OFFICIAL REPORT
AITHISG OIFIGEIL

COVID-19 Recovery Committee

Thursday 9 December 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 9 December 2021

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COVID-19 RECOVERY COMMITTEE
14th Meeting 2021, Session 6

CONVENER

*Siobhian Brown (Ayr) (SNP)

DEPUTY CONVENER

*Murdo Fraser (Mid Scotland and Fife) (Con)

COMMITTEE MEMBERS

*Jim Fairlie (Perthshire South and Kinross-shire) (SNP)
*John Mason (Glasgow Shettleston) (SNP)
*Alex Rowley (Mid Scotland and Fife) (Lab)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Hilda Campbell (Cope Scotland)
Magda Czarnecka (Feniks: Counselling, Personal Development and Support Services Ltd)
Graeme Dey (Minister for Transport)
Dr Eman Hani (Central Scotland Regional Equality Council)
Derek Holliday (Homeless Network Scotland)
Parveen Ishaq (Edinburgh and Lothians Regional Equality Council)
Dr Carey Lunan (Scottish Deep End Project)
María José Pavez Larrea (Grampian Regional Equality Council)
Professor Neil Quinn (University of Strathclyde)
Mohammed Razaq (West of Scotland Regional Equality Council)
Dr Paulina Trevena (University of Glasgow)
Dr Andrea Williamson (Scottish Deep End Project)

CLERK TO THE COMMITTEE

Sigrid Robinson

LOCATION

The David Livingstone Room (CR6)

Scottish Parliament

COVID-19 Recovery Committee

Thursday 9 December 2021

[The Convener opened the meeting at 09:15]

Subordinate Legislation

Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No 7) Regulations 2021 (SSI 2021/425)

The Convener (Siobhian Brown): Good morning, and welcome to the 14th meeting in 2021 of the COVID-19 Recovery Committee. Our first agenda item is consideration of the motion on the made affirmative instrument that was considered at last week's meeting. I welcome Graeme Dey, the Minister for Transport, to the meeting.

Minister, would you like to make any further remarks on the made affirmative instrument?

Graeme Dey (Minister for Transport): In recognition of the committee's busy schedule, I will just move the motion.

Motion moved,

That the COVID-19 Recovery Committee recommends that the Health Protection (Coronavirus) (International Travel and Operator Liability) (Scotland) Amendment (No. 7) Regulations 2021 (SSI 2021/425) be approved.—[*Graeme Dey*]

Motion agreed to.

The Convener: The committee will publish a report to the Parliament setting out our decision on the statutory instrument that we have considered. I thank the minister for his attendance.

I suspend the meeting to allow a changeover of witnesses.

09:17

Meeting suspended.

09:25

On resuming—

Vaccination Programme

The Convener: Agenda item 2 is an evidence-taking session on the vaccination programme. I welcome to the meeting our first panel: Dr Eman Hani, general manager, Central Scotland Regional Equality Council; Parveen Ishaq, office manager, Edinburgh and Lothians Regional Equality Council; Magda Czarnecka—I apologise if I have pronounced that incorrectly—chief executive officer, Feniks: Counselling, Personal Development and Support Services Ltd; María José Pavez Larrea, policy officer and project co-ordinator, Grampian Regional Equality Council; Mohammed Razaq, executive director, West of Scotland Regional Equality Council; and Dr Paulina Trevena, research associate in urban studies, University of Glasgow. Thank you all for giving us your time this morning.

We are the lead committee responsible for scrutinising the roll-out of the vaccination programme, and today's session is an opportunity to consider why uptake of the available vaccines has been below average in some communities in Scotland. Our first panel will speak to us about the experiences and perspectives of ethnic minority communities.

Each member will have approximately eight minutes to speak to and ask questions of our panel. If any of the witnesses would like to respond to any issue that is being discussed, please type R in the chat box and we will bring you in. We have a large panel, and I am keen to ensure that everyone gets an opportunity to speak, so I apologise in advance if, because things have run on too long, I have to interrupt members or witnesses in the interests of brevity.

We again find ourselves in a challenging situation with a new variant. We know that vaccinations might not stop people catching the virus, but evidence so far shows that they most definitely hinder the severity of symptoms and reduce the need for hospitalisation. As a result, in order to protect not only our communities but our health service, we need people to take up the vaccines.

This morning, we have representation from four of Scotland's regional equality councils. I know that Eman Hani has to leave early, so I will ask her the first question. What challenges have you faced in trying to get minority communities to take up vaccinations, and what could the Scottish Government be doing to give confidence to those minority groups to get vaccinated?

Dr Eman Hani (Central Scotland Regional Equality Council): Good morning, everyone. I will try to be as short and as quick as possible.

There is a variety of factors. However, I should say first of all that we are dealing with people from a wide range of different backgrounds, by which I mean not just their ethnic backgrounds but their intersectional diverse nature.

I will try to summarise the most common reasons for the people whom we deal with being hesitant or reluctant to take up vaccinations when they are offered. The main one is a lack of trust in the national health service or anything coming from an authority, mainly because of where the people in question have come from. They either grew up under communism or fled their countries because of war or because they were oppressed by their own Governments, so they often tend to see things that come from the Government as being against them, which, in turn, creates a hesitancy and resistance to anything that the Government might do and a feeling that it is not for their benefit. Unfortunately, that is the one big factor among many of the groups that we deal with.

There is also the other usual suspect: the myths and misconceptions that people have about certain aspects of vaccination. They think that it has not been around for long enough, for example. How do they know that they are not going to grow a third leg? How do they know that they are not being chipped? You must understand that for certain people—refugees, asylum seekers, illegal migrants, people on zero-hours contracts and people with poverty and childcare barriers—all of these factors come together and make it harder for them to take the opportunity to get vaccinated.

09:30

People can also be resistant because of personal experiences. For instance, they might have heard by word of mouth that someone who got vaccinated developed symptoms afterwards and were not very well for a few days, and they decide that they do not want a similar experience. On the other side of the coin, there are those who have no experience whatever and are actually in denial—they do not believe that the whole Covid thing is real until they actually see or experience it for themselves. There is a big variation in the reasons for people from certain backgrounds being reluctant about or completely against getting vaccinated.

What can we do to overcome that situation? Actually, we can do plenty of things. Communication is key. We need to communicate with people in a way and in a language that they understand—and by "language", I do not just mean the different languages that we speak, but the approach itself. There are multiple grassroots organisations that have existing relationships with people from ethnic minority backgrounds, and we can use those relationships to build trust and to deliver information to communities not just accurately but in a friendlier manner that does not feel as if it is coming from an authority.

We have been participating in BEMIS, Scotland's ethnic minority national resilience network, which has provided a lot of support. All the resources have come from the Government, the NHS and Public Health Scotland, so the stuff is valid, but because it has been delivered through grassroots organisations and community groups, it has been easier to overcome the whole trust barrier.

I hope that I have not taken too much time, convener, but that is a short summary of the current situation.

The Convener: Thank you very much for those interesting comments. I was going to open it up to Parveen Ishaq, María José Pavez Larrea or Mohammed Razaq from the other regional equality councils and see whether they wanted to comment.

María José Pavez Larrea (Grampian Regional Equality Council): Thank you very much for inviting us to today's meeting.

I just want to summarise a few key points. We have identified four main reasons for people not taking or accessing vaccinations. First of all—and, as I have said, I am just going to give you a summary, because I know that you have all the reports and can see the details there—there is the theme of information about the vaccines themselves. There is uncertainty about the safety of the vaccines, because it is felt that they have been developed too quickly compared with other vaccines, and people want more evidence to be collected. There is concern about the risk of blood clots associated with the Oxford AstraZeneca vaccine as well as concerns related to unknown long-term side effects and the impact on pregnancy and fertility, and all of that is paired with the lack of clear guidance from general practitioners and healthcare staff on the matter. Moreover, as Eman Hani has said, there is a lack of trust in public authorities and the NHS and in the information that is being provided, and there is a perception across all ages that once someone has Covid they are protected from the virus and therefore do not need to be vaccinated.

The second theme relates to an important and more practical matter that can be addressed: vaccination appointments. People do not receive the letter for their appointment; the letter gets sent to other addresses; there is miscommunication

about appointments; there is misinformation or lack of information from local helplines about when and where to get vaccinated; and there is also an issue with regard to the language support available at vaccination centres. Moreover, because of issues around language proficiency, people do not understand their letters. There is also the inability to self-register online, which I think is very relevant, given that that is the main way in which people are now registering for vaccinations. That issue needs to be taken into account.

The third theme was vaccine hesitancy. As Eman Hani highlighted, there is a perception of risk being low; there are views about Covid-19 measures being a violation of personal rights of freedom; and there is a belief that the pandemic does not exist or has been exaggerated.

The fourth theme concerned other reasons, such as the lack of a support network when someone has recently arrived in a new city or region in Scotland and is concerned about side effects and the fact that they do not have access to a support network in that regard. This theme is also important to people who are on zero-hours contracts or have no recourse to public funds because of their visa category. There are also some conflicts with personal beliefs and family conflicts because of different views about the vaccine.

How can we tackle all those concerns and promote vaccination uptake? I will just give you the main points. First, more information and resources about the vaccine are needed, along with more information about the consequences of long Covid and some positive information and resources about incentives and positive consequences of receiving the Covid-19 vaccine. For example, the information that boosters are not shown on the vaccine certificate should be included.

Secondly, just to summarise, we need to continue to increase the number of community members who encourage others to get the vaccine by including faces from the community in the promotional material. We also need to increase flexibility in access to appointments and information about them.

I am sorry if my summary was too long.

The Convener: Quite a few members of the panel want to come in and John Mason wants to ask a question.

John Mason (Glasgow Shettleston) (SNP): Eman Hani talked about scepticism about Government and health services. Do we just have to accept that it will take 20 or 30 years to overcome, or is there some quicker way of overcoming that?

It has also been suggested previously that some people in the Polish community get advice from Poland, so they hear what the Polish health service is saying. Is that an issue? Does Eman want to come back in on that?

Dr Hani: Yes, thank you. It will not take decades for people to overcome their lack of trust in authorities. From what we understand about the makeup of ethnic minorities and the fact that people are living in disadvantaged situations, we can see that it is a complex matter. However, nothing is set in stone. There are always ways that we can work together to reassure people. It is just a matter of personal experiences and, in certain situations with the communities that we deal with, those experiences have been going on for long enough to have left a scar around where and how they can accept help from the authorities. That is why I think and believe that, if we work together with existing organisations that have already got over the trust issues in their communities rather than always coming from the clinical perspective, that would help to overcome that massive barrier.

On the issue that you raised about the Polish communities, it is not only the Polish community that tends to rely on information from authorities, Governments or relatives back home; that is a common theme among ethnic minority groups. Again, that is due to the nature of the relationships among those people. I will believe what my sister tells me more than I will believe someone who is a complete stranger. That is just how it works.

Again, that is not to say that we are not going to be able to deal with the issue. Many grassroots organisations, like ourselves, deal with ethnic minority groups, and have built up a relationship of trust with them, so it is just a matter of working together with other groups and organisations to deliver information and reassurance, overcome the obstacles and help people to get vaccinated as soon as possible.

The Convener: We have a bit of time for this question, so any other witnesses who want to comment can do so and then I will move to other members' questions. Would you like to come in, Parveen Ishaq?

Parveen Ishaq (Edinburgh and Lothians Regional Equality Council): I agree with all of Eman Hani's points—those are exactly the reasons that we have found.

To speak specifically from a south Asian background, I would say that there are two main reasons that we have been given in relation to vaccine uptake. First, a lot of people in south Asian communities have long-term health issues. The many conditions include diabetes, hypertension and high blood pressure. They are just not convinced that the vaccine will help

them—in fact, some believe that getting vaccinated might lead to their health deteriorating. Further, people in south Asian communities do not have enough information to tell them that it is safe for them to get vaccinated and that doing so will not have any adverse side effects, given their long-term health issues.

Secondly, we would be more likely to get a better uptake of vaccines if vaccination was done directly by our own general practitioners. For example, for the rest of the population under the age of 50, it is fine, but anybody with underlying health issues from any ethnic background, but specifically from south Asia, would feel better if the information was coming from their own GP who knows about their health issues and any potential risks. They would be more likely to get vaccinated if it came from their GP. However, I appreciate that GPs are not able to do that work. They are already busy—they are inundated—so I am not sure whether it would be possible to do anything about that.

It goes back to the main issue: a lack of trust in the Government and how the vaccination programme has been rolled out. The people do not have any faith in the one-size-fits-all approach. During lockdown, a lot of misinformation came from different channels, including from abroad. During lockdown, we did a small project to try to combat that. However, as Eman Hani said, people would rather believe somebody who they could relate to, rather than believe the general message in leaflets or the message that is coming from NHS Scotland to get vaccinated. That is because the latter do not say why they should do so or whether it is safe for them. They do not say that, because it has been tested enough, it is 99 per cent safe for their ethnic group.

However, recently, a lot of people have had and recovered from Covid. They have not had any major side effects, apart from a persistent cough or chest problems, which the doctors have said could take months to recover fully from. People are now asking why, if their bodies can deal with Covid, flu or any other virus that comes up, they need to put a new vaccine in their bodies when there is no guarantee that there will be no adverse side effects. They are thinking that it is not worth putting the vaccine in their bodies given that they are recovering from Covid.

Those are the main issues that we have found over the past number of months.

Mohammed Razaq (West of Scotland Regional Equality Council): My organisation is part of the Scottish Alliance of Regional Equality Councils.

My colleagues have mentioned a lot of issues already. I will touch on a couple of more things in more detail. We have been talking about lack of trust. That is not just about previous Governments. Even within the United Kingdom, there is discrimination, immigration issues and hate crime. There is the negative effect of the prevent programme, the Windrush scandal and the new Nationality and Borders Bill, which can take away a person's nationality without them being notified. Those things matter.

I note the information that comes to ethnic minorities through social media, and my colleagues have mentioned information coming back from home countries. They have different cultural and environmental issues from the ones that we have here. For instance, in most of Asia and Africa, people spend most of the day outside their homes. They do not sit inside offices or in their homes; it is an outside environment. Therefore, the virus does not spread as much and people do not place as much importance on it. Also, they get social media from other countries telling them a different story, so who do they believe?

09:45

The faith-related issues are not mentioned. Certainly, within Islam, it is clear that God decides whether you live or die. Some followers, particularly the elderly, will ask why they should take the vaccine if that has already been decided and it is up to God. There is an element of the need to adhere to that.

Another thing that is not mentioned is ethnic minorities having larger families. If the head of the family is an anti-vaxxer, then there will be a large number of people who will not take the vaccine because of that. As you go along, the numbers become bigger and bigger. Similarly, word of mouth is huge in ethnic minority communities. Therefore, one anti-vaxxer could put out their information to other people and, before you know it, a lot more people are taking up the anti-vaccine message. We do not take those issues into account. The communities are close knit, as you know, so the message gets out much more quickly.

In the early days of Covid, the Government consulted us and we said that there was not enough information from role models going out to ethnic minorities. I am pleased that, within a couple of months, a lot of information came from the Scottish Government and the NHS with role models giving their views about vaccination. That had a positive effect. My organisation was able to send it out to all our client groups and partners, and I thought that we were winning the battle of getting across the message about getting vaccinated, but it stopped after a few months and now there is nothing going out.

I do not know whether the Government thinks that the job is done and that we have crossed the line, but it feels like we have not. I was thinking that we might have crossed the line because nothing was coming out from the Government, but I now realise that it is still an issue. Why did we stop? There is nothing coming out at all at the moment.

I am sure that my colleagues will agree with that. They mentioned the stigma around communication, sharing information and making people aware, along with the religious and cultural needs. It is not just about the vaccine itself. What does each religion have to say about whether people should take vaccines? We need to get role models from various religious groups saying that it is okay to have the vaccine. That happened earlier on, but it stopped all of a sudden. Continuing that work would help a lot.

We were very happy to liaise with the Government and the NHS, get the information and pass it on to our communities. Sadly, that has stopped.

The Convener: Thank you, Mohammed. You raise some valid and interesting points.

I know that a few more witnesses want to come in, but I will pass over to Murdo Fraser to ask a question and he will bring them in.

Murdo Fraser (Mid Scotland and Fife) (Con): I say good morning to the witnesses.

My question is first of all for Magda Czarnecka from Feniks. I am interested to get her views on what has been said. The numbers show that there is a particular issue in the Polish community with a lack of vaccine uptake. We have heard from other witnesses that there is an issue with suspicion of Government. I am interested to get the witnesses' thoughts on whether that is a driving factor.

Over the past few weeks, in other parts of Europe, a tightening of restrictions, particularly on the unvaccinated, has developed. Some countries have introduced lockdowns for unvaccinated people. In some countries, there has been a conversation about making vaccination compulsory. We have not gone anywhere close to that here, but vaccination passports have been introduced in Scotland and then elsewhere in the UK. I am interested in the witnesses' perspectives on whether such an approach is likely to encourage people to be vaccinated or might have the opposite effect.

Magda Czarnecka (Feniks: Counselling, Personal Development and Support Services Ltd): Thank you for inviting me. The vaccine hesitancy in the Polish community was already quite well known even before Covid appeared. At Feniks, we worked with NHS Lothian and Dr Dermot Gorman on research to understand why that was happening. It proved that the main anti-vaccine movement was coming from Poland. I am not sure whether there was anything that we were able to do about that.

It is important to highlight the opportunities that the Government and other institutions missed. Until our campaign started in June, there was no real outreach from the Government to the ethnic minorities. The anti-vaccine and conspiracy theories managed to develop in Scotland over the year after the lockdown. We at Feniks tried to do as much as possible. We translated information about the ever-changing conditions of social distancing, but we did not have the strength to combat all the myths that were developing on social media. For instance, Facebook was one of the main channels used to communicate over lockdown.

There were a lot of missed opportunities. Another aspect was that, although materials were translated into Polish and other languages and have been made available in PDFs on the NHS inform website, they are pretty much not searchable in the sense that all the files are titled in English. They say, "Vaccine information (Polish)" so, if somebody searches in Polish for "vaccine Covid Scotland or Edinburgh", that information does not come up. None of the information that was created, whether videos or leaflets, is searchable. Someone who does not use English well and is looking for information in Polish will not find it.

It must be understood that there was pretty much an information gap for one year at least. All the information came from Poland. That is another issue. It was called Ryanair medicine even before Covid. People were choosing the modality of medicine that fitted them. A lack of trust in the authorities and the system also exacerbated the situation because there was no communication with the Polish community. People felt pretty much that they were left by themselves and that they had to make choices and decisions by themselves. If there is no information, they have to make decisions that way.

The other witnesses said that it is important to give information, but it has to be understood that that information must be in much more depth than it is for the local community. It has to explain how to register for the vaccination and why it is important so that we can address the doubts that people have.

During our campaign, it came up that a lot of people wanted a personal conversation with a specialist or a GP to discuss their health issues but did not have that opportunity. There was also the problem of not having a choice of vaccine. Scotland was strong on AstraZeneca for a long

time, whereas Poland, for instance, gave people access to Pfizer or Moderna. Giving people a choice puts a bit more trust in the system.

Murdo Fraser: The second question that I asked was whether making vaccinations compulsory or making it harder for people to be unvaccinated would help or make matters worse.

Magda Czarnecka: I am in two minds about that, so it is difficult to say. If people have an economic incentive of any kind—not in the sense of being paid, but having access to places and work—they will probably get vaccinated. A big proportion of people would probably get vaccinated. We found that there is a vast group of what we call late adopters, who were trying to understand what is happening and what the effects of vaccination are but who are possibly now suffering with Covid. It is a difficult question with no specific answer.

Murdo Fraser: I will bring in Dr Paulina Trevena, who we have not heard from so far. Can we get your general reflections on the discussion that we have just heard and on my specific question about whether making vaccinations compulsory or bringing in more restrictions on the unvaccinated encourages people to take up the vaccine or has the opposite effect?

Dr Paulina Trevena (University of Glasgow): I will address your specific question first. It would cause a lot of polarisation; some people would be encouraged to get vaccinated but some would be very discouraged. Research has been done on that; there is a London School of Economics blog that shows what would happen. During Covid, I worked on a research project on Polish essential workers in the UK, and vaccination was one of the things that we discussed. The same thing came across in our research—that some people are very much against making vaccinations compulsory or bringing in restrictions on unvaccinated people. Some people do not trust the NHS or the Government, and if those people are told that getting vaccinated is obligatory, they will go even further down the conspiracy theory road. However, other people will respond well if it is made compulsory and will get vaccinated.

Being able to travel freely without tests is a big motivator. Travel is very important for a lot of Poles, not just because they love travelling but because they have families abroad and not being able to see your family is a big thing. Many people mentioned that travelling during Covid was a big difficulty for them and that if travelling was made more difficult because they are not vaccinated, they would consider getting vaccinated.

I reiterate all the points that Magda Czarnecka made. One of the biggest problems with encouraging people to get vaccinated is the fear of the vaccines not being trialled properly, not being safe or having side effects.

Also, I was quite taken aback by the fact that a lot of our interviewees did not see any medical benefits to being vaccinated. They were of the view that vaccination does not fully protect them or help to protect anybody else. Some people were sitting on the fence and saying, “Once I see how the vaccination programme proceeds, if there is proof that it actually works, then I’ll consider it.”

10:00

I cannot underline enough how important it is to get out reliable and unbiased messaging. We have already mentioned that a lot of people use information sources from abroad. One of the reasons is that they are used to it, but another reason is the language barrier and accessing reliable sources locally. Magda Czarnecka already mentioned examples such as documents that are not searchable in Polish. For people who were not entirely proficient in English, there were not any reliable sources of information, and that is why people were turning to information from their home countries. As Magda and other people have said, the problem with that is that, in Poland, there is a very strong anti-vaccination movement, and there was a lot of influence from that movement.

Another important aspect of getting information out is that it is not just about having reliable sources but about how you spread the information. For example, as Magda also picked up on, Facebook and other social media are a big thing for Poles who live in the UK; they are a big source of information and often used, but a lot of Facebook conspiracy groups were spreading false information. When we were doing our study on Covid, we used targeted Facebook advertising to recruit Poles for our survey, and we were really taken aback by how many people responded—we had more than 1,100 responses to our survey. I say that to underline the fact that placing information on social media or social media advertising might be a more effective way of getting it out than just having it on official websites.

I will make one more point, which might be specific to the Polish community’s practical barriers to vaccination. It is characteristic of the Polish community to have a very high employment rate, so a lot of people are in employment, but it is often low-paid employment in low-skilled sectors. One of the practical barriers that people come across is taking time off work, because a lot of people are in precarious employment, working on zero-hours contracts or for agencies so, if they are not working, they lose income. A lot of those people live in poverty or very close to the poverty line, and they live from pay day to pay day, so that is a big barrier for people. It would be good to

consider how the Scottish Government or Parliament can support people, who are in precarious employment, to get the vaccine.

Other people also mentioned lack of support networks. That was also a problem because, if people have vaccine side effects and cannot go to work, they are not paid, and they also have to think about what to do with their children.

I apologise if that answer was a bit long, but I wanted to reiterate a few more points.

Jim Fairlie (Perthshire South and Kinross-shire) (SNP): I will direct my questions specifically to two witnesses. My first question is for Eman Hani. You said that you need grass-roots organisations to deliver the message into communities. We have sat in this committee before and been told that that is already happening. Are you telling us that it is not?

Dr Hani: It is happening, but not as well as it should be, and that is because of more than one reason. One reason is that grass-roots organisations sometimes receive mixed messages. I have been told that, although we have information delivery systems, our organisation is not allowed to give information to ethnic minority groups.

There was an initial resistance to our involvement. I was told that the information has to come from the NHS and that only a registered NHS doctor can deliver it, but I know that that is not the case. We are an equalities and human rights organisation, and we got all our information resources from the NHS and Public Health Scotland. We did not get our information from nowhere. However, we sometimes meet resistance, because of mixed messages or confusion.

Jim Fairlie: Thank you. We can put that to the Government. Mohammed, you gave a similar message. You said that some of the older people in the Islamic faith certainly believe that, if it is God's will, it will happen—that caught my attention. Please forgive my ignorance of your faith, because I really do not know enough about it, but is there not also a message in Islam about looking after one other, which getting the vaccine would help with?

Mohammed Razaq: You are absolutely right that there is such a message and that we can put that message out, but it has to be produced by a relevant organisation in the first place. It has to come from trusted people, whether they are from the religious fraternity or they are role models. As Eman Hani said, people will not trust a message simply from the West of Scotland Regional Equality Council, which is a non-religious organisation. A religious organisation needs to produce such a message, or it needs to be produced by the Government from a religious perspective and then sent out.

Another religious message is that God has given you this life and you have to look after yourself. However, how do we pull everything together? Organisations such as ours can put the message out, because we are nearer the communities and we know where to go, but we need somebody who has the confidence of the community to pull everything together and get the message across. It needs to come from a role model or from the religious fraternity.

Jim Fairlie: Okay. I recently attended a Sikh women's event, and one of the phrases that they kept coming up with—again, this is a new phrase to me—was that they live in a very gendered society. Mohammed, you said that, if the head of a family was anti-vax in his thinking, that would determine how the whole family would react. Will you expand on that? Is there a way of finding out where that is happening?

[*Interruption*.]

The Convener: I am sorry. I think that we temporarily lost the connection with the panel members, but everyone can hear us now. Could Jim Fairlie repeat his question, please?

Jim Fairlie: I am sticking with Mohammed. I recently attended a Sikh women's organisation briefing session in which they talked about a very gendered society. I did not understand what they meant by that until they explained it. You spoke about how the head of a large family could end up influencing the entire family. How do we get to those individuals in order to be able to get the vaccine into more arms?

Mohammed Razaq: I think that I explained that in terms of getting role models. If there is a religious aspect, you have to get somebody religious within the community to get out the message about getting the vaccine, whether that is an imam of a mosque or they are from the Muslim Council of Scotland, which has members who could get that message out. For example, the Muslim Council of Scotland could produce a video in certain languages that we could pass on to our community. However, the Government or the NHS has to take the lead in putting that message together.

As I said, in the early days—around June or July last year—a number of good things came out in relation to passing on that message, and we used those as an organisation, but nothing new has come out from the Government since then. For three to four months, quite a number of different things came through, including pro-vaccine information from role models, but that stopped. No new material came through that we could send out. Things are changing all the time, so the

messages from a year ago will not be relevant now. It is about how to change those messages so that we can pass them on.

Again, it has to be somebody from the faith who puts together the message, whatever religion that may be. Ethnic minorities do not have one religion, such as Islam; they have different religions, including Christianity, Buddhism and everything else. Each religion has to be represented to ensure that all the communities get the message.

Jim Fairlie: I am trying to focus on how we get the message to each individual group, which is why I went to you and Eman. We have heard clearly from Paulina Trevena about Facebook and social media. The point that I am making to the clerks and to the committee is that we need to focus on where the messages need to come from.

Brian Whittle (South Scotland) (Con): I am interested in the term "vaccine hesitancy". I wonder whether there is almost an inertia within that, in that the vaccine is perceived as being too difficult to access or to travel to. To extend the conversation that we have had so far, and in relation to behavioural difference, do we need to take the vaccine to the public and to ethnic minority groups rather than wait for them to come to the vaccine, for want of a better expression? We have talked about social media, fake news and how people access information. Do we need to be more proactive in taking the vaccine into communities?

Do we have Dr Carey Lunan with us? I am sorry; she is on the next panel. I have got that wrong. In that case, I will put that question to Magda Czarnecka.

Magda Czarnecka: We have found that a proactive approach is very important to address hesitancy. That can be done in many ways. For example, we have been thinking about buses getting people closer and being more available in rural areas.

It would be great if María José Pavez Larrea could say a bit about the project at GREC with community navigators and health champions. That personal approach and contact, with people having conversations in the community with health champions who are trained well enough to be able to speak about the vaccinations, would probably be best. A more proactive approach is definitely welcome.

María José Pavez Larrea: I completely agree with Magda Czarnecka. Facilitating and flexibilising access to vaccines is key. Having vaccination clinics in churches and mosques, for example, has been really good at the local level. In addition, making it possible to go to those clinics without an appointment allows the whole family to go together, which also increases the conversations that the family has with a healthcare specialist. Healthcare staff are a source of trusted information. Those conversations have to be prompted, and community links are a way of doing that.

It is also important to show that staff trust the vaccinations, not only in the clinics, but in all healthcare settings. As I mentioned, some pregnant women who sought advice regarding the vaccine asked their midwives and GPs, but they did not find the reassurance that they were looking for. Those people are the most trusted sources of information.

Magda Czarnecka mentioned our community health champions. We have been working with that structure in order to approach community members. Creating one-to-one conversations with members of the community has been really positive.

Members of the community want to see themselves represented in the information and material that is out there. It has already been mentioned that the resources that have been translated are not too friendly at the moment. It is also about the format. A lot of members of our community have asked for more resources that are in video format or have subtitles, or even come straight from community members in their language. That would be another way of further reaching people.

On the earlier question about making vaccinations compulsory, people have told us that they will not get vaccinated until it is made compulsory, but it is really important that we make every effort to reach and communicate with communities before any such decisions are made.

10:15

Brian Whittle: I think that Mohammed Razaq wants to comment, too.

Mohammed Razaq: The idea of bringing vaccinations to the people is excellent; indeed, we had something like that at Glasgow central mosque, and it encouraged a lot of people. However, I think that the powers-that-be felt that it was the only mosque in Glasgow. There are, after all, 22 others, and normally people go to only one in the same way that there might be just one church that most Polish people go to or that ethnic minorities from south Asia go to. We need to pinpoint those churches and put the vaccination centres in them. I realise that some of the buildings in question might not be large enough, but there could be mobile vaccination centres sitting outside on, say, Fridays for mosques and on Sundays for the Sikh community and other faith groups and churches. We have to go to the people and give them the information, instead of just

sitting back and saying, “We’ve sent out a wee message, and I’m sure that people will get it.” It is very important that we get to people.

Of course, that is just the religious aspect. Some people have talked about the places where communities work. There are lots of shopkeepers in the different communities, but they all buy their stuff from the same cash-and-carry. How about putting a mobile centre outside it? After all, it takes only a couple of minutes to get vaccinated. We need to go out to the communities, but that has not really happened, apart from what happened at Glasgow central mosque. It was a very good idea by whoever came up with it, but it needs to be extended if everyone is to be caught.

There is also an issue in south Asian communities with regard to women not going to mosques. The question is how we capture them. Are there any local groups that can be used? Local organisations such as ours can provide that information. There are, for example, elderly care centres for minority communities, particularly in Glasgow, so why can we not set up something there for local women?

The Convener: Thank you, Mohammed. I am conscious of the time, because we have to stop by 10.30.

Alex Rowley (Mid Scotland and Fife) (Lab): Picking up on Brian Whittle’s point, I think that we know that our health service is overrun, with people struggling to get GP appointments, and the ability to extend the health service into communities is limited. However, it has been suggested that as long as there was a doctor or nurse overseeing things more people could be trained in giving vaccinations, and local organisations could be supported to deliver them, too. Should we engage and involve the local community not just in encouraging people to get vaccinated but in delivering vaccinations?

The Convener: Do you want to direct that question to anyone in particular, Alex?

Alex Rowley: I cannot really see anyone else. [*Interruption*.] Oh, I can now. Perhaps we can start with Magda Czarnecka.

Magda Czarnecka: To be honest, I find it a surprising idea. There would have to be additional resources for our staff, or, indeed, for employing a new member of staff, because at the moment we are pretty much having to deal with other impacts of Covid on the Polish community. There has been a massive increase in requests for emergency appointments, for example, and we just do not have any capacity free to deliver what you have suggested. It sounds very innovative but, as I have said, any such move would have to come with resources.

Dr Trevena: I think that it is a good idea, too. If people from the community are trained to deliver vaccinations and can explain the advantages and the possible side effects, that would really build trust. For our study, we interviewed a number of nurses, for example, who deal with people who advocate for the vaccine on their own initiative, but I think that anything that builds trust, provides access to information that is—and I must underline this—unbiased and really reliable and allows vaccinations to be done there and then is a good idea.

Going back to the earlier suggestion about bringing the vaccine to the people, I have already tried to underline the fact that a lot of people of Polish origin are in employment and work long hours. If what you might call vaccination buses could be brought nearer to their workplaces—there are some workplaces with 1,000 or more people who are migrants—or the areas where they live, it would make it easier for people to get vaccinated. It would be a good mix.

Alex Rowley: It is important that the committee is able not just to highlight all the concern and misinformation that the anti-vaxxers are creating but to put forward some positive ideas. Do we need more resources for, say, community organisations? Perhaps María José Pavez Larrea can answer that.

María José Pavez Larrea: Community organisations need that support, and I would also point out that, because the pandemic is on-going, communication efforts and work with the communities must continue, too. It cannot be a case of simply saying, “We have been working on this for a year, so it should be done by now”; it is going to take time—although perhaps not 20 years—and it means that we have to keep working with the communities. As I have said, we need to follow all the steps with regard to all the communication and conversations that must be carried out in support of the vaccination effort.

There is also a big number of health staff from minority communities, and one option could be to liaise through them to see how many members of the community might be interested in participating in the more concrete way that you have suggested.

The Convener: I call John Mason.

John Mason: Thank you, convener. It is nice to get a second shot today.

This follows on from Alex Rowley’s questions about funding, but I want to ask about the vaccine information fund, which I think is administered by BEMIS Scotland and which I think a couple of you have had experience of. Some of the things that you have asked for today probably need to be done by the NHS or the Government, but have

you tried applying for more of those types of funds so that you can do more yourselves?

I will ask Parveen Ishaq to respond, as she has not said anything recently.

Parveen Ishaq: I cannot remember whether it was from the BEMIS Scotland fund, but we got a small grant of, I think, £500 to disseminate some general information about the need to get vaccinated and how to do that. That was during the lockdown, and we have not had anything else since then. That said, we are past the stage of getting the information out there in different languages. People now have different concerns, which are mainly about the effectiveness of the vaccine in general and any impact that it might have on them if they have underlying health issues.

As for the question about resources and getting the community involved, I think that that is a great idea that would definitely work, but again, everything needs resources. We should get more community champions to do this work, which might not necessarily involve vaccinating the community but might be about assisting health professionals in getting to communities by helping with translating, dealing with other issues that people might have and getting over these barriers. It brings us back to the question of working together, but I agree on the need to get into communities and to get rid of some of these barriers and the myths that people believe.

That said, we also need to differentiate between anti-vaxxers and people who genuinely do not want to be vaccinated for more general reasons; for example, they might not take medicine or they would rather have a more holistic approach. We have been discussing how we get black and minority ethnic communities to have their vaccinations, but I would also point out that there will not be 100 per cent take-up of vaccination in Scottish communities. There will always be people who are not anti-vaxxers but who would rather deal with Covid through a more holistic approach than be vaccinated. As I have said, we need to differentiate between those two groups.

John Mason: Thank you—that was helpful. Did you want to come in, too, Mohammed Razaq?

Mohammed Razaq: Getting local organisations to help out is a wonderful idea that would work but, like everyone else, I think that it would require to be resourced.

As for your questions about the BEMIS Scotland fund, we were one of the organisations that applied to it. Parveen Ishaq has said that the grants were small—I believe that they were £1,000 maximum. We got one of those £1,000 grants, which funded three or four months of work to pass on information about vaccinations. The project was no bigger than that because, to be honest, £1,000 will not take you very far.

What is needed is longer-term thinking and projects that run perhaps for a whole year and which cover a range of different issues such as getting out information, getting in more people to volunteer with the health service and so on. We need things that are bigger than those that can be funded with a £1,000 grant. They need to be worth while for organisations to do.

John Mason: I take your point that there is probably a long-term and a short-term issue to deal with and that we probably need to do more in the long term. Do you think, though, that it would be worth repeating that short-term project, even though it would involve funding of only £1,000?

Mohammed Razaq: Yes, but it would need to be coupled with fresh resources. We can make a certain amount of resources available ourselves, but the Scottish Government or the NHS needs to provide resources that we can pass out, such as bilingual material, videos and so on. Another £1,000 grant would help to reinvigorate what we along with other organisations did last year, but I think that in the longer term we need something more than that.

John Mason: We are just about to run out of time, but I see that Magda Czarnecka wants to come in, too.

Magda Czarnecka: We, too, received £1,000 from the BEMIS Scotland vaccine fund, but we calculated that the three months' work that we did was worth at least £6,000. We did what was necessary and arranged meetings with the specialist Jason Leitch and another specialist from the University of Oxford, and we created a guide to vaccination, which is now available on our website.

The biggest issue was that, as a result, we were invited to communicate with Public Health Scotland and the Scottish Government in the Parliament. Because we were the only organisation reaching out to the Polish community, we were suddenly invited to all these conversations that were happening in the background. It was not what we had expected to happen when we applied for the grant, and we had to carry out a lot more engagement than we had expected. The grant was for producing materials and perhaps extending them a bit further, but the unexpected engagement meant that we had to put a lot more work in.

John Mason: We will make a note of that and take it on board.

The Convener: We are out of time, so I thank all the witnesses for their evidence and their time this morning. If you have any further evidence that

you would like to give the committee, please do so in writing. The clerks will be happy to liaise with you on that.

10:30

Meeting suspended.

10:31

On resuming—

The Convener: We will now continue to take evidence on the vaccination programme. I welcome our second panel to the meeting: Hilda Campbell, the chief executive of Cope Scotland; Dr Carey Lunan, a general practitioner at the Craigmillar Medical Group and chair of the Scottish deep end project; Derek Holliday, the peer development lead at Homeless Network Scotland; Dr Andrea Williamson of the Scottish deep end project; and Professor Neil Quinn, professor of social work and public health and co-director of the centre for health policy at the University of Strathclyde. Thank you for giving us your time this morning.

As I explained to our earlier panel, we are the lead committee responsible for scrutinising the roll-out of the vaccination programme. Today's session is an opportunity to consider why uptake of the available vaccines has been below average in some communities in Scotland. We will discuss the vaccine uptake in communities that are experiencing higher levels of deprivation, as defined by the Scottish index of multiple deprivation.

Each member will have about eight minutes to speak to and ask questions of our panel. If any of the witnesses would like to respond to any issue that is being discussed, please type R in the chat box and we will bring you in. We have a large panel, and I am keen to ensure that everyone gets an opportunity to speak, so I apologise in advance if, because things have run on too long, I have to interrupt members or witnesses in the interests of brevity.

My first question is for Hilda Campbell. Thank you for the extensive briefing that you provided to members, in which you highlight many reasons why vaccines might not be taken up. I note an issue that I thought was interesting. We are all aware about misinformation and scaremongering about vaccinations, but you highlight a BBC broadcast about recent queues for vaccination in which one person, who had waited for 45 minutes, said that it was worth it because vaccination was saving lives. I could not agree more with that comment. In your submission, you suggest that

"perhaps more work needing done, to praise those who are taking the vaccine and recognise their contribution to helping us all move out of this pandemic."

What else should the Scottish Government do to increase vaccine uptake in minority groups from more deprived areas, where living day to day is perhaps more important than getting vaccinated?

Hilda Campbell (Cope Scotland): Thank you very much for inviting me. I will not go over all the points in the report that I sent in, much of which resonates with earlier witnesses' points about lack of trust, zero-hours contracts and people seeking information from their peers. However, I think that there is need to use something like an appreciative inquiry approach to build on what works. I included in the report an image that someone had taken while in a queue for two hours to get vaccinated. Despite the wait, they stood in the queue. A simple thing like giving people a banana or a hot drink might have given encouragement to those people who ended up leaving that queue because they were too cold. There are practical things that can be done and we can celebrate the fact that people are coming forward.

To gather that information, which is anecdotal, I spoke to a variety of colleagues about the experiences that they had had with people they were working with, community leaders and others. I heard that the people who were not taking the vaccine were not uniquely those who are facing inequalities. Some professionals were choosing not to take the vaccine. They felt that it was not right for them, for whatever reason; some were not sure that enough research had been done.

I noticed that, when someone asks a vaccinated person whether they should get vaccinated too, the vaccinated person is usually pretty positive about it. However, when a person who has not been vaccinated is asked their opinion, they are more likely to say, "Well, I'm not really qualified to tell you. You should go and ask your GP." One local support worker said that they recognised that GPs do not have the time to reassure everyone about vaccination, and that, if they had had more helpful information, they could have given that reassurance. That resonates with what people were saying to you earlier.

I mean no harm to Jason Leitch, but a lot of people will not identify with him, so instead of using him, the Scottish Government could have people who work with communities make videos that do not just get shown in little halls but go on the television, because that is what people watch. We need to get them on the television when it is peak-time viewing. That could be real people, who people identify with, talking about the benefits that they have had from the vaccine. That could be one of the steps that is taken.

I listened to conversations about whether to make vaccination mandatory. We have a Twitter account and there has been some tweeting this morning. I noticed that there is a scary trend going on, which is #WeWillNotComply. I do not want to get into the party business, but I raise it because things like that do not help. When the public see something that they view as unfair, they think, "Clearly, there can't be such a problem—if there was a problem, they wouldn't have been partying. The fact that they were partying means that they know something that we don't." Whatever people's view on partygate is, the fact is that #WeWillNotComply is trending on Twitter. I had a quick scan through the tweets, because I knew that I was coming here today, and a lot of them are saying, "I won't be taking the vaccine."

There is something about role models and who is perceived to be someone who can be trusted. The Scottish Government is doing a lot of good work through lived experience panels on gambling harm, suicide awareness and many other things. That could be tapped into, and people could be asked, "Could you give us a hand to put together some materials to go out that will actually have some credibility?" Govan Youth Information Project did an amazing piece of work on gambling harm. I am quite sure that, if it was approached to ask whether young people would be willing to work with it on an animation about how to overcome young people's anxieties—[*Inaudible*.]—that would be really valued.

When people are asked why they chose to go for their vaccination, consequences are one reason. People feel pressurised by the Government to take it. The other day, I received a communication from the Glasgow Council for the Voluntary Sector, because we are on its human resources contract. It was a template for a vaccination policy for the workplace. We already have one in place, so it was nothing new to us, but for others, it will have given them something to think about. In the workplace, we need to begin to have vaccination policies and training on vaccinations, and we need to look at staff and volunteer attitudes to vaccination.

There is a lot of information out there. I heard somebody ask whether information is going out, but there is information overload. We get the public bulletin and it is dry reading. There are no pictures or images—no cheery things—just a lot of text in Times New Roman. When you are busy reading 101 other things, you need something that cuts to the chase.

We were fortunate that we worked with Jacqui Sneddon from the Scottish Antimicrobial Prescribing Group to put together a tips sheet on antibiotic resistance and to raise public awareness of the role of antibiotics, the importance of not demanding an antibiotic when it is not appropriate, and how to prevent infection. Although that is not directly related to Covid, I have mentioned it and I am happy to send a copy of it to the committee.

The Convener: That would be great. I am sorry, Hilda, but I am conscious of time and I have used up mine, so I am going to have to move to questions from Murdo Fraser.

Hilda Campbell: No probs.

Murdo Fraser: Thank you, convener. I will bring in some other panel members. Who will I pick on? Professor Quinn, I am interested to get your thoughts on the questions of vaccination hesitancy and people's distrust of Government, which we discussed earlier and which Hilda Campbell just touched on. There is a conversation about making vaccines compulsory or at least, as other countries have done, imposing additional restrictions on the unvaccinated. Would that be helpful or counterproductive?

Professor Neil Quinn (University of Strathclyde): Thank you for inviting me to be part of the panel.

I was going to talk about our research with excluded communities, with which Derek Holliday was also involved. It looked at the experiences of a number of excluded groups in relation to accessing services more generally. We did not focus on vaccine take-up, but I think that there are lessons to be learned from that research that would be helpful for the committee.

We spoke to people who have experience of homelessness, people who have poor mental health, refugees, asylum seekers and women facing commercial sexual exploitation. Some of the key lessons were about the barriers that prevented people from accessing health services and how they seemed to have worsened during the pandemic. People described services being limited or withdrawn and there being less face-to-face provision, and they said that that affected their ability to access the services and support that they required. Many respondents also felt that statutory services were inaccessible during lockdown, and there were also issues around poor communication.

I think that, particularly for excluded communities, there are issues around trust and barriers to access, and I guess that that will flow on to some of the problems around vaccination uptake. Perhaps as a first step, we should try to remove some of those barriers to access.

There are pros and cons to compulsory vaccination. We need to increase roll-out of the vaccine, but before we decide whether we should go down the road of making it compulsory, we should look at other countries and other settings to

see whether it could be deemed appropriate. Removing the barriers facing certain excluded communities would be a good first step.

Murdo Fraser: Thank you. Could Dr Lunan come in and give us some general observations and then some thoughts on that specific question?

Dr Carey Lunan (Scottish Deep End Project): It is good to be here. A general observation is that our findings with the Covid vaccine roll-out—[*Inaudible*.]—the findings that we have had with all vaccine roll-outs. There is a lot to learn from previous vaccination campaigns in that uptake tends to be lower in certain groups, which is, I guess, why we are having these conversations today.

We have talked a little bit about trust issues, and that comes across quite strongly. People are also generally feeling a bit more disconnected from the world at the moment, which has probably not helped. There are also questions about Governments having the moral authority to give advice to populations when they might be perceived as not acting in the way they should.

The question of why people who live in more deprived settings do not necessarily have the high levels of vaccine uptake that we would like to see, there are issues around access—

The Convener: Sorry, your sound is going. We cannot hear you. Do you want to direct the question to someone else, Murdo?

10:45

Murdo Fraser: Dr Williamson, can you give us your perspective on this?

Dr Andrea Williamson (Scottish Deep End Project): Speaking specifically about whether we should make the vaccine compulsory, I echo what other contributors have said so far. Building on the first evidence session this morning, I would say that the issue of who communities and individuals can trust and believe is a big factor in what we are doing. People have to trust and believe what they are hearing before they take action.

From my perspective, I would say that compulsory vaccination would be challenging. It would definitely drive some people to get vaccinated but, thinking about the communities that we are focusing on this morning, I do not think that that is a good reason to do it. The Scottish Government has made a commitment to move towards being a trauma-informed nation, and the principles behind that approach involve always working collaboratively with people and never telling people what to do. That is particularly the case in a healthcare setting, and we must remember that the vaccination is a healthcare intervention. We must be really thoughtful about that. Before her sound failed, Carey Lunan was starting to talk about the fact that we have precedents that we can draw on. Throughout history, people have not taken up offers of healthcare unless they felt that it was right for them and would be of benefit to them.

While I am speaking, I would like to mention the wider context of what is happening. Although we might have forgotten it, there was a world before Covid and, hopefully, there will be a world after Covid, too. I want to specifically mention some of the research that I led on, which was about missingness in healthcare. Before the pandemic, my team and I conducted a large-scale epidemiological study that looked at patterns of missed appointments in healthcare—our focus was on missed appointments in general practice, but we also looked across the healthcare system. The study, which took in one sixth of the population of Scotland, found that 19 per cent of people had missed an average of two or more GP appointments a year over the preceding three years.

The issues that we are grappling with around Covid vaccinations do not exist in a vacuum. People have a history of interaction with healthcare, and we have to think about what that means for things that we do in the future. I will stop talking now, but I am happy to come back in later to talk about what we think could be done to address those issues.

The Convener: Alex Rowley, who joins us remotely, has some questions for the panel.

Alex Rowley: With regard to what we have just heard, it would be good for us to talk to Dr Williamson and Dr Lunan about how GP services are addressed. The committee has previously discussed issues such as the Nuka model, for example. We can perhaps come back to that.

I have another question that is specifically for the two GPs. Is it practical to say that we should put in place training to support local people from hard-to-reach communities to work in organisations, with the correct supervision, to deliver this programme? Due to the urgency that we face with this latest variant—I think that we are in for a difficult few months—there is a need to get as many people vaccinated as possible. I ask Dr Lunan to answer that first, if her sound is working again.

The Convener: Dr Lunan is back and she has a new headset, so her sound should be all right.

No, we are still having problems with her sound.

Alex Rowley: Dr Williamson, could you give us your view?

Dr Williamson: We already have people trained up to deliver vaccinations and there has been a

huge recruitment campaign to further increase the numbers. During the first evidence session this morning, we heard that an amazing number of fantastic people and communities are connected across the communities of Scotland, whether that be ethnic minority communities or people in areas of high socioeconomic deprivation. There is often a great overlap in that.

If I were running this, I would be thinking that, as we already have people trained to give vaccinations, it is not physically giving vaccinations that is the issue; it is about getting them to people who still need to be vaccinated. It is about helping people to overcome their vaccination hesitancy. How do we do that? We heard earlier that it is about trusted people who have on-going relationships with individuals in the community acting as community champions, going on national television and getting out and about in local communities, and I absolutely agree with that. They would perhaps even have to accompany vaccinators into localities, whether on buses or chapping on doors. We have had to do that across the health service for many years, and we do it in inclusion health settings. It is about chapping on doors, meeting people where they are and helping them to understand, and moving them towards a place where they feel that vaccination is the right thing for them, then being able to give it.

Alex Rowley: Is there not a capacity problem? Politicians are telling us that it will be a full task to deliver the booster to all over-40s by the end of January. We see more and more young people coming on, so decisions need to be made there. Do you believe that there is capacity to do all that and manage the health service through what is going to be a very difficult few months?

Dr Williamson: Absolutely—we are living that difficulty right now. On balance, it is better to think about increasing capacity among the groups of people who have already been targeted as vaccinators, such as retired staff or staff who work part time and can increase their sessional commitments. I am not saying that we should take people away from mainstream services. I absolutely recognise that there is a capacity challenge but, if we were to suddenly switch at this point to training up lay people to vaccinate, it is possible, as we know from evidence from other countries with a long history of creating—[*Inaudible*.]—with health interventions, that is not the sort of capacity that we could upskill quickly.

Brian Whittle: I will move on a little bit from my colleague's questioning on vaccine hesitancy in the groups that we are discussing. I wonder whether there is inertia and a perceived difficulty in accessing vaccination. Perhaps vaccines are seen as another issue that needs to be dealt with among so many other issues that the people who we are discussing have to face. As Alex Rowley said, do we need to take vaccination to the public rather than waiting for them to come for vaccination? Most people seem to be getting their knowledge from social media and fake news, which is undermining trust. Should overcoming that be the approach that we should be taking? That is a question for Derek Holliday.

Derek Holliday (Homeless Network Scotland): Good morning, everyone. We have talked a lot about trust in people and environment, which is the key component to people taking a risk and putting themselves outside their comfort zone. We must focus on place-based approaches, using all the relationships around a community such as family, friends and peer networks, as well as local health and pharmacy staff who people see for their wellbeing, and spiritual, faith and recovery networks. That is where trust is.

There is transport poverty, yet we are having a conversation about sending people for a life-saving vaccination without assessing whether they can afford to get there. Who will take care of their kids during a lockdown? Who will support the members of their family for whom they have caring responsibilities? When we look at vaccinations, we just look at the end of the journey. Vaccination must be much more based in the community than it was during the first half of the pandemic.

I remember that in the first year, unless you drove, you could not get a vaccine because the set-up was geared towards those who could drive. Any time we want to build trust, we need to work in the community. That is where the trust is, where the relationships are and where people feel safe. We also have to think about travel, poverty, caring, babysitting and other duties, as well as mental health and anxiety among the people who are still scared to leave their homes because the messaging has not targeted them.

We also need to focus on the younger generation as a priority group. They were left until the end and now we are wondering why we are struggling to get that community to take up the vaccine. We did not communicate with them, or trust them, and the media attacked them during the lockdown. As we move into the next phase, we should add them to the priority group list and show them that they are part of society, rather than discrediting them as the ones who are driving the pandemic, when everybody has that responsibility.

Hilda Campbell: I echo what has been said about recognising what the barriers are and how they can be overcome. The anecdotal evidence is that more people are willing to take the vaccine than not. As has already been mentioned, there might be barriers such as the person being a carer who cannot get out, or they might live in a property

with a communal area where mail is left and they do not actually see their appointment letter.

Transport is also an issue. Sometimes people are given an appointment 18 miles from where they live, which is two or three bus journeys away, depending on the route that they are on. Someone could have just checked the person's postcode and looked for the nearest vaccination centre. That is the kind of thing that people have been saying. We have to take the vaccine to people.

We need to build on what works. It is about values and attitudes. If we shine a light on the people of Scotland's positive response to dealing with Covid, other people who are reluctant will be inspired by that and want to join in. However, if we go down the route of mandatory vaccination, it could undo a lot of good will, make people feel very hesitant, and further enhance the scaremongering that we are all part of some big experiment.

We should take the message to people and recognise where they are. The vast majority of people want to take the vaccine, but some people have valid reasons for not doing so. Perhaps they have other health conditions and they are concerned that the vaccine will make it worse. We need to go into communities, make local contacts and build up a rapport. Keeping the message simple makes all the difference.

Brian Whittle: I want to finish that line of questioning by taking it to its ultimate conclusion. Do we know who the people are who have not taken up the vaccine? Should we approach them to ask why they have not taken up the vaccine so that we can reassure them that it is a safe way to protect themselves and then offer them the vaccine locally? Is that the point that we are getting to? I put that question to Dr Andrea Williamson.

Dr Williamson: The answer to that question is yes and no. The important thing is that it does not come across as a criticism. It is key that we suspend moral judgment, which is creeping into a lot of the public discourse on the issue. We have to approach people and say, "We want to support you the best we can to be healthy. We would like to offer you a Covid vaccination. What are your worries, what are your worst fears?" It cannot be a conversation in which we say, "You've not had the vaccine, so fill in this questionnaire about what's going on."

Another key thing that we have heard from many of the contributors to the meeting this morning is that we cannot take an impersonal approach. The approach must come from someone in that person's life who they trust, who they will listen to and who they will accept that from. From many years of experience, public health colleagues know that simple things matter. One of the reasons why the vaccination letters are blue is because whenever we send letters out in brown envelopes, by and large, people throw them away because they think that they are bills. We know that people are worried by letters on official, headed notepaper.

11:00

The Convener: I will bring in John Mason.

John Mason: My question is for Derek Holliday. We have long had a problem of men in general, especially younger men, not engaging with a range of health services—it is not just about the vaccine. Is there a particular problem to do with the vaccine? I represent the east end of Glasgow. Are men in poorer areas not getting involved? Are we talking about a longer-term problem, rather than just a problem with vaccines?

Derek Holliday: I am also from the east end of Glasgow and we have many problems in the area. Toxic masculinity, which historically comes from our upbringing, makes it difficult for men in the west of Scotland to deal with emotions. Four or five years ago, I was homeless because of energy poverty, rent poverty, debt collectors, travel poverty, phone data poverty, internet poverty and poor mental health. Those are the things that come first in a poor area, before there can be a focus on a vaccine, unless the message about the vaccine comes from someone in my community who I can trust and the vaccine is easily accessible and I do not have to go out of my way to get it, because just living day to day is consuming me.

If we are looking at access in areas of deprivation, we need to be in those communities, and giving time to them. We need to have expert panels and community members in town halls, talking until they cannot talk any more, so that everyone gets to ask every question that they can think of. We have not had that on television: we have not seen people sit down with communities and unwrap what the vaccines mean, the process and the details. We have not had a day-long programme that would let the whole country ask their questions and really understand what is going on.

We should not mandate people to do something. That would be a measure of our not having done our jobs right. There is no one-size-fits-all approach; we need more specialised, tailored approaches. We need to understand communities' needs, and we cannot do that from afar. We really need to connect with and have proper partnerships with third sector organisations and health settings, so that we get a whole-person view.

John Mason: You are suggesting that some people have questions but are not getting the opportunity to ask them and have them answered, but do you think that some people just would not engage even if you were there all day to answer questions? Is not that the traditional male view that you described?

Derek Holliday: Yes, but we are focusing on that, when, if we are honest, we know that not every person in the world will get vaccinated. Not every person in England, Wales or Ireland will get the vaccine; we will never get to 100 per cent. There will always be a percentage of people who do not take up vaccination, out of whatever personal choice.

The more we attack people and push them into it, the greater the damage will be when it comes to future pandemics. It is about understanding how something impacts on a person. It is about understanding individuals' learning needs. We do not all learn from a picture or a book. People have different styles of learning and some need more time to reflect and think about how something will impact on their life. A booklet or leaflet is very one-dimensional.

As everyone here has said, we need the proper people to speak to groups and communities that are not trusting and not taking medication, and that has to be people who those communities really connect with, identify with and trust. We can have lots of committees that presume things but, until we sit down with those groups, the message will not get to them properly and we will still have the issue that we are dealing with. It is our responsibility to be more flexible and adaptable and more specialised and targeted.

John Mason: Okay. Let me put the same question to Dr Williamson, from the deep-end practice side of things. I see that you are back with us, Dr Lunan, so I will try you again. I am a fan of the deep-end movement. Is there a problem with contacting men, and especially younger men, in poorer areas and getting them involved with health services? Is that the issue, rather than vaccination specifically?

Dr Lunan: Can you hear me okay?

John Mason: The sound is great.

Dr Lunan: I am not sure that I heard the whole question. Were you asking about targeting younger men?

John Mason: Yes. I asked Mr Holliday the same question. I think that, in general, health services have struggled to interact with men, especially younger men, in poorer areas. It is not just about the vaccine, is it? Is there a particular problem with the vaccine?

Dr Lunan: As I tried to say at the start, the demographics of the Covid vaccine roll-out very much mirror the demographics that we have seen with previous roll-outs. There are specific, practical issues to do with the ability of younger men who live in poorer communities to get to mass vaccination centres.

General practice was involved in vaccinating people over the age of 75 and people who were shielding, but vaccines for all other groups have been delivered largely through mass vaccination centres. That often requires people to be able to drive, because a lot of people are fearful of taking public transport, and to have secure employment that lets them get away.

A lot of our patients have struggled because they have been matched with vaccine centres that are quite a long way from where they live. That can make it very difficult for people to attend the vaccine appointments that they are allocated. In order for someone to change their vaccine appointment, they need to either get through on the phone lines, which are incredibly busy, or go through the NHS inform website, which can be challenging for other reasons. There are practical issues that have made it difficult for people to be vaccinated.

John Mason: I will come to Professor Quinn on the same theme, although I have another question for you. It was suggested earlier that age should not be the only criteria for vaccines. For example, it is clear that people in more deprived areas are experiencing older-life issues earlier on. Do you agree with the Joint Committee on Vaccination and Immunisation in its rigid use of purely age-based criteria?

Dr Lunan: I could—

John Mason: Sorry—that question was aimed at Professor Quinn.

Professor Quinn: Will I answer the first question first?

John Mason: Yes, that would be great.

Professor Quinn: All the witnesses have talked about the issue of trust. There are obviously major issues in certain communities around people's trust in services, so we have to look at ways to build trust. That is partly about removing barriers, and engaging in more active and assertive outreach. We also need greater involvement for lived experience in the design of services; Hilda Campbell mentioned lived experience panels. There is some creative and innovative work going on around how we bring in the value of lived experience. Derek Holliday has done a lot of work on that—we have been working in partnership. It is very important that we look at ways of building

trust and bringing the lived experience dimension into service design.

I do not have expertise in your second question, to be honest. My sense is that we have to be a bit more flexible. Using age as the only criteria probably does not make sense. We need to think about communities that are excluded, such as people who are experiencing homelessness, and how we reach those communities. Being flexible on the criteria is important. Dr Lunan might want to respond to that question.

John Mason: I think that Dr Williamson wants to come in as well, so she can go first, if we have time for that.

Dr Williamson: I come back to the previous question about young men living in socioeconomically deprived communities. We need to pull back to the principles. If we are not effectively managing to meet the health needs of a group in society, that means that we are not doing our job right, and policy planning and healthcare delivery are not working effectively. We should not try to problematise a particular group. I am thinking about the language that Derek Holliday used when he talked about the need for understanding. How do we better understand how to meet people's needs? We need to move forward on that.

The principle that underpins all that is proportionate universalism. In many ways, the vaccine campaign has been really successful: coverage has been really high; people have pulled out all the stops to help with vaccination; and people have worked hard to get vaccinated. However, we are now at the point where a proportion of people in our communities are struggling to get vaccinated. We need to think about the additional resource and expertise that needs to be pulled in, and we need community expertise. I absolutely agree that the lived experience element is vital.

I do not want to pre-empt what Carey Lunan will say, but we will probably say the same thing, which is that the age issue is important. We have strong evidence that people experience more health conditions, or multimorbidity, at a much younger age in socioeconomically deprived communities. From the health point of view, that is a key driver of the health equity gap. In more socioeconomically deprived communities, we need to target younger people.

John Mason: Can we have a final word from Dr Lunan on that point?

Dr Lunan: Deprivation-adjusted age is really important. In more deprived communities, people develop the diseases of old age at least 10 to 15 years earlier. The JCVI guidance specifically allowed flexibility to address health inequalities but, without clear guidance on how to do that, there was quite a lot of anxiety about delivering that on the ground. Clear public messaging is needed about why there might be deviation from the JCVI cohorts, so that we do not see kickback, discrimination or stigmatisation. A sensitive approach needs to be taken.

We must be guided by the evidence base and by the needs of patients who are in such groups. I agree that we need to take age into account for future vaccine roll-outs.

Jim Fairlie: I will summarise what I am taking from what I have heard. The hashtag #WeWillNotComply really concerns me, because it demonstrates a lack of trust. Carey Lunan talked about the Government's moral authority and how far back we are now from where we were at the start of the programme.

I see all these silos of problems. For example, Neil Quinn talked about restrictions on the unvaccinated and excluded groups. How much community concern does a homeless person or a refugee or someone who is being sexually exploited have in relation to getting a vaccination? It has been suggested that people in the Polish community want face-to-face GP appointments to persuade them that vaccination is the right thing to do.

I struggle to see how we tackle all those small groups in a way that gets us the maximum roll-out. Significant numbers of people are not getting vaccinated. Does anybody have a one-size-fits-all answer to that? I see lots of little problems that are creating a big issue.

Dr Williamson: The situation feels quite overwhelming, for sure. What struck me in today's first evidence session was the point about the expertise of localism; we echo that point. Connected communities are the key, and that is something that we have in Scotland that is fantastic in lots of ways. We have amazing community groups and voluntary organisations that deliver important services. The first panel talked about how, with a bit of extra resource, those organisations could help to reduce vaccine hesitancy and increase uptake by being community champions. That is one element.

The other element is extending what has already been done pretty well in some places. Members might remember that when the big outbreak or bump in cases occurred last year in Glasgow—where I live—buses were available for vaccination, and people appreciated the fact that a bus came to local secondary schools, and that public health colleagues and the planning for that were visible.

We have the building blocks; it is a case of getting local intelligence and knowledge about

what will work for communities. That involves a lot of intersectionality. People from black and minority ethnic communities might have precarious work experiences or might live in socioeconomically deprived communities—or they might not. The position is mixed. Local people and communities can help.

11:15

Dr Lunan: There is no one-size-fits-all approach—if there was, I think that we would probably be implementing that already. The important thing is that we learn as we go and that we tweak the roll-out based on that learning.

In addition to what Andrea Williamson said about the importance of community networks and lived experience, we should not underestimate the importance of relationships of trust. I listened to parts of your earlier session. A theme that consistently came across was people wanting to speak to people who they knew and could recognise so that they could have conversations with them in which they could unpick some of the things that they were struggling with.

As a GP, I have felt very conflicted about general practice involvement in vaccination. At the very beginning, when we were involved in vaccinating the over-75s and the shielded group, that was hugely rewarding. I think that we all hugely enjoyed doing that. Since then, vaccination has been largely taken away from general practice for lots of complicated reasons, which are essentially to do with workload, other priorities and lack of workforce.

I have found that often, you need to have serial conversations with people over time to help them unpick why they are concerned about getting vaccinated. I have been doing that for the past 10 or 11 months. People will often have a light-bulb moment—a family member will get sick or they are worried that they might have had Covid—and they suddenly decide that they would like to be vaccinated and, at that point, you can plug them into the system where they can get the vaccine.

There are pros and cons to the involvement of general practice, but if general practice had the workforce and the resource, a lot of people would prefer to be vaccinated in their surgery—there is no getting away from that.

It is difficult to offer opportunistic vaccination in general practice because the vaccines come in packs of 10. Once you open one pack, you need to be able to use them all to avoid vaccine wastage. When we design and deliver single dose vaccines, that will make it much easier for general practice and community pharmacies to deliver vaccines opportunistically to people who are coming in about a different problem. That will allow those people to be vaccinated at that moment. There are a lot of different things to be considered.

Jim Fairlie: We will definitely run with that excellent point.

I ask Hilda Campbell to come in on that quickly, too.

Hilda Campbell: It is a huge problem. We can become overwhelmed by everything that is happening and by trying to find a solution for every distinct group. There are common themes across all groups, and perhaps we could provide bespoke responses to those themes to address the concerns of individual groups. If we agreed on an effective communication strategy, we could adapt it depending on who it is being targeted at. That should include the media. With the coverage in the media, and the sheer plethora of experts, I sometimes find that I am asking myself what is really being said—and I am a health professional. If you do not have any medical background, the messages can be really confusing.

We need an overarching strategy that recognises, for example, the barriers to working people getting vaccinated. That would include asking what can be done in order to have a vaccination bus near to lots of workplaces so that those people could get vaccinated. What would be the messaging around that? How would we involve people who have had a positive experience? How would we personalise it? Does NHS 24 or some other helpline have capacity to help? People with individual concerns about the vaccine could be encouraged to phone such helplines. That service could be made available to people from multiple cultures, recognising the particular challenges that each culture has.

We could also try to make going to be vaccinated more of an event. A few years ago, I tried to increase the uptake of the flu vaccine by having a jolly jab day. We did not have Covid restrictions then, so maybe it would not work in the same way, but the aim would be to have some sort of social event. A two-hour queue gives a rare public health opportunity. We need to make use of that.

Although some people would want to get vaccinated by their GP, a lot of people would like to go to a sports centre, because it is non-medical and less threatening. This is about finding what suits different people, whether that be getting vaccinated in a bus, a community centre or at a general practice, where practice nurses would probably do the vaccinations because GPs have so many other things going on.

I hope that that is helpful. We need to look at the themes and target the messages.

Jim Fairlie: That is very helpful. I ask Neil Quinn the same question.

Professor Quinn: You raised a range of challenges in your introductory comments. I, too, would be loth to suggest a one-size-fits-all approach. I have found it helpful to take a human rights-based approach, which is gaining more traction at policy level and in health services. People, particularly those from excluded groups, are being denied their right to health, so it is important to view the issue through a human rights lens. There are different aspects to that. It is about tackling stigma and discrimination in communities and services, removing barriers and promoting the voice of lived experience in service provision.

Derek Holliday and I are part of the Covid-19 inclusion health group, whose research is funded by Public Health Scotland. Taking a human rights-based approach is important. That includes people having the right to complain if they are not receiving a service. That is my take on the question.

Jim Fairlie: I will not bring in Derek Holliday because we are very short of time and the convener wants to bring in someone else.

The Convener: There is an important point that has not been raised today. As the only woman on the committee, and having had three children and gone through three pregnancies, I know that every woman tries to look after herself and the baby through the nine months of pregnancy. We know that some pregnant women are hesitant about getting vaccinated. I will ask Dr Lunan and Dr Williamson a brief question, because we are short of time. What can we do to encourage pregnant women to take up the vaccine, especially as we go through winter, to protect themselves and their babies?

Dr Lunan: It has been difficult for pregnant women because the guidance changed a lot at the beginning of the vaccination programme, which left people feeling quite confused and anxious. The guidance is now clear, but the anxiety has persisted for longer.

There is no substitute for hearing directly from pregnant women who have been vaccinated, so that pregnant women can see people like them who have had the vaccine and feel confident about it. Pregnant women should also have access to resources that are easy to understand, relevant and available in lots of different languages. There are lots of good resources on the Royal College of Obstetricians and Gynaecologists and the NHS inform websites, but those are not a substitute for an additional conversation with midwives or GPs, if that is needed.

We need to make ourselves available to people who are worried, we need to know where people can find good information, and we need to recognise that there was a lot of confusion at the beginning and to understand why people might still feel anxious about getting vaccinated.

Dr Williamson: I do not have anything to add to that excellent and comprehensive answer.

The Convener: Great.

Brian Whittle: I have a specific question for Derek Holliday. We have not really focused on people who are caught in homelessness and addiction. How do we reach out to those communities, bring them into the fold and ensure that they are offered vaccination along with everybody else?

Derek Holliday: We need more place-based health settings with multidisciplinary services that contain everything that such people would need in one day, rather than the subway experience in which people are constantly travelling to address different aspects of their lives, such as those relating to health, wellbeing, finance, security, information and rights. The Simon Community Scotland hubs in Edinburgh and Glasgow are perfect examples. We should have such hubs that provide a one-stop shop in every deprived area, so that we stop people having to go round 14 or 15 services when they are in the worst state of their lives. They have so much trauma, but we ask them to do all those tasks.

We should provide a service that is in the community and is staffed by health workers and those with lived experience. Compassion, non-judgment and dignity should be the words at the fore. We should give people space so that they can make the decision to trust a service, rather than the service forcing them to trust it. During the lockdown, all the services that provided face-to-face contact closed, but the ability to deal with aspects of people's lives other than health relies on those services—it is literally a matter of life and death. Such services become more of a priority than getting the vaccine, so there is a balance to be struck.

All our services need to take a place-based approach. We should stop asking people to travel for their health, because that is not a free health system. People should be able to get everything that they need from their community. That is how we build long-term trust and long-term relationships so that people can start to manage their life system. Currently, we have people moving here, there and everywhere to see doctors whom they do not see the following week or month. There is no consistent trail in the majority of services, so relationships cannot be built. If people can never build a relationship with a

professional who manages their health, how will they ever feel safe to discuss their trauma, find out their options and move forward with support?

The Convener: That brings us to the end of our evidence session. I thank all the witnesses for their evidence and for giving us their time. If they would like to give any further evidence to the committee, they can do so in writing. The clerks will be happy to liaise with them on how to do that.

The committee's next meeting will be on 16 December, when we will take evidence from the Deputy First Minister and Cabinet Secretary for Covid Recovery on the Coronavirus (Discretionary Compensation for Self-Isolation) (Scotland) Bill, ministerial statements on Covid-19, and subordinate legislation.

11:26

Meeting continued in private until 11:34.

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