



## Whose health profile?

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**ABSTRACT** *'Community profiling' is seen as the essential starting point for area-based policy initiatives, particularly in public and personal health. Whilst researchers acknowledge that profiles should try to encapsulate the realities of the everyday lives that they depict, 'reality' is a slippery and often ill-defined concept. This article uses a meta-theoretical sociolinguistic theory of 'language creation from below' to ground the construction of a health profile. Drawing on fieldwork, the paper relates this theory to community participation research. It explores ways of developing a knowledge base that integrates qualitative and quantitative datasets. It argues for a form of community health profiling that represents the variety in people's experiences of unequal socioeconomic-cultural circumstances. Audio interviews, photographs and results of residents'/inhabitants' surveys were used alongside mapped, quantitative indicators using geographic information system (GIS) technology. Use of information technologies enabled the creation of a collaboratively owned, multi-sectoral profile. The paper concludes by arguing for the theoretical framework used.*

### Introduction

This article discusses the processes and research tools involved in creating a community health profile.<sup>1</sup> In doing so, it draws extensively on experience gained in developing a community health profile of a low-income population in an area of a large, northern English city. The paper draws on a perspective that is rooted in a meta-theoretical framework derived from linguistics.<sup>2</sup> Underpinned by this meta-theory, literature on the value of accessing lay knowledge<sup>3-10</sup> and ensuring community participation<sup>11-18</sup> in the development of health and social care helped the authors to evolve a method of working that enabled the perspectives of people who have been historically excluded from profiling processes to become visible and audible alongside more dominant perspectives. In combination with arguments and strategies that have been developed to strengthen the authenticity of qualitatively derived data,<sup>19-23</sup> this framework also guided the synthesis of output from both quantitative and qualitative methodologies<sup>24</sup> within the profile.

The paper stresses that the issues of who owns the profile's data and how data

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are accessed are deeply significant for how such a profile might be used subsequently. Ultimately, it argues for further developments in profile construction that enable people who experience the worst health and health outcomes to become involved<sup>25</sup> in community health profile construction through the application of participatory methods coupled with the judicious use of new technology.

### **Creating a health profile**

In 1997 one of the authors took up a new health and local authority shared post, project managing the Manchester Healthy City Initiative. An area-based initiative of this kind needed to be underpinned by a baseline assessment of the health situation of its residents, and the author concluded that a comprehensive and multi-sectoral health profile of the city was required.

Early discussions with those working to improve health in the area produced another compelling reason for this profile. There was widespread recognition that potentially useful information existed that could be used to underpin the development of integrated and participatory planning of health and social care throughout the city. However, that information was dispersed over different agencies, held in different formats, and no mechanisms existed to enable it to be shared or made more widely available. The creation of readily available, good quality information about health circumstances and provision was seen as a potentially important contribution that the Healthy City Initiative could make to supporting health improvement work in the city.

The circumstances were propitious for a variety of reasons. There was agreement across voluntary and statutory, health and social care sectors on the need to create such a baseline of the city's health and socioeconomic infrastructure and outcomes, and a multi-sectoral and multidisciplinary will to work together to achieve this. The initiative had access to a reasonably large, time-limited budget. Amongst other things, this enabled the secondment to the project of a lead planning officer from the local authority with experience in developing information systems based on data derived from service records, and links with GIS expertise in one of the local universities. There was also a particularly well-developed voluntary sector-based health infrastructure in a delimited area of the city whose workers were prepared to become involved.

From the outset, the aim was to create a 'living' health profile<sup>26</sup> through finding ways of incorporating and extending the different forms of information that were available. This was partly born out of a dissatisfaction with much of the community profiling that forms the basis of an increasing number of area-based policy initiatives. As Hawtin *et al.*<sup>1</sup> have pointed out in their typology of forms of profiling, there are a number of exercises that tend to be referred to collectively as community profiling, but actually describe somewhat different approaches:

- needs assessments, which make extensive use of existing data, tend to relate to single issues, but rarely involve the community;

- community consultations, which usually present the community with pre-defined proposals, and where the ‘consultation’ involved may be perfunctory;<sup>b</sup>
- social audits which, though covering a wider range of issues, concentrate on relationships between needs and resources within localities (the ‘balance-sheet’ approach);
- community profiles, which are the broadest in scope, comprehensively covering local issues, including those of needs and resources, but where the essential requirement is the active involvement of the community.

It is only the last of these definitions that meets the public and personal health policy criteria first set out in 1992.<sup>27</sup> Borrowing from the sentiments first expressed in the Skeffington Report of 1969,<sup>28</sup> health policy now insists that *jo/anne* public, whose health it is, should be involved in the processes of defining and developing health services. Rather than analysing prior community health profiles,<sup>c</sup> this article sets out the approach to creating a Health Profile for Manchester, where from the outset *jo/anne* occupied a critical position.

### The meta-theoretical framework

Most often, community profiling is conducted with little reference to any theoretical framework to guide the research process. This can often mean that the implicit conceptual issues of such work are not addressed openly, making it difficult to understand why particular data have been included or excluded.

All research aims, methods, results and analyses are communicated and interpreted through some combination of language-based text, diagrams, pictures and numbers. The importance of language in the research process—its impact upon the formation of research questions, the methods adopted, the resultant findings and their analyses and dissemination—is rarely recognized or explored. At the meta-theoretical level, this research process has been guided by our interpretation of Volosinov’s theory of language creation, which underpins the method of working that has been developed.

The essential parts of Volosinov’s theory of ‘language creation from below’ are that:

- The critical purpose of language is to communicate.
- It is through language that the reality that people experience is communicated.
- This ‘reality’ is both objective (i.e. it exists independently of what people may or may not say about it), and intersubjective (i.e. it is defined *between people through the communication of language*).
- Intersubjective reality is fundamentally affected by the socioeconomic position (and inside of this, differences in gender, race, age, culture, and able-bodiedness) of those who experience it.
- There are competing views of reality at any one point in time, held by different population groups. There is a continual process of struggle over, or ‘contest’

about, what is the dominant meaning of reality, and also over the means of communicating different versions of reality.

- What comes to prominence within any society as the dominant meaning of any particular reality is the result of that contest and is a refraction, rather than a direct reflection, of reality.

These arguments make it possible to appreciate the connections between the meanings developed and communicated through language and the socioeconomic context of those who are producing and using that language. How has this approach helped to shape the research processes involved in developing this community health profile?

First, it enabled the researchers to focus on the fact that people express different views about the reality of health and the factors that affect it. It accounted for these differences, which arise from the distinct socioeconomic contexts within which the holders of these different views live their lives. This community health profile therefore sought to encapsulate both the material reality<sup>25</sup> (the socioeconomic context), and the ways in which this reality is refracted through the social lens (the differently held views).

Second, alongside the well-established arguments for relating the experience of *health* to the social and economic circumstances of the individual life<sup>29, 30</sup> Volosinov offered an additional dimension. He demonstrated that all *language* produced is fundamentally affected by its socioeconomic context, and this includes the language which is used to describe and account for the health status of a population. The socioeconomic context, then, influences how individuals and groups in that population actually define their experiences, both of their own and of other's health.

By insisting that there are different views of the reality (and therefore of health), and that these will and do compete with one another for acceptance as the legitimate version of reality, Volosinov opened up two specific challenges. First, to create a health profile that captured and accommodated these different versions of reality. Second, to ensure that the profile gave expression to versions that, historically, have been omitted from community social and health profiling.

## **Lay participation and knowledge**

The process of meeting the first of these challenges centralized the development of an approach that enabled local residents and/or inhabitants to participate directly in both defining what would be investigated and how, and in creating datasets that captured their 'lay' knowledge about their health. This involved using participatory research methods that draw on community development skills.<sup>15, 16</sup> For example, and by way of introduction to the project as a whole, delegated representatives from a range of local health and social care voluntary sector groups and organizations were invited to come together to explore the health needs of the people living in their area.<sup>12</sup> In the opening session, facilitated by a community health development worker, they selected cuttings from magazines and newspapers to create collages that

represented their small-group perspectives on the range and health of their local population. Then, the representatives were invited to consider a prior example of a professionally developed research tool (a lengthy, closed questionnaire) and resultant findings that, in the recent past, had informed health policy and service development professionals about the health of the population in that geographical area. Their appraisal of this tool and of the findings that the tool produced led to a unanimous rejection, both of the method and content of the questionnaire and of the subsequent report on findings.

In response to the second challenge, Volosinov's insight that the version of reality that comes to dominate is intimately connected to the means of communication, the community health profilers involved sought methods to accommodate information in a range of media and, simultaneously, to ensure equal access to that information. By using different media, it became possible to capture views in ways which the holders of those views related to and felt comfortable with.

The taped interview, for example, is a valid way of capturing information, and one which is open to use by those without any specialized technological or statistical expertise. Through using the taped interview to capture data, the person who may otherwise remain excluded from the profiling process (because he/she cannot read or write, or because English is not his/her first language for example) is enabled to become involved. This is an important dimension to consider when seeking to ensure that the content of the profile is not confined to the views of any elites operating within the community organizations that are participating. In our profile, for example, the voice of a young woman resident, who looks after her younger brother, talks about how she and her family experience pollution in the local park. This voice can be heard while the viewer is looking at a photograph of the park, which can be juxtaposed with information about the distribution of play spaces in the local area.

Volosinov's theory describes the different perspectives on reality as refractions, perspectives skewed by the socioeconomic context, rather than mirroring reality. By using participatory research methods and community development skills to create a profile which put together a number of these refractions of 'health' including 'lay' refractions, and enabling them to be viewed simultaneously, the profile reached a more complete understanding, or a mirrored reflection, of reality. In this way the diversity of perspectives and their relative integrity have been maintained, even in the final stages of profile construction.

From the point of view of the person who uses the community profile, the differences in viewpoint that are circulating about health, what Volosinov describes as the intersubjective reality, and what subsequent writers have identified as being key differences between lay and professional perspectives are left intact for their independent consideration by the profile user (e.g. a purposefully selected excerpt from the raw taped interview). However, at the same time and through viewing a map, those different viewpoints are situated within their specific physical and social contexts, or objective realities.

Taking more of the complexity of the real world into the version of the profile that is presented has broken a well-established mould; usually data tend to be

‘cleansed’ in preparation for consumption<sup>31</sup>. Volosinov argues that, historically, such cleansing has been the outcome of the struggle between competing views of reality and that, in the main, the conflict has tended to result in the assertion of the *meanings* of the socioeconomically dominant in society, and the corresponding exclusion of the views of those perceived as the least socioeconomically powerful.

### **Choosing appropriate methods**

How can the desire to maintain the richness of reality, inspired by Volosinov’s perspective, be operationalized in the development of a community profile? Many population profiles rely extensively upon the use of statistical indicators to portray the characteristics of an area and its residents. Statistical indicators have traditionally been seen as heavyweight weapons in the armoury of quantitative methodology. This methodology has been defined as ‘an approach to the study of the social world which seeks to record and measure the life-style, behavior and attitudes of individuals in a way that is objective, reliable and quantifiable’.<sup>32</sup>

Far fewer community profilers have employed qualitative methods for this purpose, although their use is well established in other areas of social and health research. The qualitative method can be defined as ‘an approach to the study of the social world which seeks to describe and analyse the culture and behaviour of humans and their groups from the point of view of those being studied’.<sup>33</sup>

As Finch<sup>34</sup> points out, there has been a long ascendancy of the quantitative approach over the qualitative. The former’s concern with ‘measurement’, in particular, has been identified as the essence of the scientific method when applied to social behaviour. The capacity of a method to ‘measure’ continues to confer upon that method a high level of apparent objectivity.

However, there are many problems with relying solely upon quantitative indicators to portray material reality accurately. This is because the decisions about what will be measured, how that measuring will take place, and the interpretation of the results, are implicitly ‘refracted’ through the social lens of the profiler. There are contests, both about the meaning of concepts and their measurement. By themselves, indicators can provide little understanding of the material reality that they are supposed to represent. Frequently they offer a ‘snapshot’ view, all too often out of date by the time it is presented.

There is, though, a wealth of social science and other methodological literature that argues for joint qualitative and quantitative approaches. Over the last decade in particular, and as qualitative methods have become more commonplace in areas such as health services research and health technology assessment,<sup>20</sup> there has been an important opening-out of this debate to explore the integrity of qualitative data, in particular the extent to which it can embody validity, generalizability and reliability and how such qualities can be developed within qualitative approaches. This exploration has included the development of rationales and quality standards designed to enable the systematic review of qualitative health services research

literature.<sup>28</sup> Very recently, an implicitly Volosinovian technique has been suggested to support a strategy for enhancing the validity of health services research that collects and interprets qualitative alongside quantitative data: that of ‘fair dealing’.<sup>20,33</sup> Here a research design is advocated that explicitly incorporates as wide a range of perspectives as possible so that the viewpoint of one group is never presented as if it presents the whole truth about any situation!

Whilst quantitative indicators frequently contain inherent distortions and often do not reflect the ‘objective’ reality they claim to, they do, nevertheless, provide important comparative data over space and time. We included a number of them (such as infant mortality rates, measures of air pollution, and proportion of households on welfare benefits) as essential ingredients of the profile. Inside them we embedded robust qualitative data<sup>35</sup> that offered depth of understanding about the ‘why’ of peoples’ behaviours through its capacities to portray the ‘realities’ experienced by the subjects in a vivid way.

Looking more broadly, social context has been constructed as a key component of any analytical framework for treating both qualitative and quantitative data. Almost 40 years ago, the sociologist C. Wright Mills<sup>33</sup> urged that:

Rather than interpreting actions and language as external manifestations of subjective and deeper lying elements in individuals, the research task is the locating of particular types of actions within typical frames of normative actions and socially situated clusters of motive.

Through attending to the ‘social context’ that has been contemporarily identified as a foundational criterion for good qualitative research,<sup>33</sup> the perceptions captured through the qualitative methods in the health profile could be interpreted against the background of the socioeconomic circumstances of their holders and of the area in which they live.

Having set out why the community profiling approach was taken, how Volosinov’s framework accounts for the dominant form and the content of community profiles, the projects’ beginnings and the importance of choosing appropriate methods that fostered community lay as well as professional level participation, the remainder of this paper concentrates on the project’s development. It explains how the project tried to shape the process of collecting quantitative and qualitative datasets that amplify one another, before illustrating the methods and nature of the data collected. Then it describes and explains why and how two information technology tools were combined to realize a synthesis between the different forms of data in a way which enabled them to be jointly owned. The concluding section returns to the questions posed by the paper.

## **Content**

With the language-based approach to profiling in place, incorporating different perspectives of reality through the participatory collection, analysis and presentation

of quantitative and qualitative, lay and professional material this article now considers two of the many content-related issues: what statistical indicators should be selected, and how should local voices be incorporated? Little is to be gained in health profiling through selecting a set of statistical indicators and a set of qualitative material that barely relate to each other: there is a need for congruence between the different elements.

### **Statistical indicators**

As in most profiles, the choice of statistical indicators for the baseline measure was constrained in practice by what was available. In turn, the range of available indicators was constrained according to what had already been defined as important by professionals, working with political representatives. Volosinov's perspective offers an account for these constraints: decisions taken about what to measure are the outcome of struggle between competing views of reality at any one time. What ends up being measured is no more than a refraction of reality that has acquired the dominant meaning, and which can be connected up to a historical body of theory about social and economic determinants of health.

Rather than filling a ragbag with available indicators, we aspired to select and/or create indicators that actually interrelated with the issues that residents/inhabitants felt to be important. Establishing this interrelationship within the profile appeared promising to us. Potentially, residents would be able to compare their perceptions (or refractions of reality), with the 'bigger picture' (the range of refractions that the profile would make available). They would have access to contextual information to enable them to argue a case based on *their* priorities. In turn, health and related professionals would gain a better understanding of how peoples' circumstances, captured in part through the quantitative data, were actually being experienced in real lives, and communicated through language. It would open up scope for dialogue about different perceptions of reality, and about what was being measured and how.

It seemed to us that if the indicators that were combined did not interrelate with issues of local concern, there would be one of two outcomes: the more likely of those was that they would simply be seen as irrelevant by residents/inhabitants because they did not connect to their views of reality. The less likely was that the indicators would, by the provision of 'objective' information, change people's views about the things that affect their health, and perhaps affect the way they acted as a consequence: this is the hope of many health promotion professionals who aim to change peoples' lifestyles by providing information about the consequences of poor diet, smoking, and so on, and it is usually a forlorn one.

The alternative approach would be to start from the issues of concern to residents, and let these determine the 'objective' indicators to be employed. This would ensure that there would be a degree of congruence between the quantitative measures included in the profile and the qualitative material collected by residents, and also that the latter were effectively driving the profile content. This is the



challenge for professionals: to produce measures that meet their professional criteria of objectivity, and at the same time help to throw light on issues defined by residents. The potential spin-offs—in terms of dialogue between residents and professionals, and community development gains—are considerable,<sup>36</sup> and in themselves health promoting.

### **The health needs assessment dimension**

In most areas there is understandable and widespread cynicism about past attempts to engage local people in needs assessments. All too often what has been asked, how it has been asked for, and how the results have been presented and used, have been decided by others. Indeed frequently people have not been told how the information that they have provided has been used. In this health profile and through dialogue, agreement was reached over the process through which information about the local population would be collected.

We used a community-led health needs assessment approach. This tries to deal with those concerns by acknowledging past failures, explaining the purpose and objectives of the process, and inviting participation<sup>12</sup>. It works with existing community structures—mother and toddler groups, detached youth workers, pensioner groups—to assist local people to define for themselves what they want to find out and express about health in their area. A fundamental part of the process is the presentation of information back to residents as the first stage of output, before it goes anywhere else.

The format will vary, but in the case of the pilot work on which this article is based, it included:

- a questionnaire survey, developed with representatives of the community groups operating in the area, who then carried out the survey themselves, usually after group discussion;
- tape recording views in interviews and group discussions;
- developing an audio-visual presentation to present the findings of the process, bringing together data (from the survey and available baseline indicators), recordings of interviews, and photographs taken by students at a local college;
- feeding information back to the groups that were involved. This included distributing a video of the audio-visual presentation, and the reports, to all of the groups involved, and arranging feedback sessions for people to comment.

Crucially, the process was led by the community. The role of the researchers was to provide expertise and experience in survey and other data-collection techniques and analysis, to suggest and debate, but not to dictate the process.

The result was a set of information which the groups involved felt represented their views, and over which they retained ownership. In some cases there was congruence between concerns that were raised by residents and the selected

statistical indicators. In others, community members highlighted areas where quantitative data were not readily available, challenging researchers to develop more relevant measures.

As well as being written up in report form,<sup>37</sup> and incorporated into an audio-visual presentation,<sup>38</sup> the information was put onto a website<sup>39</sup> and hyperlinked to an existing website of the umbrella community organization involved.

### **Making use of technology**

This community health profile set out to achieve two things. First, to capture different perspectives of reality. Second, to construct an organizing framework that was flexible enough to provide the user with the autonomy and freedom to interact with the material, selecting which information they wanted to view and compare, and exploring the data and links provided to other related information.

One of the problems is how to represent such a multi-dimensional representation of reality in an accessible fashion. Fortunately, technology can provide assistance. Geographic information systems (GIS) offer the potential to handle simultaneously many layers of information. They enable indicators to be mapped onto underlying geographical features of an area: roads, building outlines, open spaces—the sociogeographical context. The resulting ability to zoom in to see greater detail, or out to situate and compare one area with another, can greatly enhance understanding.

Historically, most information has been represented by straightforward thematic maps (showing the variations across an area of variables such as unemployment, by means of different shading), or points (dot maps showing the locations of facilities, for example). However, any kind of data can be linked through a spatial reference. GIS enables the combining of quite different kinds of information, by using spatial referencing as the ‘hook’.

In our profile, qualitative data were in the form of photographs, audio interviews, video clips and written quotations. These could be seen alongside quantitative, statistical information about a locality, adding a resident’s-eye view of the ‘reality’ which the quantitative data sought to portray. This provided the potential, therefore, to access simultaneously wide-ranging but related forms of knowledge about health. This process of embedding qualitative data inside quantitative data enabled the profile user to consider the significance of those different forms of knowledge for one another, and whether or how one form of knowledge changed the meaning of another, and vice versa. Eighty years after its creation, Volosinov’s concept of refracted reality is able to be realized technologically.

Table 1 demonstrates how this worked in our approach to community health profiling. It uses examples from three issues that were addressed within the profile. The table is split into qualitative and quantitative types of data. Thereafter, the medium of each data type—all of which are language based, the source of the data—including the lay perspective, and examples from the topics involved—selected through a community participative process, are described.

TABLE 1. Examples of topics included in the Profile.

Type of data	Medium	Source of data	Air quality	Security	Facilities for young people
Qualitative	Visual	Community groups	A photograph of a low flying plane, or smoking car exhausts	Photographs of badly lit areas where people feel unsafe	Photographs of young people in the street, and of the state of existing facilities in the area.
	Aural	Community groups	A tape recorded voice of an older man describing the perceived impact of poor air quality. 'The motorway fumes are really getting serious now and at rush hour of course they are unbearable. The noise from the motorway is really loud, very loud, and especially since they've put another width on it there's a lot more traffic there.'	The voice of an older woman saying where she does not feel safe to walk at night. 'I walked through civic centre the other night it was pitch black, there wasn't a light on, there wasn't a policeman, we could have been murdered before we got out of there.'	A young female voice, deflated in tone, saying 'Parks, it's all crap now innit, there's nothing in them no more. You want to take your little brothers or sisters to 'em don't ya? You get 'em there and it's all crap and everything, they just get upset . . . all you can do is let 'em run around on a field and that's no fun is it?'
	Textual	Community groups	An excerpt from a transcription of a group discussion about the impact of air pollution in the area.	Transcript of discussion between different age groups about security issues in the area.	Transcript of group discussion between adults, on their views of young peoples behaviour, and the need for more youth oriented facilities in the area.
Quantitative	Spatial	Ordnance Survey	Mapped locational features such as main roads, open space and local landmarks.	Locations of shopping precinct, underpasses, communal spaces.	Parks and other existing facilities in the area.
	Statistical	Local Authority, Health Authority and Trusts, Police Authority, Voluntary sector, residents surveys.	Measured levels of air pollutants at monitoring sites.	Mapped police statistics; data collected by local community survey and security issues.	Maps showing distribution of young people across the area.

The column on the far right, entitled 'Facilities for young people', demonstrates how, side by side, the profile carried different points of view about the nature of these facilities, and about the social relations between the young people in the area. It did this through the qualitative, textual data derived from group discussions and the qualitative, aural data that comprise the individual perspective. However, both of these forms of data were physically situated (the Security column) through the qualitative, visual medium of photographs, and through the quantitative, spatial medium of the Ordnance Survey map. The map acted as the 'hook' for all of the forms of data. The final, quantitative statistical cell, derived from census data, shows the actual distribution of the young people, which can be compared with the distribution of facilities across the same area.

Through moving across and between each of these layers of the profile, the user was given access to a wider and deeper range of information about the issues that had been explored, described and measured. Their own evaluation, or intersubjective version, of the actual reality of young peoples' facilities in the area could be created out of this assemblage of refracted versions of reality.

Despite the fact that many communities and interests have no *locality* in any real sense, this approach is feasible because all lives have a spatial component to them: the home or the absence of a home, the local environment and the facilities within and around that environment affect every life.

The GIS system used was *Internet* based. This enabled users to move seamlessly from maps of quantitative data to the qualitative material on the local website via a series of hyperlinks, juxtaposing very different perspectives on health issues in the area (as demonstrated in Table 1).

We wanted our profile to create a 'means of viewing' different perspectives on reality, rather than prescribing one 'authorized version'. Through enabling a radically different way of organizing information, the Internet provided a powerful tool for realizing this aim. Further, because it changes the parameters of information ownership, the Internet makes it possible for information to remain with its owners and, at the same time, be shared with whomever they wish. In this profile, indicators of poverty, drawn from systems set up to administer welfare benefits and located on a local authority's computer, were linked to survey and interview information, held on a local group's website, describing the lives of residents on the breadline. Both sets of information were enhanced by their interrelatedness, and the whole was genuinely greater than the sum of its parts.

The Internet also enabled the creation of a community profile which is now jointly owned by its contributors. The contributors not only keep the information in their ownership, but also decide on what terms they will make it available to others. This is a very powerful capacity when applied to something like a profile which must, by its nature, be multi-sectoral. The third column of Table 1, Sources of data, demonstrates the range of sectors that were able to make data contributions to this profile and who, ultimately, retain ownership over their data.

## Conclusion

This article has sought to demonstrate the value of adopting methods that present 'traditional' or superordinate views about health while, at the same time, making visible and audible the living experiences of the lay resident/inhabitants. It has advocated synthesis between qualitative and quantitative approaches in creating such profiles so that their relative strengths and weaknesses can be critically appraised through the terms of reference that are available to the individual or group who uses the profile.

While quantitative indicators provide breadth of coverage and helpful spatial and temporal comparisons, they are not as objective as they first appear. The capacities for qualitative methods to provide in-depth understanding of issues from the perspectives of the subjects involved have to be set against the fact that individual experience is not, necessarily, generalizable. Taken together, though, they provide a range of perspectives such that the health profile user becomes able to situate and critically appraise each perspective about health in relation to every other either marginally or significantly different, or even contradictory, perspective. It is through this process that light is shed on both the objective and the intersubjective reality of lived experiences and views about health in the areas that the profile seeks to portray.

Creating a profile of the kind advocated can be facilitated by the use of technology. Geographic information systems enable the interweaving of very different sorts of material, using geography as the organizing principle, and allowing simultaneous access to statistical indicators, visual images and sound. The Internet provides a way of accessing material in a variety of locations and ownerships, on terms negotiated between the agencies involved.

There are technical issues involved in creating such a dispersed, collaborative, multimedia profile, but of greater importance is clarity of purpose from its collaborative creators to which the technology can be harnessed. Bringing together genuinely different perspectives requires a multi-agency approach. This is best captured in the form of coalitions where the different views of reality are acknowledged and the profiling process allows them to be expressed.

Community profiling is a required input to many policy initiatives, as is the desire to tap directly into the views of service users and local inhabitants. Despite the fact that many communities and interests have no *locality* in any real sense, all lives have a spatial component to them—the home or its absence, the local environment and the facilities around that environment affect the health of every life.

Volosinov provides an inspiring explanation and account of how human beings communicate through language, and why their different perspectives *are* different. His work offers a starting point for a journey that can be specified through scholarship, which explores the value of enabling lay knowledge to become encoded through participatory research processes. In turn these research approaches can draw upon community development work skills. This pathway is helpful for meeting the contemporary challenge of developing meaningful community health profiles: how to produce measures that retain professional criteria of objectivity in describing

health experience and outcome, and at the same time help to throw light on what the pertinent issues are, as defined by those whose health it is. Arguably, it is only through this combination of approaches that the gap can be closed between the institutional powers who have, historically, controlled profiling processes and those who have been 'profiled'.

## Acknowledgements

The authors would like to thank Angela Young, Tim Preston, Bob Barr, Hermione Lovel, Jenny Popay, Andrew Young and the reviewers of Critical Public Health for their interest, support and critical reading.

## Notes

- a This dual definition is coined here in an attempt to capture the fact that, within geographically delimited areas, there are both people who reside in dwellings and a minority of people without residence. This profile included data derived from interviews held between detached youth workers and those who, at that time, did not perceive themselves as having a single, or perhaps any, 'residence'.
- b See Jewkes R, Murcott A. Community representatives: representing the 'community'? *Soc Sci Med* 1998;46 (7):843–858 for full discussion on whether and how the community representatives being 'consulted' actually do represent the community.
- c See the annotated bibliography in Hawtin *et al.*, 1994, for brief descriptions of community profiles up to 1994. See training pack produced by Labyrinth for the conference Methods of Health Needs Assessment, University of Bradford, October 1997 including *What is Community Health Needs Assessment? A Protocol*.
- d Typal, 1853. Of the nature of, serving as, or answering to a type or pattern or specimen. *Oxford English Dictionary*, 1986.

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