conditions are also influenced by socioeconomic factors. Information on these can come from a variety of agencies, and will depend on national and local distribution of responsibility for services. Items for inclusion might include:

- education
- employment
- income
- crime and violence
- cultural participation.

Physical environment

The physical environment of the city has a major effect on both health status and the citizens' perception of health. A variety of measures are available, and statistics can usually be obtained from the local environmental health services on:

- air quality
- water quality
- water and sewage services
- noise pollution
- radiation
- open spaces
- infestations
- food quality.

Inequalities

Any assessment of a city's health will reveal that different groups of citizens experience very different states of health. If the status of the most deprived could be brought closer to that of the most affluent, many of the city's health targets would be achieved. It is therefore extremely important that the city's health profile identifies and if possible quantifies the inequalities in and determinants of health. Many of the statistics set out above can be analysed according to population characteristics to demonstrate the gradients across groups.

Physical and social infrastructure

A city's infrastructure influences and in some respects determines living conditions, the physical environment and lifestyles in the city. This section of a city's health profile may be more descriptive and qualitative rather than statistical and quantitative. It may include information about transport, communications and city renewal and planning. Social infrastructure topics may include training opportunities, descriptions of community development projects and evidence on social isolation.

Public health policies and services

The interpretation of public health varies across Europe. Here, we mean services and policies which aim broadly at health promotion or disease prevention. It may be useful to include a list of those policies which exist and a commentary on the effectiveness of their implementation. Areas for inclusion may be grouped according to:

- policies and services aimed at disease prevention in the population
- educational policies and services
- environmental policies and services.

Although no city health profile will include comprehensive information on all these subjects, a profile which presents some evidence on most of them will give a good account of health status and the factors that affect it and will make a powerful contribution to the identification of health problems and development of plans.

5. Analysis and interpretation of data

Key points

- Wherever possible, expert advice should be sought on the analysis and interpretation of the data in the city's health profile.
- Criteria should be agreed for the assessment of data submitted for inclusion in the profile.
- Statistical information is usually best presented as rates or ratios.
- Trends and projections are useful for developing plans.
- Comparisons with national figures or with data from other cities can identify areas for detailed examination.
- Graphical presentation adds interest to the report.

Whenever possible, the team producing the city's health profile should include or be supported by people with training and expertise in statistics, epidemiology and analysis of the data used, and who can advise on the selection, technical use and interpretation of the data. Without this expertise, statements may be made which are misleading, conclusions may be drawn which are without foundation and the work may be brought into disrepute.

Selection of data

Criteria for selection of data for inclusion in the profile should include:

- relevance to health
- statistical validity

- statistical reliability
- availability of historical trend data
- potential for projection into the future
- relationship with other health data (social isolation–alcohol–health; poverty–housing–health)
- availability of comparative data within the country at national, regional or city level and with foreign cities and countries.

Analysis of data

Each city will obtain guidance on the most appropriate methods of analysis of its particular data sets, taking account of factors such as sample size and response rates. There are some general points which it may be useful to consider.

- Raw numbers of events are rarely useful: they should be included in the text, to enable readers to assess the data. Whenever possible, *rates* should be used which relate the event to the population, e.g. deaths per 1000 inhabitants, immunizations per 1000 children under 5 years, cervical screening per 1000 women in the target age group.

- *Ratios* such as the standardized mortality ratio allow comparisons to be made between populations with different demographic characteristics – for example, comparison of death rates between a town with many retired elderly people and an industrial town with a younger population.

- *Trends* are usually interesting and informative. Care must be taken, however, to ensure that the data have been collected uniformly during the period in question (definitions, data sources, sampling, etc.) so as to ensure that like is being compared with like.

- *Projections of data* into the future are difficult and need expert assistance. Account has to be taken of likely changes in the population structure, etc. Straight line projections are virtually never correct.

- *Calculations* derived from the data can be of considerable interest and assist in assessing priorities. For example:

  potential years of life lost: this measures the gap between age at death from a specific cause and general life expectancy. It shows up the burden of deaths in young people from, for example, accidents, where the numbers may be relatively small but each event represents 50 years' foreshortening of life;

  avoidable deaths: designation of certain causes of death as avoidable may relate to failures in prevention (coronary heart disease, stroke), screening (cervical cancer) or medical care (appendicitis).

  Analysis of deaths in these categories may identify useful areas for action.

- *Comparisons* with similar cities or with regional or national figures can provide valuable insights and generate questions about the causes of significant differences, which may lead to action.

- It is often helpful to *present data graphically* as histograms or pie-charts or on maps. When this is done, at least one version of the profile should include the data from which the illustration is derived. Presentational tricks (different scales used in comparisons, etc.) should never be used.

- Readers who have not been involved in the preparation of the report may wish to know how the data has been analysed. At least one version of the profile should include *technical details* of statistical tests, sample sizes, response rates, etc. In this version, the more detailed tables of data may also be included as an appendix for those who wish to examine the figures in depth.

Data sources

The sources and availability of data will vary widely from city to city. The production team should, between them, be able to generate a useful list of sources, including:

- national surveys undertaken by government departments, statistical services or other agencies on a regular basis
- census data
- city council statistics
- Healthy Cities indicators database
- university departments of medicine, public health, social science, economics or education
- institutes of epidemiology
- health service data derived from hospital or primary care facilities
- environmental monitoring services
- voluntary agencies
- commercial organizations (e.g. for tobacco, alcohol or food sales)
- statutory health examinations (e.g. school, military)
- local surveys.

6. Presentation, dissemination and communication

Key points

Presentation

- Medium
- Format, size
- Layout
- Illustration
- Readability
- Identity

Dissemination and communication

Distribution

- Number of copies
- Leaflets
- Locations

Communication

- Formal public meetings
- Informal public meetings
- Media
- Launch

However impressive the contents of a city's health profile may be, the profile will only serve a useful purpose if it is read and understood. Effort put into the presentation and dissemination of the profile and communication of its messages is never wasted. Each city will know how to attract the attention of citizens, taking account of local culture and tastes. In this section, we set out some pointers which may help to generate ideas in cities.

Presentation

An early decision is needed on the *medium* in which the profile is to be produced. Every city is likely to want a written version. Some Healthy Cities have produced very successful video versions of health profiles to complement written versions. Local voluntary groups may be able to assist in preparing Braille or taped versions for people with visual impairment.

The *format and size* of each version should be decided. Technical advice is valuable at this stage, as small differences in page number can have major implications for price because of printing and paper size considerations. If a version is to be distributed by post, paper thickness should also be decided, to minimize weight and postal costs.

The *layout and presentation* of pages should be decided. Issues to consider might include typeface, colour of text print and figures (clear, dark and large print is much easier for older people and those with visual handicaps to read). Clear diagrams and figures can also be easily photocopied.

- Page layout – do you want double or single columns, and a figure or illustration on each page?
- Will statistical tables be incorporated in the text or presented as an appendix?
- Will technical definitions be included as footnotes or a glossary?

Illustrations can contribute to the attractiveness and accessibility of the profile. Decisions should be taken on the types of diagram to be used, the inclusion of photographs and the use of cartoons. Action should be taken at an early stage on the preparation of the illustrations, so that production is not held up.

The text can be measured for *readability* to take account of range of vocabulary, length of sentences, etc. Local educationalists can advise on an appropriate level. It is also worth looking at popular local newspapers to obtain guidance.

Readers should be able to recognize the *identity* of the document. It is worth including both on the cover and in the text a well known logo or city symbol.

Dissemination and communication

The production of the profile is not an end in itself. Energy and resources also have to be invested in communication to ensure that the need for change is recognized, that interest is sustained and that action is taken.

Distribution

The distribution of the profile will be influenced by the *number* of copies available. If there are several versions of the profile, care must be taken that the right version reaches the right target audience.

A small *leaflet* highlighting some key points of the profile can usually be produced quite cheaply. This can include information on how to obtain a copy of the full report. City councils often have distribution systems for other purposes such as electoral registration or local tax collection and leaflets may be sent round to all households with these at minimal cost.

Copies of the city's health profile should be sent to as many *public places* as possible, for example:

- libraries
- schools
- hospitals (the video can be shown in waiting areas)
- primary care premises and clinics
- leisure and sports centres
- churches.

Communication

The city's health profile must make an impact on the public, policy-makers and opinion-formers. Arrangements should be made for presentations at:

- formal public meetings of health boards and committees
- informal public meetings for voluntary organizations, local community groups and the general public.

A press release should be prepared and distributed before publication day. This can be followed by a press conference and interviews on local radio or television. Some local media representatives may be willing to prepare articles or programmes on health subjects to coincide with publication if they are given notice of the proposed date.

It may be useful to organize a launch event to attract attention to the profile, perhaps involving local personalities such as sports stars. Some cities have also arranged "health fairs", events in shopping centres and widely publicized health competitions.

7. Monitoring and evaluation

Considerable effort and resources go into the production of a city's health profile. It is strongly recommended that the profile should be evaluated, both because this is good practice and because it shows to other groups and bodies that high standards are being set.

There are many approaches to monitoring and evaluation. Each city will choose its preferred approach, but in selecting a method attention should be paid to its validity. Although evaluation methods are complex, it is possible to undertake simple studies which are entirely satisfactory. Some resources should be set aside for monitoring and evaluation when the budget for the project is set.

It is not generally possible to use outcome measures such as morbidity or mortality, as it is hard to make a direct connection between the publication of a city profile and changes of this kind. It is usual, therefore, to evaluate the production and content of the city's health profile and its impact.

Evaluation of the production and content

Production

- Was the timetable adhered to?
- Was the budget adhered to?
- Was the distribution satisfactory?
- Were the arrangements for the public presentation and launch of the profile satisfactory?

- Was the information which was required located and was it accurate?
- Were the illustrations clear and appropriate?
- Were the conclusions based on evidence?
- Were recommendations clearly spelled out?
- Were the readability standards met?

Impact

The aim of the exercise is to improve the health of the population. It is difficult, however, to measure this outcome, especially in the short term, and even more difficult to ascribe cause and effect. The impact of the profile must therefore be judged by various other proxy measures.

- Were public meetings well attended?
- Did the profile have good media coverage?
- Was there a good response in terms of requests for copies of the profile or return of questionnaires enclosed with it?
- Did the policy-making bodies endorse the recommendations?
- Did the policy-making bodies produce plans in line with the recommendations?
- Were the plans implemented?

If plans or projects are developed as a result of the profile, these should also be evaluated. It may then be possible to assess resulting changes in lifestyles or health. Wherever possible, these should be reported in subsequent profiles to encourage future work.

Each profile should include a short introductory section on the impact of the previous profile and any action arising from it.

8. Follow-up

Producing a city's health profile will almost always establish alliances between sectors and generate enthusiasm for the promotion of health in the city. The profile itself will identify areas for action and suggest possible partnerships.

It is important that the production of the city's health profile is not seen merely as a task and an end in itself, but as part of a dynamic process. The momentum achieved should, if possible, be maintained. Partnerships for health should be nurtured.

The profile itself should explicitly be part of a cycle, containing reviews of earlier achievements and recommendations for future action. It should be used regularly as a means of communication with the public and policy-makers until it is replaced by the next edition. The expectation is that over the years a city's health profile will become an influential part of public health policy and activity.

The production of a city's health profile will not necessarily be easier as time goes by, but there will be satisfaction in noting the progress which it will record. The document should sustain and develop interest in health and act as a mechanism to ensure accountability for health in the city.

Part II

Contents of the profile: detailed suggestions

Note

Part II supplements Chapter 4 of Part I. It contains examples from a range of existing city health profiles. They are a limited sample of the types of data that could be used in health profiles and the ways in which these could be presented.

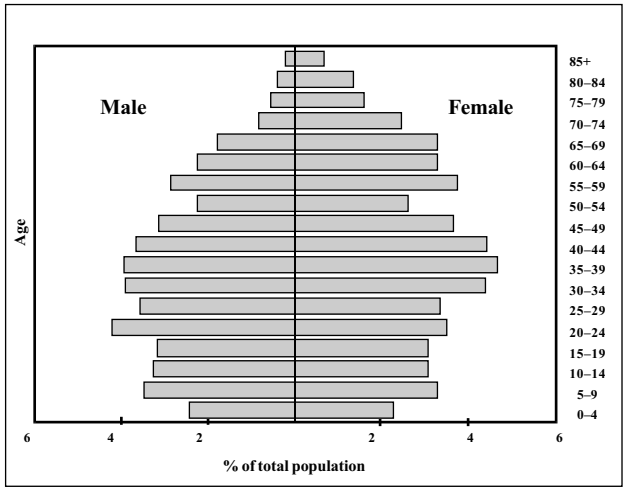
Full details of the source of the examples used are listed at the end of the booklet.

9. Contents of the profile: detailed suggestions

This list is not intended to be prescriptive but to provide a "menu" from which cities may select items for inclu sion in their profiles. Neither is it comprehensive: as they work on profiles, cities will identify other topics for inclusion.

Some items of information are almost universally available, have agreed definitions and are therefore valuable for comparisons between cities and countries. They are marked with an * and should normally be included in at least the first health profile produced in each city.

Population



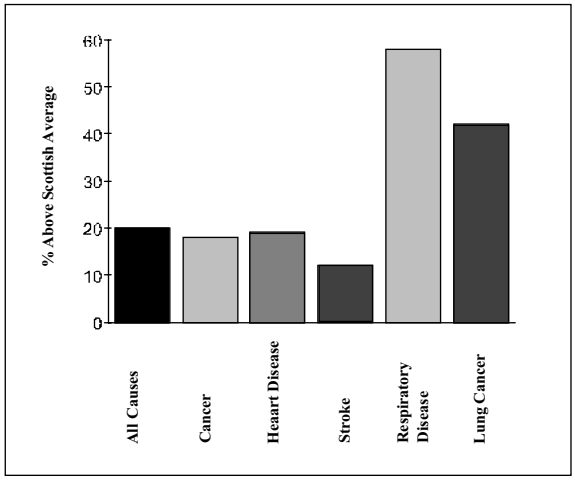
Example 1. Age pyramid

- Total number of citizens on a specified date
- Age and sex structure of the population by 5-year age bands
- Percentage of children (0–1, 1–4, 5–14 years)
- Percentage of older people (over 65, over 75, over 85 years)
- Historic trends and future population projections
- Ethnic origin of major population groups (this may not be relevant in cities which have not experienced significant immigration)

Health status

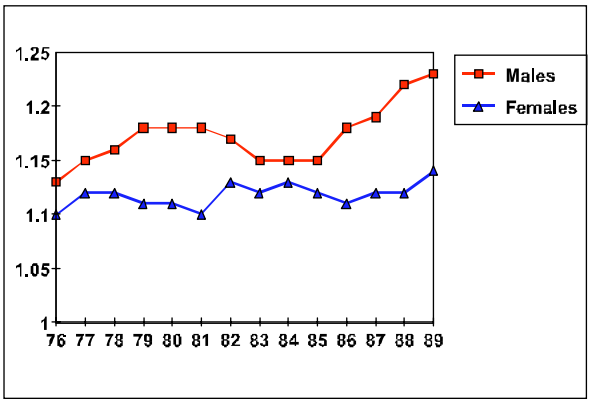
Vital statistics

- Birth and fertility rates
- Death rates
- Standardized mortality ratios (compared with national figures) for all causes and selected causes of death
- Perinatal mortality rate
- Maternal mortality rate
- Abortion rate



Example 2. Standardized mortality ratios for major causes of death in Glasgow

- Years of life lost (this is derived from mortality statistics and represents the difference in years between age at death from specific causes and national life expectancy)
- Avoidable deaths (deaths from conditions where there are effective forms of prevention and/or treatment)



Example 3. Trends in standardized mortality ratios for 0–64 year age group, by sex, all causes

Measures of morbidity

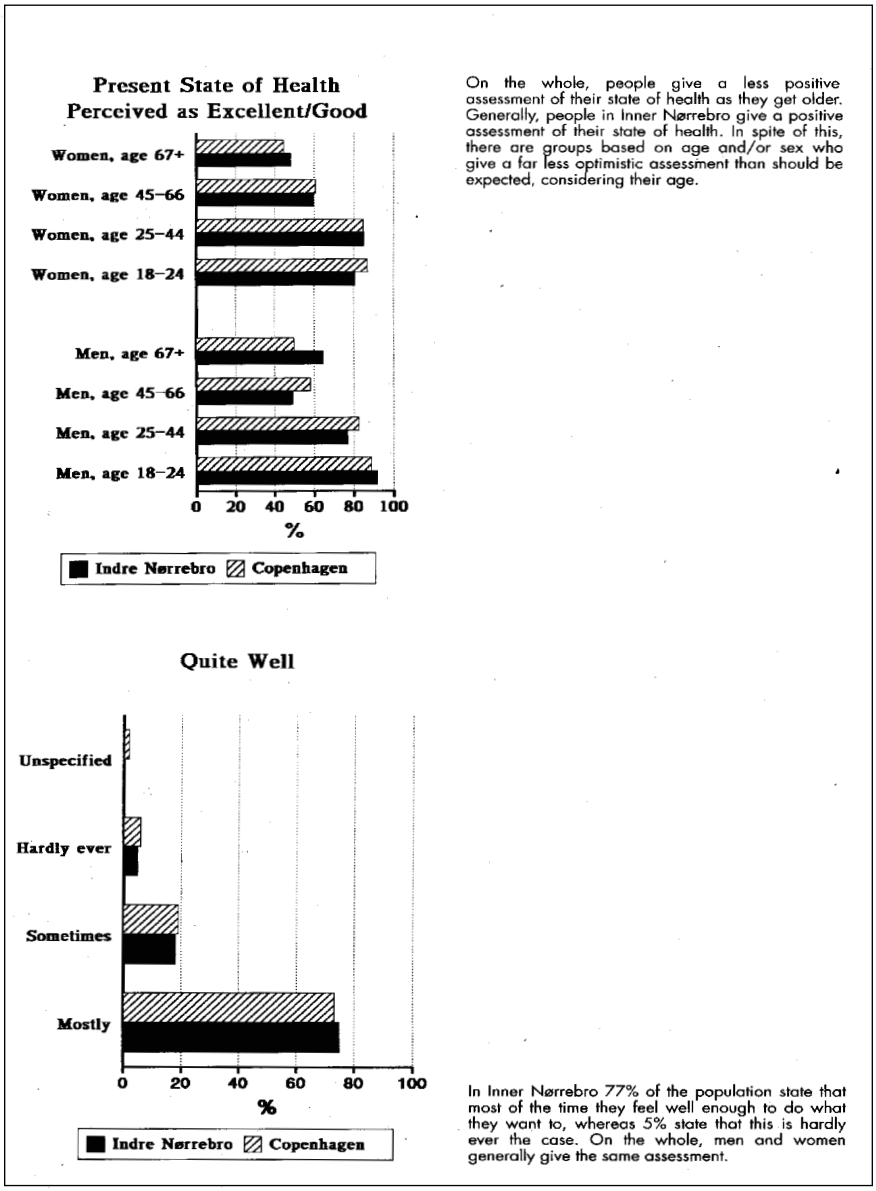
- Use of health services. Although information derived from the use of health services does not necessarily reflect the population's needs, it nevertheless provides evidence about some illnesses that would otherwise not be available. Examples are hospital admissions by selected ICD codes and primary care attendances by cause.

- Other primary care measures may be valuable, as this is the level where the vast majority of morbidity is managed. The arrangements vary from country to country, so each city should try to develop measures appropriate to its own system.

- Statistics from statutory procedures: examples include compulsory admission to hospital because of mental illness or

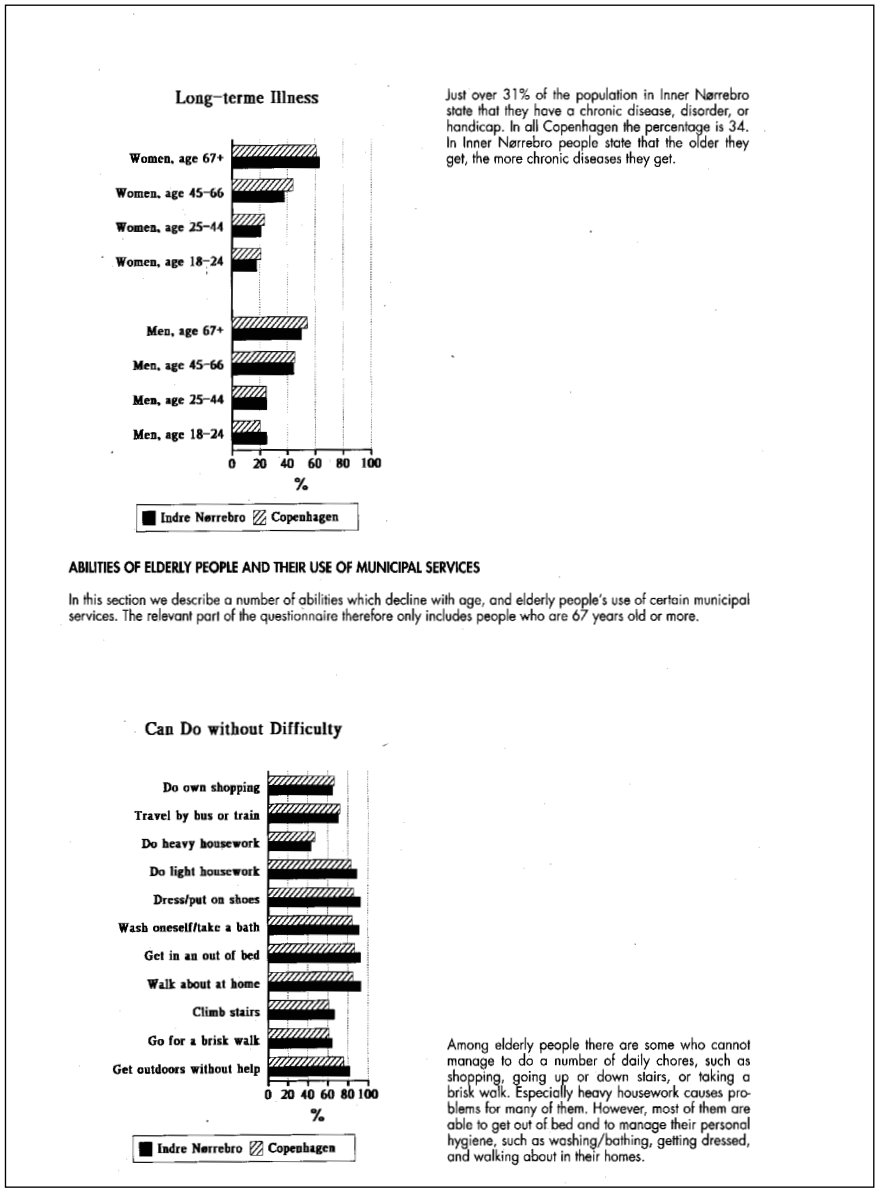
physical infirmity statistics from registration procedures. The main examples are statutory notification of infectious diseases and cancer registration.

Example 4.
Measures of perceived health and wellbeing



- Measures of perceived health and wellbeing. There are several validated instruments which measure individuals' assessments of their own health. Information of this kind usually requires a special survey.

Example 5.
Long-term illness



Lifestyles

The following are the major lifestyle factors for which there is good evidence of a relationship with health.

Smoking

Example 6.
Lifestyle factors

CHAPTER 4

LIFESTYLES

TARGET 16:

By 1995, in all member states, there should be significant increases in positive health behaviour, such as balanced nutrition, non-smoking, appropriate physical activity and good stress management.

TARGET 17:

By 1995, in all member states, there should be significant decreases in health-damaging behaviour, such as overuse of alcohol and pharmaceutical products; use of illicit drugs and dangerous chemical substances; dangerous driving and violent social behaviour.

There is considerable evidence that the lifestyles we lead have a marked influence on our subsequent health. In particular, poor diet, cigarette smoking, lack of exercise, and alcohol and drug abuse have all been shown to increase the likelihood that a person will die prematurely.

The *Mortality Patterns in Dublin* report (1989) showed considerable variation in the risk of dying between small geographical areas (Johnson and Dack, 1989). As a result, a further study was carried out to determine whether there were population lifestyle differences between the areas of high and low mortality which could explain the differences (Johnson et al., 1991). While this study does not give the prevalence of lifestyle factors for the whole Health Board area, by concentrating on the areas with highest and lowest mortality, it gives an indication of the present and the potential for change. A further strength of the *Risk Factors for Premature Mortality in Dublin* study is that it was carried out among persons aged between 25 and 44 years of age, an age group in which modest lifestyle changes could bring significant health benefits.

The next section will consider the available information on current lifestyle practices in Dublin keeping in mind targets 16 and 17 which deal specifically with lifestyle factors such as diet, smoking, exercise, and alcohol and drug abuse.

4.1 SMOKING

Smoking is the single greatest reversible cause of premature mortality, accounting for an estimated 5,000 early deaths in Ireland each year. It is interesting to examine trends in cigarette smoking in the Irish population. Overall prevalence has decreased from 43% in 1972–73 to 30% in 1989-90 (*Cancer, Ireland and the EC*, 1991).

Figure 9 shows that the decrease has been greatest in men (49% to 31%) while in women it has reduced from 37% to 29%. It can be seen therefore that the difference in smoking habits between men and women is now quite small. In addition, there is a worrying trend of increased

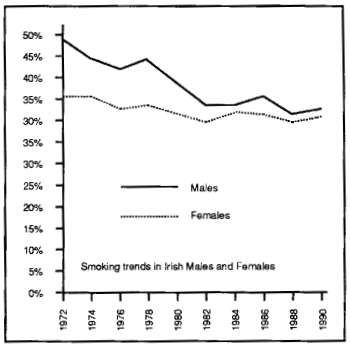


FIGURE 9. TIME TRENDS IN SMOKING

smoking in young women and it is likely that women will soon overtake men in overall smoking prevalence.

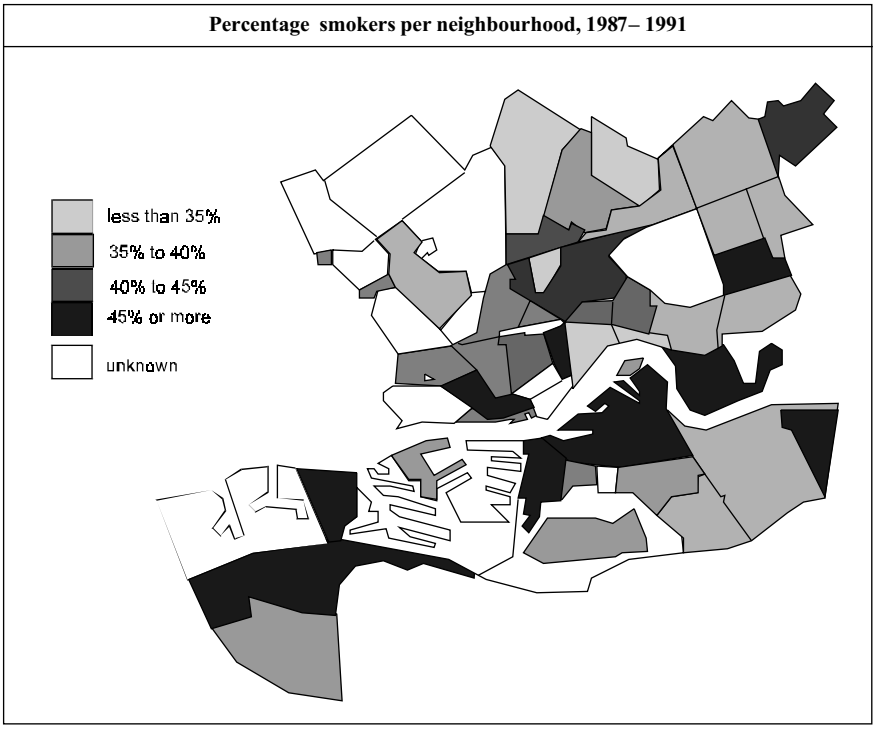
Table 24 is taken from the *Risk Factors for Premature Mortality in Dublin* study. Overall, 40% of the study population were current smokers which compares with a

TABLE 24. SMOKING STATUS IN HIGH AND LOW MORTALITY AREAS OF DUBLIN, 1989

Smoking Status	Mortality Area	
	High	Low
Male:		
Current	50%	27%
Ex	8%	21%
Never	42%	52%
Female:		
Current	52%	30%
Ex	4%	15%
Never	44%	55%

- *Direct measure*: population surveys identifying trends in tobacco consumption and smoking levels in groups such as women and young people
- *Indirect measure*: hospital admissions for smoking-related diseases (coronary heart disease, lung cancer, bronchitis)
- *Indirect measure*: information from suppliers and retailers on tobacco sales (this may only be available nationally or through customs and excise authorities)

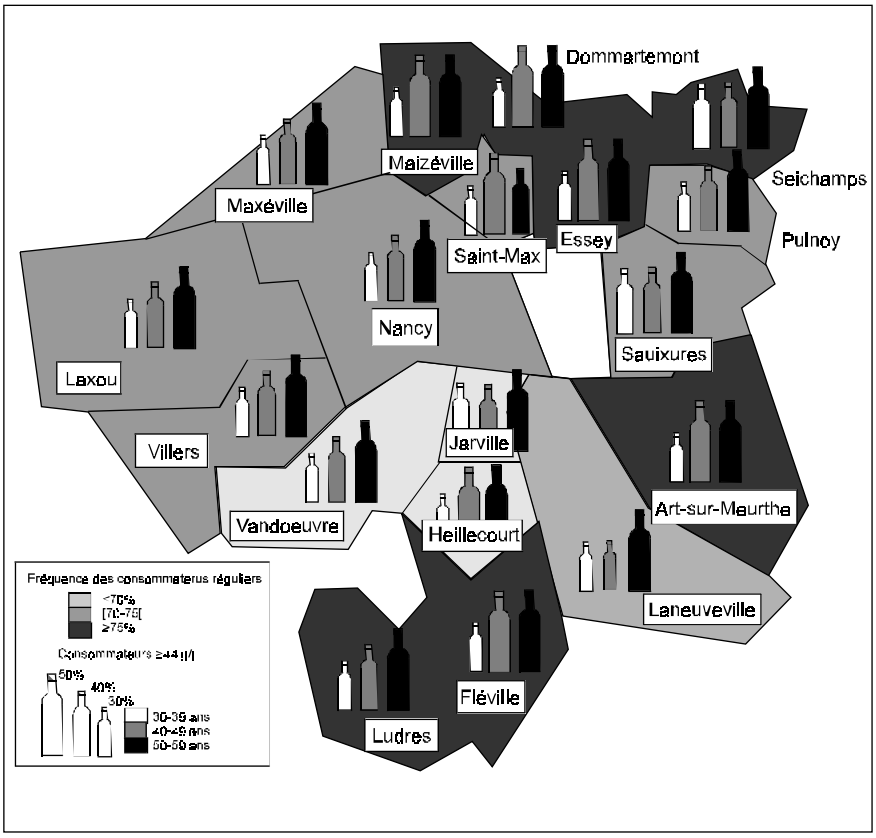
Example 7.
Variations in smoking rates in districts of Rotterdam



Alcohol

- *Direct measure*: population surveys (as above)
- *Indirect measure*: hospital admissions for alcohol-related conditions (alcohol-related violence, cirrhosis)
- *Indirect measure*: police records of drunk driving
- *Indirect measure*: information from suppliers and retailers (as above)

Example 8.
Alcohol consumption in districts of Nancy



Misuse of drugs

- There are few satisfactory direct measures, except where addiction to hard drugs must be registered – and this is usually not comprehensive. Information may be obtained from drug clinics, needle-exchange schemes or hospital data.

Exercise

- *Direct measure*: population surveys (as above)
- *Indirect measure*: attendance at sports centres, swimming baths, etc., and participation in team sports

Diet

- *Direct measure*: population surveys (as above) or more detailed food consumption/expenditure studies
- *Direct measure:* anthropometric assessment of population samples (height and weight)
- *Indirect measure*: information from major local food suppliers on trends in sales of low-fat milk, wholemeal bread, fish and red meat

Housing

Information may be available on the number of homeless people or those in temporary accommodation in the city.

Physical characteristics of housing

- Availability of basic amenities (hot water, toilet, kitchen)

Occupation density

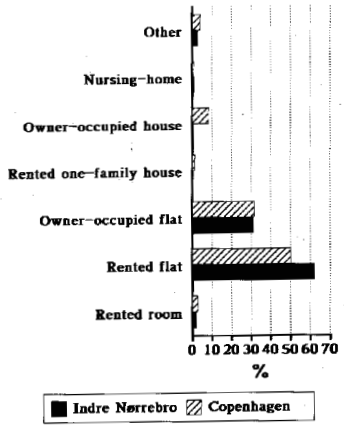
- Number of persons per household
- Number of persons per room
- Number of persons sharing a bathroom
- Number of persons sharing a kitchen
- Number of single-person households

Example 9.
Home environment

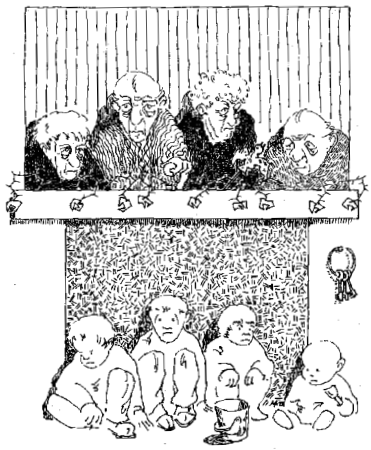
DWELLINGS AND ENVIRONMENT

There is a connection between an individual's state of health and the influence of his or her surroundings. Thus, there is a certain connection between long-term exposure to poor housing conditions and a poor state of health.

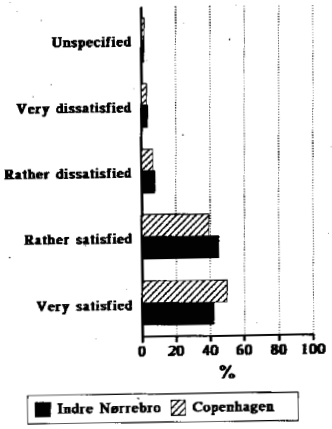
How Do You Live



Almost everybody in Inner Nørrebro lives in a tenement block. About one third live in freehold flats. One to two percent live in rented rooms. Other types of dwellings are for example nursing-homes and private houses.



Satisfaction with Dwelling



Just over 87% of the citizens in Inner Nørrebro are rather or very satisfied with their dwellings. Eleven percent are rather or very dissatisfied. Generally, people in Inner Nørrebro are as satisfied with their dwellings as people in the whole of Copenhagen.

Socioeconomic conditions

Many socioeconomic factors are known to be associated with health status.

Education

- Proportion of children still in full-time education at 14, 16 and 18 years
- Literacy rates
- Participation in adult education programmes

Employment

- Numbers of people registered as unemployed, by sex and age
- Major employers and industries in the city

Income

- Range of income levels (obtained from population surveys, fiscal records or benefit claimant records)

Crime and violence

- Police statistics on crimes of violence against the person (assault, mugging, homicide)
- Car and domestic theft conviction rates

Example 10. "Unemployment can seriously damage your health . . ."

Cultural participation

- Availability of cinemas, sports events, theatres, concerts and other entertainment
- Attendance at art galleries, museums and exhibitions

Physical environment

Air quality

- Average and peak levels of pollutants ($N0_x$, $C0_2$, 0_3, particulates)
- Morbidity, hospital admissions from pollution-induced respiratory diseases

Water quality

- Levels of chemical and biological pollutants
- Outbreaks of waterborne diseases

Water and sewerage services

- Proportion of households with mains water supply and sewage disposal

Noise pollution

- Monitoring of noise (average and peak levels)

Radiation levels

Open spaces

- Areas of designated public open space per hectare

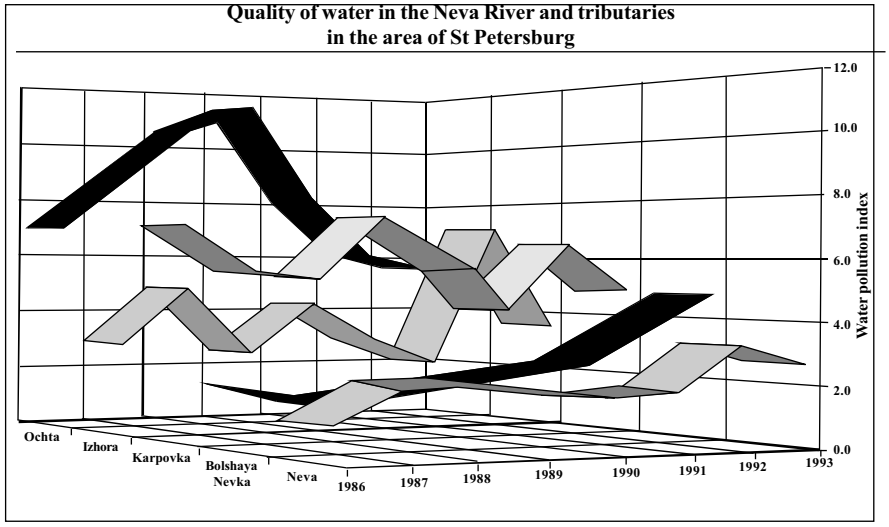
Infestations

- Notifications of infestations by rodents, insects, etc.

Food quality

- Data from environmental services' routine monitoring of food sources and distribution centres
- Outbreaks of food poisoning and other foodborne diseases

Example 11
Quality of water



Inequalities

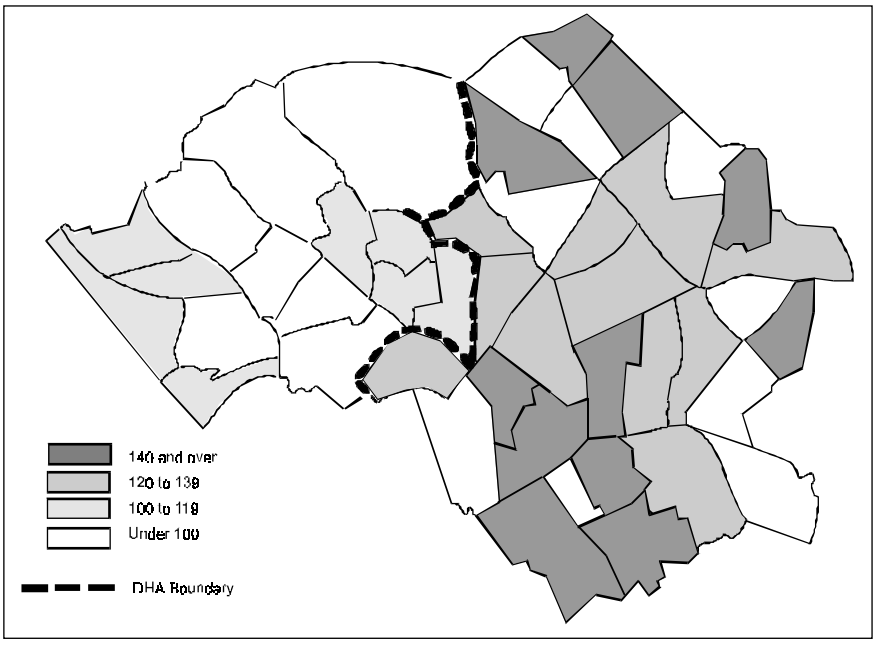
Much of the data in other sections can be analysed according to population characteristics to draw attention to inequalities in health and in the factors which influence health.

Example 12.
Inequalities in health – variations in standardized mortality ratios in Hampstead, Bloomsbury and Islington (London)Example 13.
Main factors influencing health and illnessPhysical and social infrastructure

Physical infrastructure

- Transport systems (public and private)
- Communications: the number of households with telephones, including households with children and elderly people living alone (as a measure of social isolation)
- Urban renewal: rehousing programmes, slum clearance, commercial development
- City planning: coordination of leisure, cultural and education facilities and public open spaces within urban renewal programmes

Example 12.
Inequalities in health – variations in standardized mortality ratios in Hampstead, Bloomsbury and Islington (London)



Physical and social infrastructure

Physical infrastructure

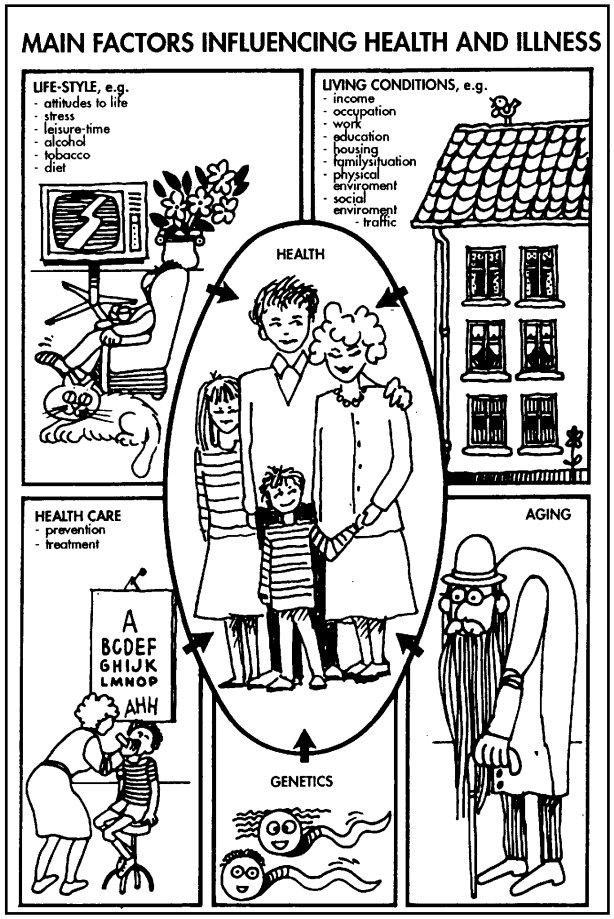
- Transport systems (public and private)
- Communications: the number of households with telephones, including households with children and elderly people living alone (as a measure of social isolation)
- Urban renewal: rehousing programmes, slum clearance, commercial development
- City planning: coordination of leisure, cultural and education facilities and public open spaces within urban renewal programmes

Social infrastructure

- City council employment and training programmes
- Devolution of budgets for city services and works to localities
- Development of and involvement in community groups

Public health policies and services

The policies and services included in this section are those whose prime aim is the promotion of health or the prevention of disease.



Example 13. Main factors influencing health and illness

Services aimed at individuals

- Immunization (uptake rates, infectious disease notifications)
- Cervical and breast screening (uptake rates, morbidity and mortality statistics)
- Family planning services (uptake, abortion rates)
- Stress management services

Educational policies and services

- Health education in schools
- AIDS awareness programmes
- Smoking education
- Alcohol education
- Drug misuse education
- Nutrition education

Environmental policies and services

- Smoking in public places
- Statutory authorities' nutritional policies
- Statutory authorities' alcohol policies
- Air and water quality controls

List of examples and their sources

Example 1.
St Petersburg City Health Profile (draft), p. 4.

Example 2.
Black, D. & Womersley, J., ed. *Glasgow's health: old problems – new opportunities.* A report of the Director of Public Health, Dr G.D. Forwell. Glasgow, 1993, p. 24.

Example 3.
Black, D. & Womersley J., ed. *Glasgow's health: old problems – new opportunities*. A report of the Director of Public Health. Glasgow, 1993, p. 25.

Example 4.
Copenhagen Healthy City project. *Your district – your health*: *Inner Nørrebro*. Copenhagen, 1992, p. 20.

Example 5.
Copenhagen Healthy City project. *Your district – your health*: *Inner Nørrebro*. Copenhagen, 1992, p. 22.

Example 6.
Dublin Healthy City project. *Dublin 1992 – a healthy city?* Dublin, 1992, p. 38.

Example 7.
van Oers, J.A.M., Garretsen, H.F.L., Verbeek, H.A., ed. *A healthy view on Rotterdam and the Rotterdam population.* Report No. 93–02, 1993.

Example 8.
Nancy Ville-Santé. *Les indicateurs de santé dans la ville.* Nancy, 1992, p. 25.

Example 9.

Copenhagen Healthy City project. *Your district – your health*. *Inner Nørrebro*. Copenhagen, 1992, p. 37.

Example 10.

Black, D. & Womersley, J., ed. *Glasgow's health: old problems – new opportunities*. A report of the Director of Public Health. Glasgow, 1993, p. 14.

Example 11.

St Petersburg City Health Profile (draft) p. 54.

Example 12.

Hampstead District Health Authority, Bloomsbury and Islington Health Authority, Camden and Islington Health Authority. *Public Health Report, 1991*. Camden, 1991, p. 18.

Example 13.

Copenhagen Healthy City project. *Your district – your health*. Inner Nørrebro. Copenhagen, 1992, p. 8.

(By courtesy of the Danish Institute of Clinical Epidemiology)