



Transcript of Professor Jennie Popay's lecture:
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**WHERE'S THE EVIDENCE? THE CONTRIBUTION OF LAY KNOWLEDGE TO
REDUCING HEALTH INEQUALITIES**

Prof Margaret Reid:

Well, I'm delighted to welcome you to the second seminar series from the Glasgow Centre for Population Health and delighted to see such a good turnout. Many of you will be very familiar with Jennie Popay's work. She has pioneered, I think, the interest and the incorporation of lay knowledge within the health service and has been essential in getting medics and others to take lay knowledge as an important factor in thinking about the aetiology of health and illness. She has been a long time researcher and activist in public health and started out work in Peter Gabriel's unit in looking at the study of health policy. She has made many friends in Glasgow she tells me and she's pleased to be here and we are delighted to welcome her. She is currently Professor of Sociology and Public Health at Lancaster University and she is going to speak to us today on the contribution of lay knowledge to reducing health inequalities. So, please give a warm welcome to Jennie Popay.

[Applause]

Professor Jennie Popay:

Thanks very much. Can you hear me all right? I have got this microphone on.

When I came here today I was feeling really confident but as the faces that I recognise have increased in number I'm beginning to think "oh God!" *[Laughter]* I had the great pleasure of spending some time working in Glasgow in the 1980's. One down side of that period was that the research I was doing funded by the then Health Education Council was mentioned in Hansard by Margaret Thatcher as a sign of her government's concern about the health consequences of unemployment! The other is that a number of people here today will have heard the one joke I am going to tell you - some 20 years ago! Anyway, I am absolutely delighted to be back in Glasgow again and than you for inviting me to speak.

I have been asked to talk about the contribution what I refer to as lay knowledge has to make to policies and practices aimed at reducing health inequalities. I want to do that by focusing on three questions. Given that I set these for myself I should be able to answer them, but you'll be the judge of that. First I want to consider what I mean by 'lay knowledge' just in case there are some different understandings of this term in the room so you understand where I'm coming from. Second, I will consider how I think it can inform action to reduce health inequalities and then finally I want to comment on why the contribution of lay knowledge isn't taken more seriously in public health policy and practice.

Now I'm not going to be presumptuous and say that it isn't taken seriously in Scotland. It may very well be taken very seriously in Scotland. From an English perspective it isn't taken seriously - you can form your own judgement about how Scotland performs.

So what do I mean by lay knowledge? I wanted to start with this quote from one of my favourite books 'The Classic Slum'. It was written by Robert Roberts, the son of a small shop owner who was born and brought up in Salford, my home town and the place where Marks and Engels also worked. Right at the beginning of the book there is the following passage. "This is a book made much from talk; the talk first of men and women fifty or more years ago, of ideas and views repeated in families, streets, factories and shops, and borne in mind with intent. Many amongst them, shrewd and thoughtful, could not only recapitulate experience, they knew how to assess its value in relation to their lives".

For me this quote illuminates the key characteristics of the knowledge or expertise that lay people develop in the course of their lives - characteristics that determine the utility of this expertise from a health inequality perspective. First, lay expertise is an empirical approach to understanding, explaining and assigning meaning to everyday experiences. The issue of meaning is absolutely critical to its value as I shall come back to. Second, this empirical body of expertise comes in the form of everyday 'talk' or stories. Importantly, it is not only them that have stories - all of us talk about everyday life in story form. And third this expertise is subjective - it's about me, my life, my experiences - in contrast to the objectivity that is claimed for professional and research based knowledge.

A number of problems flow from the characteristics of lay knowledge from the perspective of evidence based policy and practice. Perhaps the most important of these is the difference between the kinds of questions that public health science and public health practice based knowledge seeks to answer, and the kinds of questions that lay knowledge seeks to answer. Science is concerned with lots of questions but at its core from a public health perspective it is concerned to explain the causes of health problems. What causes this particular problem? What do we know about the causes of coronary heart disease? What do we know about the causes of health inequality? What do we know about the effectiveness of this intervention? Whereas for lay people, for all of us, when we are operating as lay people, the question we are much more interested in are: Why is this happening to me? Why now?

So lets look at my second question: how can lay knowledge inform action to reduce health inequalities? I want to comment briefly on three areas that I think are important: first the appropriateness, accessibility and effectiveness of health care; second understanding of health related behaviour and thirdly, the addressing the wider social determinants of health inequality.

Quality of care

So what about the contribution of lay knowledge to improving the quality of care? There are two different stories here. The first is around lay people being involved in individual treatment decisions and the second is about collective involvement in decision making. In terms of individual treatment decision I want to briefly comment on medicine taking and on the notion of an 'expert patient'. In recent years there has been a rethinking of the notion of non-compliance. Underlying this rethink is the growing understanding from research that people, all of us, will use medication as a resource. We will make our own decisions about when to take a drug. If we are taking a cocktail of pills as many older people are, if they get a side effect they'll reduce one of the pills and see whether it has an effect on the swelling in the ankles, or they will increase another one to see if it stops the headaches. They are doing their own fine calculations about how these drugs affect their bodies. And they/we will do it. So if we reformulate the issue of compliance as an issue about how patients can best be enabled to use medication as a resource then there is a different kind of dynamic set up in terms of the kind of knowledge exchange that goes on between an individual clinician and a lay person.

There is the increasing interest in the concept of 'expert patients'. We have a programme in England called the 'Expert Patient Programme' - I don't know whether it's found its way to Scotland – and I find this really problematic, the notion that we have to train patients to be experts in the same way as we need to have train health professionals because it's quite clear from the research that many people are already experts about their health and illness. The classic example of this, of course, is people with AIDS/HIV who frequently are more expert than their health care provider. But there are many similar examples of groups with particular long-term conditions who already have considerable expertise and research has also shown that mothers also have important health expertise about their children. Against this backdrop, the response of the health care system in assuming that they have to teach lay people to become experts rather than recognising and listening to their expertise is profoundly problematic. There is a growing body of evidence that if decisions about treatment are taken collaboratively between clinicians and individual patients then the health outcomes are better. So I have absolutely no doubt now that if individual clinical behaviours were influenced more strongly by lay expert knowledge then we would get better care and better outcomes.

So what about the impact on quality of care of the collective voice - that's the idea that groups of people who use services, groups of people can act together to shape the services. Originally, of course, this involved a struggle. One of the earliest examples of that struggle was parents of young children not being allowed to stay in hospital with their children. It was mothers, in fact, that started a movement to force the health care system to begin to create environments where mothers could stay in hospital with children – a movement that has transformed hospital care for children – although much is left to be improved. Similarly, mental health services have been transformed by the collective voice of mental health survivors. Now, around the globe there is an increasing number of examples where groups of people take control of the services including, for example, services run by Aboriginal and Torres Islanders communities in Australia and having good results in terms of health outcomes. The service changes that collective groups of users call for are based on their experiential lay knowledge and this experience means that care will be more appropriate, more accessible, and as a result you will get better outcomes from the care.

Understanding health related behaviour

The second area in which I believe lay knowledge can contribute to the reduction of health inequalities is in providing a better understanding of health related behaviour. UK public health policy seems once again to be dominated by a focus on health damaging behaviour. The white paper is almost entirely about individual behaviour. There's a little bit on communities leading for health, but the thrust is about stopping people from damaging themselves one way or the other. And there is in there still a sense that the problem is primarily about lack of knowledge. I believe very strongly that the reason we get ourselves in that pickle is because we don't really understand the meaning of the behaviour in question - dietary behaviours, smoking - in people's lives. The classic example of research that has really illuminated this is Hilary Graham's work on poor women and smoking where she did quantitative work which shows that the poorer women are the more likely they are to smoke and the more they smoke. And the more children they have and the poorer their children's health then the more likely women are to smoke, and the more they will smoke. But the qualitative research she did showed how this behaviour could be better understood if one understood the meaning of smoking in those women's lives. She used the notion of coping to explain why poor women are more likely to smoke and less likely to give up smoking. All the women she spoke to recounted stories of stressful situations where the kids were driving them mad, they were at the end of their tether and what they did was go out of the room, close the door, have a cup of coffee and a fag. That cigarette was a really important aspect of their coping mechanisms so if you remove the cigarette without changing the situation then it is highly likely these women will find something else to do to help them cope. What we need is a much more sophisticated understanding of the social meanings of what are widely perceived to be health damaging behaviours. In my experience, we don't come at these behaviours initially by thinking about social meanings, we come at it from a lot of different perspectives, but not from meaning.

The wider social determinants of health inequalities

There are many examples of how lay knowledge can make a really valuable contribution to action to reduce health inequalities in terms of the wider social determinants. There are, for example, examples where lay people have identified the causes of health problems before the professions. In relation to asbestosis, for example, there are records of the widows of men who died of asbestosis decades ago giving evidence to tribunals in which they claimed that it was what the men had breathed in that was killing them, but it took twenty or thirty years before anybody took any notice. Similarly women who took medication to stop premature miscarriage complained that this was causing cancer in their female children but it was decades before professional researchers 'heard' what they were saying and tested the association.

There are many more examples of the potential insight to be gained from listening to what lay people have to say about the causes of health problems. But I want to talk about something a bit different than that - a piece of research that I've done with others into lay theories about the causes of health inequalities. This was a study that was conducted in Salford in Greater Manchester and Lancaster and we had four neighbourhoods - two in each of these cities, one high income the other low income. We conducted surveys and qualitative research and I want to talk about the in-depth interviews we did with about sixty people. For these interviews we took back to people evidence on the health experience of their area and the other area in their city. So if they were in the rich area we showed them their health profile and the health profile in the low income profile and vice versa. We aimed to have conversations with people about what they thought were the reasons for the stark differences in health experience between these areas. At the beginning of these conversations there was a really obvious divergent response to the initial question about, "what do you think causes these differences?" The people in the poorer areas without exception all challenged the evidence, whereas the wealthier people accepted the evidence and started immediately talking about causes. There was a sense, in fact, amongst people in the wealthier areas of embarrassment about the privileged position they thought they were in.

I am going to focus on the interviews with people living in disadvantaged areas. These are some examples of how these interviews started: "I don't believe it" or "that puzzles me" or "I can't believe them" referring to the data. We explored why they didn't believe the data that showed that the health of people in their area was much worse than that of people in the high income area. The first reason was they didn't believe it, which perhaps won't surprise you - they just didn't trust the statistics, okay. For some the evidence contradicted the facts as they understood them as illustrated by this wonderful quote. He wasn't the only person that made this kind of comment, but he just turns public health knowledge on its head. *"I would think actually that they, the rich, weren't as healthy as the poor cause of all the spirits they drink and the stuff they eat. I mean, if you eat the basics like we do I think you're much healthier. I mean, they just make the figures look bad. I don't trust statistics at all"*. So they don't trust statistics - this is quite widespread, I think.

The second and much more common reason for rejecting the data had to do with the fact that it was labelling them and the fact that implicit in the data there was an inevitability of premature death for them and for their children. This is an example of a common response - the notion that the place where these people live, is generally seen to be a dump and therefore the people in it are outcasts. *"There's pollution, other than that its attitudes. They're making out that it's all like scum and they're all dying, it doesn't make sense."* So people were rejecting the labelling and stigmatisation that goes on in much of public health geographical information, system mapping, etc.

But despite the fact that at the beginning of the conversation people living in low income areas rejected the data as these conversations moved on people did provide very vivid accounts of the lived experience of inequality and embedded in these accounts were clear relationships between living in 'this' place and having poor health experiences as this quote shows: *"I'm a strong person, I can deal with a lot of things, but this particular place and living in this area has made me ill. At the end of the day you've got to feel happy in the place you're living in cause that's your source, it's where you're based. I can't deal with it."* This woman like all the others we spoken to had very clearly stated at the beginning of the interview that she didn't believe the statistics. So they were not denying a relationship between poor living conditions and poor health at all.

Why do they think the place is affecting their health? How do they explain the problems? Well, without exception in the interviews with people living in poor areas, what was emphasised above everything else was indirect mechanisms. The relationship between poor places and poor health for these people was mediated in particular, by stress. There was a very clear stress discourse in these stories. And one, albeit not the only one, source of stress people talked about was social comparisons - what it felt like to be me living in this place, seeing these other people living in different places. And again here's a quote. *"It's only obvious that we would not feel health-wise as someone would who has all the comforts and luxuries around them. You know they go on holidays three times a year, whereas we can't afford to go on one holiday, so that's the difference. Their outlook on life is more relaxed and at ease and comfortable whereas we are struggling day to day with pressures and to keep up with things."*

So in summary, although people initially denied the data highlighting their health disadvantage, they went on to acknowledge the relationship between poor places and poor health and focused in particular the indirect mechanisms mediating this relationship. But they also talked about protective factors. Here the most prominent theme was about the individual's strength of character, their ability to overcome these difficulties. Again, these are typical of the statements people made: *"The first thing you do when you get up is see the graffiti, the vandalism and it doesn't help. But at the end of the day if you let it get to you it just causes you ill health. It's how the individual deals with it all. If you let it get you down, you are going to have the health problems".* At the same time, however, there was absolutely no lack of understanding about the wider structural determinants of ill health. As this woman makes clear with her interesting distinction between 'your own worries' and 'outside worries': *"I mean everybody has a bit of worry, but it's our own worries brought on by ourselves. But outside worries that you haven't got any influence on changing, that has a bigger effect on you I think. You can't sit down and think 'well, I've got this problem and how can I solve it' because you can't solve it and it's outside your house. It's an outside influence that you can't control, you can't change it, you haven't the power to change it and it takes over your life".*

So, in summary, like a lot of research, if you present people with a picture of inequality where they're on the disadvantaged end of the continuum, they will reject it. There's quite a lot of research that shows that. But when they talk about the experience of living in places which represent major hazards to health, they recognise that. There is absolutely no denial of that, but the theories they have to explain it emphasise indirect mechanisms and the most important protective factors are to be found within oneself - strength of character will allow the individual to overcome difficulties.. So, what do we make of these theories? I think the key to understanding their utility for public health policy and practice is to ask what purpose they are serving. The first thing to recognise is that far from being primitive leftovers of a bygone age, these theories are very complex. They're multi-factorial, they recognise life course influences, in fact they are very similar to the current academic theories about the causes of health inequalities. Lay people use different language, they're not medicalised, they have not picked their understanding up from reading the BMJ etc. It's been drawn out of their experience, but, as I said at the beginning, the core purpose of lay theorising is to assign meaning to an experience and in these interviews the experience was of inequality, an experience of being at the bottom of a social gradient and because of that, because that's the experience that these people were trying to explain, understand, rationalise, these theories, I would argue, are doing three things. The first thing that they do is allow people to reconstruct their moral worth in a situation where it is being undermined. This idea is very common in the literature on chronic illness.

One of the things people experiencing chronic illness do in making sense of their experience is to try and explain why it has happened to them in a way that give them back moral status. We live in a society in which to be ill is morally suspect. You can't be chronically unwell without being suspect morally. So these theories allow people to reconstruct a morally acceptable position for themselves and they do that at the individual level, but also at the collective level as people living together in a particular place.

The second purpose of lay theories about health inequalities and place is to reassert the possibility for individual control in a situation where there is recognition that the scope for that control is very limited. This, I believe, is how the emphasis on indirect mechanisms is to be understood and it's also where the emphasis on strength of character is to be located. It's the worries outside ourselves that we can't do anything about, so we focus on the little worries and on the personal capacities that allow us to control those. Finally and importantly these theories are constructed in a way that allows people to reconcile the need for control with a recognition of the wider social determinants of ill health. So these theories are a really important part of being a socially acceptable human being or of being a socially acceptable community of people living in a particular place.

So what?. Well that is all very interesting but what has it got to do with policies and practices aiming to reduce health inequalities. Well one practical step might be to think about an audit framework drawing on this research. If you were thinking about policy and practice for health inequalities and you wanted to take these lay theories seriously then what questions might you ask of your policy? These are just off the top of my head, they may seem ridiculous, but at least they provide a starting point. "Does this policy or practice recognise the moral nature of health inequalities?" I would argue, in England, that most of the policies don't. Often in fact they are a direct challenge to peoples' moral worth. Many of our neighbourhood renewal policies, for example, force people to go through a postcode 'ugly' contest to get the money. So not only do they not recognise the moral aspects of social life they may actually undermine it. Other audit questions might be: is this policy/practice seeking ways to avoid increasing the stigma of inequality? How can we do that? Is it giving people real control over the design, delivery and evaluation of interventions; real control, not just letting the residents chair the neighbourhood panel, but letting them have control over what happens? This isn't a plea for blindly doing what lay people ask public policy makers and practitioners to do but rather to take their knowledge and expertise seriously and respond to it in a serious dialogue between participants who are equal but different.

So to the third and final broad question I wish to address. Is lay knowledge being taken seriously and if not why not? Well, my answer to the first part of this question is a definite no. Well not in England. Maybe in Scotland you have cracked it. So why not? I want briefly to comment on some of the work colleagues and I have done on what's getting in the way. I don't expect you to read this [*referring to slide*], but [*laughter*]that's what's getting in the way. Okay. You're absolutely not supposed to read it, but the reason for putting this slide up is to give you a sense of the complexity of the things that are getting in the way of public health policy makers and practitioners taking lay knowledge more seriously. What this model is trying to do is highlight the barriers to community engagement. Community engagement is the rhetoric in England for listening to local people, taking lay knowledge seriously, engaging with the community. The model focuses on two types of barriers. It looks at barriers in public sector organisations and professions and it looks at barriers in local communities, and I'll say a little bit about both.

We may not have public sector organisations in England for very much longer, but while we've got them it might be worth thinking about how we address the barriers operating to prevent more effective community engagement in decision making because chances are that the barriers will be transferred to whatever mixed economy of health care delivery organisations we have.

The barrier identified is the lack of appropriate skills and competences amongst professionals. If you do a quick skim of continuing professional development opportunities there are loads of courses and seminars on how to increase your skills and competences in community engagement and public involvement or whatever. So this barrier gets lots of attention – probably the most - but it is, of course, the least important.

The second, and probably one of the most important barriers is the culture of our public sector professions and our organisations and in particular there is a major problem with risk aversion. Some of you may have filled one of those long forms required to get the hundred quid for the community group or tried to get the twenty page final report out of the community group after they've spent the hundred quid. This type of nonsense is still going on. Then there are different understandings amongst lay and professional groups about the meaning of that tricky word 'health' And not surprisingly, there are problems in the wider system and in particular with the way in which policy is implemented. These problems have been highlighted by the evaluations of initiatives such as Health Action Zones, Healthy Living Centres, New Deal for Communities and Sure Start. One of the biggest problems is that these initiatives are set up to be genuine attempts to engage the community over the long term, in social change, but six months downstream the sponsoring department insists on quick wins. Do something on smoking cessation or whatever but do it quick and, of course, that breaks the 'psychological contract' with the community who have been told that they can set the agenda and then are told 'but meanwhile we are going to do all these things over here while you're setting the agenda'. I was going to say that a major problem is the lack of clarity about the purpose of community engagement but I think that this is not the case. I think actually you will find there is a lot of clarity about the purpose: community engagement in many of our English public health initiatives is simply a delivery mechanism not an end in itself. It isn't something we value because we believe in it, it's a way of delivering whatever it is we are supposed to be delivering and that perhaps is the most fundamental problem of all. .

Paternalism is also still a problem in the public sector. The assumption that poor people have to learn to participate and that professional experts are best placed to teach them how to participate is still widespread. And, of course, because professionals have positional power, they can dictate the terms on which the learning is done. In these circumstances and with the best will in the world the system may be reinforcing dependency and inequalities of power rather than the opposite.

The Safec barrier model also highlights some of the barriers to releasing the capacity of local people to engage. What research has shown us, however, is whilst there are barriers these are not about a lack of innate capacity: local people don't need to learn to participate and they're do not lack relevant knowledge. As I have tried to show, lay people have a lot of relevant knowledge about health and health care issues. in relation to . This is vividly illustrated by my joke which is apparently derived from Glasgow in the 1930's during the depression. At that time well meaning middle class women – the twin set and pearls brigade as some people call them in England - used to give classes for poor women to teach them how to cook nutritious meals on very low incomes. In fact, we have reintroduced this individualistic approach to addressing the impact to poverty on health in our new public health white paper in England with the notion of health trainers! One of these lessons was about how to make cod's head soup, which is apparently a very nutritious soup. At the end of the lesson the lady who was doing the teaching said to the women whether they had any questions. and a woman at the back said: : "I've just got one question. While we're eating the cod's head, whose eating the cod?" I think this is a wonderful humorous illustration of the knowledge and insight lay people bring to the dialogue - lack of knowledge here, no lack of political understanding.

So what are the barriers operating to discourage lay people from engaging with the public sector to take action to improve health and services? The research does seem to present a bit of a puzzle, although it is a simple puzzle to answer. In my research I have found that when you talk to people living in poor circumstances they will generally say that they will act collectively to change the circumstances, but only if they believe that there are important and relevant issues to act on and only if they believed that collective action would be effective. Surveys of people living in disadvantaged areas and/or groups show that there's no lack of issues that are relevant to these groups. But there are relatively few people willing to engage to try and change things. There is then only one explanation for this lack of collective action - people don't believe that it will be effective. And unlike professionals, I think that this is because people are acting on the evidence. In a couple of studies we've done we talked to people about their history of being engaged, of participating in public sector initiatives aiming to improve their lives going back to the 1950's through waves of regeneration. We identified three groups of people. There were 'the engagers', a very small group of people for whom the experience of being engaged in action to change the circumstances in which they lived had transformed their lives. They've got skills, some have got into higher education, some have paid jobs and careers. They were on a completely different trajectory than they had been before. There was a slightly bigger group, who we call 'the disillusioned', for whom the experience of being engaged had had a significant negative impact on their lives. This is one of the most neglected issues in the debate about community engagement in health decision making – that fact that if we do engagement wrong, we damage people. And in this research and research in Australia, there are instances of people with serious enduring mental health problems which were triggered by being involved, for example, as resident chairs of committee where an initiative had gone pear shaped and the individual was left to carry all the anger of the community. We clearly need to recognise that there can be iatrogenic consequences from poor practice in community engagement. It's not always a good thing. . Finally, there is the largest group of all who we have termed 'the reluctant'. These are people who have never been engaged in action locally to change things. They see no evidence of action ever having changed anything and so they don't see why they should be engaged.

I believe that for public health and for people who are really serious about working to reduce health inequalities there's a central paradox. On the one hand I do accept that there is widespread and genuine commitment in the public sector to take lay knowledge seriously and to engage more equally with lay people in decision making. I think some people might actually be ill informed about what genuine community engagement requires but that shouldn't negate the fact that many people in the public sector have a genuine commitment to doing community engagement.. As I have argued I believe that there is a widespread capacity for engagement in even the most disadvantaged of social groups, but people learn from experience, and not just their experience. It is important to take an historical perspective on this. There is evidence that the experience of engagement not working and damaging people is carried over generations – today's young people in inner city areas like Salford, for example, know that their grandfathers and grandmothers who were involved in the 1950's and 60's slum clearance had had a terrible time. Given this they are not going to be rushing to get involved in New Deal for Communities. Stories of the damage that can be done to individuals by bad practice in community engagement are passed down through generations and people learn: they're acting on the evidence they're not going to get engaged.

So to deliver more effective and equal engagement with communities of interest and/or place there is a need for profound cultural and structural changes within public sector organisations and professions. It is also important to recognise that the agenda is not about building capacity (in communities, professional groups and organisations) but about releasing capacity for more effect engagement. In part the resistance to these changes in the public sector arises from the indoctrination not to think about barriers - you have to think positive, think assets, strengths, etc I believe that this is a waste of time unless you address the barriers. There's a management guru called Llewellyn, I think, who argues that if you put pressures in place to try to change things without seeking to reduce the barriers to change then then you will just get an equal resistance coming back. I think that's what you can see around community engagement in many places in England.

So, what's to be done? First, I think it is important to to recognise that taking lay knowledge seriously is not the silver bullet for policies aiming to reduce socio-economic and/or health disadvantage. Like all other areas, there isn't a silver bullet, but it's a really critical piece of the jigsaw. Second, the public sector needs to acknowledge that engagement can damage people if it's not done well. So if it's not going to be done well, we shouldn't do it. Third it is important to recognise that the core challenge, as I said, is to release capacity, not to build it. To do that the public sector has to recognise and reduce the barriers operating within organisations and professions. And importantly, lay people have to see power being redistributed and engagement has to be seen to have real impacts if it's going to begin to work Above all, perhaps, what the public sector and in particular politicians have to do is to recognise that involving people in decisions is not about involving them in how public money gets spent. There might be conversations about how money gets spent, how resources get distributed, but that's not the bottom line. The bottom line is that community engagement is about involving people in enduring long term processes that give them a real say in how life is to be lived. To come back to where I started, community engagement involves a struggle because it's about redistributing power: but it is a struggle over meaning, not a struggle over resources.

Thanks.

[Applause]

Prof Margaret Reid

Thank you Jennie that was a very stimulating and challenging session. I think it was a good session entirely in keeping with the Glasgow Centre itself which has been set up to ask difficult questions and to challenge the status quo.

I think we should probably draw the session to a close and thank you very much Jennie for coming up and sharing your thoughts and views with us. It has been an extremely super session, it's been very stimulating. Many in us in the room have been involved in and continue to be involved in community action and in trying to change things. I think it has been good to have this sort of debate and I think it has been salutary to hear about the barriers that face... affects everybody in trying to get change, but I think it has also been very stimulating. So thank you very much indeed.

[Applause]