OFFICIAL REPORT
AITHISG OIFIGEIL

Equalities, Human Rights and Civil Justice Committee

Tuesday 12 March 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 12 March 2024

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EQUALITIES, HUMAN RIGHTS AND CIVIL JUSTICE COMMITTEE

8th Meeting 2024, Session 6

CONVENER

*Karen Adam (Banffshire and Buchan Coast) (SNP)

DEPUTY CONVENER

*Maggie Chapman (North East Scotland) (Green)

COMMITTEE MEMBERS

*Meghan Gallacher (Central Scotland) (Con)
*Marie McNair (Clydebank and Milngavie) (SNP)
*Paul O'Kane (West Scotland) (Lab)
*Evelyn Tweed (Stirling) (SNP)
*Annie Wells (Glasgow) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Daniela Brawley (NHS Grampian)
Dr Dan Clutterbuck (NHS Lothian)
Nicky Coia (NHS Greater Glasgow and Clyde)
Alan Eagleson (Terrence Higgins Trust Scotland)
Professor Claudia Estcourt (Glasgow Caledonian University)
Dr Bridie Howe (NHS Highland)
Gabrielle King (Waverley Care)
Dr Kirsty Roy (Public Health Scotland)

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Equalities, Human Rights and Civil Justice Committee

Tuesday 12 March 2024

[The Convener opened the meeting at 09:47]

Interests

The Convener (Karen Adam): Good morning, and welcome to the eighth meeting in 2024, in session 6, of the Equalities, Human Rights and Civil Justice Committee. We have received no apologies this morning.

Our first agenda item is an invitation for our new members, Marie McNair and Evelyn Tweed, to declare any relevant interests.

Marie McNair (Clydebank and Milngavie) (SNP): Thank you, and good morning, convener. I am delighted to be here.

I declare an interest in that, until 2022, I was a councillor for West Dunbartonshire Council.

Evelyn Tweed (Stirling) (SNP): [*Inaudible*.]—for Stirling Council.

The Convener: I am sorry, Evelyn—could you repeat that? The first part of your answer was cut off.

Evelyn Tweed: Similarly to Marie McNair, I declare that I was a councillor, at Stirling Council, in the same period.

The Convener: That is great. Good morning to both of you, and welcome to the committee.

Subordinate Legislation

Act of Sederunt (Fees of Messengers-at-Arms and Sheriff Officers) (Amendment) 2024 (SSI 2024/41)

09:48

The Convener: Our second agenda item is consideration of a negative Scottish statutory instrument. I refer members to paper 1.

Do any members have comments on the instrument?

Marie McNair: The letter from Alan McIntosh contains interesting suggestions. The reduction in sheriff officer fees sounds quite attractive to me. Obviously, it is not feasible for us to do anything about that just now, but could we at least pass on the letter to the appropriate ministers so that it is not lost?

The Convener: That is a reasonable request. As no member has other comments to make, does the committee agree that we will do that?

Members *indicated agreement.*

HIV: Addressing Stigma and Eliminating Transmission

09:49

The Convener: Our third agenda item is evidence on the HIV anti-stigma campaign and achieving zero new transmissions of HIV in Scotland by 2030. We will take evidence from two panels.

I welcome our first panel: Alan Eagleson, head of services at Terrence Higgins Trust Scotland; Professor Claudia Estcourt, professor of sexual health and HIV at Glasgow Caledonian University; and Gabrielle King, policy and research manager at Waverley Care. Joining us remotely is Dr Bridie Howe, chair of the British Association for Sexual Health and HIV Scotland and the HIV lead at NHS Highland. You are all very welcome.

I refer members to papers 2 and 3, and I invite each of our witnesses to make brief opening remarks.

Alan Eagleson (Terrence Higgins Trust Scotland): On behalf of Terrence Higgins Trust Scotland, I thank the committee for inviting us to give evidence today and for its focus on ending new cases of HIV in Scotland and ensuring that every person who lives with HIV has equitable and comprehensive access to care, treatment and support. I also congratulate the convener on her recent appointment to the convenership of this important committee, and I thank the clerks and the previous convener, Kaukab Stewart, for their time and interest in the topic.

The Terrence Higgins Trust is a leading United Kingdom HIV and sexual health charity. In Scotland, we support people who live with HIV, amplify their voices and help the people who use our services to achieve good sexual health. Our work includes peer support services, testing services, health promotion, counselling, advocacy and working with our partners to combat stigma and achieve positive change for people living with HIV.

We have a national ambition to end new cases of HIV in Scotland by 2030, and we have all the tools that we need to achieve that. We can do so without a cure and, potentially, can become the first country in the world to do it, but it will not happen by accident. We need bold action and focused investment to test more people for HIV, widen access to post-exposure prophylaxis, retain people in HIV care and combat the stigma that still surrounds an HIV diagnosis. Importantly, if we are to end new cases of HIV by 2030, we need to tackle the inequalities that persist and ensure that progress is felt equally among all communities.

We have the opportunity to lead the way not only in the UK but across the world, but we are letting this moment pass us at a rapid pace. The reality is that, in Scotland, we have fallen behind other UK nations in our HIV response. We all know what the end goal is—to eliminate new transmission by 2030—but we do not yet have a published plan on how to achieve that or the funding resource to make that ambition a reality. If we are to be successful in reaching our 2030 goal, we need equitable progress among all communities that are impacted by HIV, and we need sustainable investment to match that. We need bold words to be met with bold action and resource. Without a substantial refocusing of our approach and a funded framework for achieving our common goals, we are at risk of failing the very communities that we seek to support.

The Scottish Government must refocus and match words with action and investment. The publication of a funded action plan has long been promised and is long overdue. It needs to be delivered as a matter of urgency. We need to see the normalisation of HIV testing through a national HIV testing week for Scotland, and there must be substantial emergency department opt-out testing pilots of at least 12 months' duration, with a bidding process that is fit for purpose. We need to increase awareness of PrEP and must make it easier for people to access that game-changing drug. We also need to invest in our third sector and in our sexual health services, so that people living with HIV in Scotland have equitable access to support, care and treatment.

We need to continue our work to combat HIV stigma wherever it presents itself. Scotland's HIV epidemic is one of inequality and is driven by stigma and harmful yet common misconceptions about the virus. We can choose to meet that head on, unwavering in our determination to leave no one behind as we seek to end new transmission of HIV in Scotland by 2030. We are therefore pleased that the committee has taken a timely interest in this area, and we look forward to discussing the matter in more detail.

Professor Claudia Estcourt (Glasgow Caledonian University): Good morning. I am the lead for the Scottish Government-funded ePrEP research project and co-author of the HIV transmission elimination strategy. I also co-lead PrEP implementation as part of the roll-out of the transmission elimination strategy. My main research focus is on the prevention of transmission of sexually transmitted infections and HIV, predominantly through e-health and public health interventions. I am also a consultant physician, so I see people who could benefit from PrEP when I work in the Sandyford sexual health clinic in Glasgow.

Gabrielle King (Waverley Care): Thank you, convener, committee members and clerks, for time on this topic. Waverley Care is Scotland's HIV and hepatitis C charity.

Over the past 40 years, HIV care has been transformed to the point at which someone can live with an undetectable viral load. On world AIDS day 2020, we heard a commitment from the Scottish Government to reduce new transmissions of HIV to zero by 2030. We are now almost halfway to 2030 and we are concerned that action is not happening fast enough and risks being insufficiently resourced. We live in a Scotland where people do not have equitable access to testing, treatment and support for HIV. I will outline some of the challenges that inhibit Scotland from reaching zero new transmissions and that reduce quality of life.

First, access to services, particularly for rural communities, is patchy across the country. Some regions have no sexual health services, so people must travel for hours to access treatment, sometimes outwith their own health board area. Where people live determines the care and support that they can get.

The second issue is testing. Many people across the country do not know their blood-borne virus status. That is particularly challenging in the context of getting to zero new transmissions, because it makes it difficult to identify those who are living with undiagnosed HIV or who are lost to care. It also leads to later diagnosis, which is detrimental to quality of life. Without substantive, nationwide testing provision, we simply cannot support people or reach our targets. That goes hand in hand with the need for up-to-date data.

Thirdly, certain groups continue to be poorly served by testing and support and in accessing preventative treatments such as PrEP. PrEP is a game changer in stopping transmission for some people, but it is not a game changer in equality. Since it was made available in Scotland, 92 per cent of those accessing it have been white, and data from 2020 shows that fewer than 10 heterosexual men and fewer than five women were prescribed PrEP. The needs of women, people from minority ethnic communities, trans folk, those in the refugee and asylum systems, those facing a range of intersecting inequalities and those living in rural areas are not being met by the existing provision. We need on-going, tailored and community-focused approaches.

Fourth, and finally, stigma and misconceptions about HIV remain pervasive. The impact of stigma cannot be overstated. It affects quality of life, mental health, public health and the population-wide levels of testing and education. We know that people across the country feel unsafe in sharing their status. I will finish with some quotes from people living with HIV. One said:

> "I left Scotland and only very recently returned because I felt unsafe".

Another said:

> "I've not told anyone apart from my doctor because I'm scared of how they will react."

We need a society in which people feel safe, cared for and supported. We want properly resourced and funded commitments, reliable data and tailored and person-centred approaches. The need for those will only increase as and if we get closer to zero new transmissions by 2030.

Dr Bridie Howe (NHS Highland): Thank you for inviting me to the committee. I represent the British Association for Sexual Health and HIV, which promotes excellence in STI and HIV care across the UK and delivers and supports education, training and innovation in sexual health and HIV. I am also part of the Scottish sexual health lead clinicians group and the HIV lead for NHS Highland, so I speak from a remote and rural perspective and can echo some of Gabrielle King's concerns about patchy access to sexual health and HIV care in Scotland.

The Convener: Thank you so much. We will now move questions from members, and I will kick off. We heard about stigma in your opening statements, and the evidence suggests that there are still many outdated views about HIV. I note that the Scottish Government funded a short film, which was produced by the Terrence Higgins Trust, to help to tackle stigma. Why is it important to address the stigma associated with HIV?

Alan Eagleson: It is important on many levels. Stigma still acts as a barrier to people testing for HIV or accessing, and staying in, HIV treatment and care.

The Terrence Higgins Trust very much welcomed the recent stigma campaign, and we were delighted to work with colleagues across the sector to deliver that. Before that, we undertook a YouGov poll to survey public attitudes and held focus groups with people living with HIV. It was clear that public attitudes are still very much in the 1980s, when we last had a national televised campaign about HIV in Scotland. We are currently working on an evaluation of the anti-stigma campaign, and we can certainly forward the results when they are available.

We would be keen for this to be just the start of a conversation. There are opportunities to follow the stigma campaign with, for example, an ask of the wider public in Scotland with an HIV testing week. Scotland is behind England and Wales in that both of those countries have a funded HIV testing week while we, in Scotland, do not. That would be an opportunity to normalise testing among the general population, and it would be possible through existing testing provision—for example, the online postal self-testing service for HIV that the Scottish Government currently funds the Terrence Higgins Trust to deliver.

10:00

The Convener: Would anybody else like to come in on that question?

Professor Estcourt: I add to Alan's excellent points that we must be very clear about how the stigma relates to people's mental health. As soon as somebody feels stigmatised, they are unable to talk about their diagnosis or their potential for acquiring HIV, which also means that they potentially cannot negotiate safer sex with sex partners. They might not feel comfortable about talking to healthcare professionals, and they might not even feel comfortable looking for prevention information online for fear of privacy breaches in the home environment and what might happen as a result of their being found out. If people are unable to find out about health conditions because they feel so stigmatised, they cannot protect themselves and they will not come to sexual health services. In that way, we get a vicious cycle that absolutely has to be broken.

I am not sure that I agree that a national testing week would necessarily be good value for money, but it is certainly one measure that we might want to consider in relation to raising the population's awareness of HIV in a positive light.

The Convener: So, stigma is absolutely a barrier to people seeking additional support. That is really interesting.

Gabrielle King: I will to add to what Claudia and Alan have said. We know that stigma is pervasive across Scotland, and it can be really important to note the places where stigma can happen and where people can encounter it. We know that stigma across health and social care is a real challenge. The positive voices 2022 survey found that one in 13 people have been put off accessing healthcare support because of it. We also know that stigma takes place in allied health professions such as dentistry and that it can take an indirect form, such as people double-gloving or people being given appointments at the end of the day rather than being slotted into a normal appointment schedule.

As we see a population that is now ageing with HIV, we also see stigma appearing in additional spaces—in parallel and intersecting statutory services such as housing and social security. It also takes place in care homes, which are spaces in which we have not previously really encountered it.

As Claudia Estcourt said, the impact of stigma on mental health cannot be overstated. The positive voices survey found that only one in eight people living with HIV had told most people in their life about their status and diagnosis.

We know that there are higher rates of depression, anxiety and post-traumatic stress disorder among people who are living with HIV and that they unfortunately experience physical and sexual violence, too. That has a knock-on impact on the level of public testing and how empowered and supported people feel to get a HIV test and know what their status is, which means that it will be incredibly difficult to reach the goal of zero new transmissions by 2030.

Dr Howe: I agree with all the other witnesses and add that stigma is often higher in low-prevalence areas such as the remote and rural parts of Scotland, where there is a lot less awareness of HIV. Therefore, people in those areas who are affected by, and at risk of, HIV face additional barriers.

The Convener: That geographical point is really interesting.

I am grateful for your answers. Maggie Chapman now has some questions for you.

Maggie Chapman (North East Scotland) (Green): Good morning. Thank you for joining us this morning and for your opening remarks. I want to explore in a little more detail two issues on stigma—how we tackle it and the complexities around it. Gabrielle King and Bridie Howe, both of you have spoken about rural and other inequalities. What data do we have on the inequalities related specifically to stigma that might indicate that we need different approaches to tackling it in different communities?

Gabrielle King: There has been extensive research, usually on a UK or international level, about what stigma looks like and how pervasive it is in particular settings. However, Scotland is typically underrepresented in much of the data collection. For example, only one clinic in Scotland was able to respond to the positive voices survey that I referenced. There is, therefore, a real gap. We know all about the anecdotal examples of stigma, and we have some local-level data, but there is a real gap in Scotland-specific data across health and social care and other statutory services—although Alan Eagleson touched on the YouGov survey of public opinions. In addition, to touch on what Bridie Howe said, it can be difficult to disaggregate that data to a local level in order to understand how the stigma can be different across Scotland.

Maggie Chapman: In your work, do you have anecdotal information that you can use to target different types of anti-stigma message? What would help us to understand exactly what needs to be targeted where and by whom?

Gabrielle King: We have a range of anecdotal evidence from people who provide support services, as well as from people who have done smaller-scale research with, for example, trans communities, minority ethnic communities and people who live in rural and remote areas. From those conversations, we know some of the culturally specific issues around the knowledge and understanding of HIV and around how that plays out.

We also know that significant structural barriers can inhibit people accessing services. For example, in refugee and asylum communities, if you get £49.18 a week, or £8.00 if you have accommodation with food—I cannot remember the exact figure—that does not leave you any resource to travel to a sexual health clinic or to increase your sexual health education.

It is about tailoring the resource to the needs of those communities—asking what they need and what they would like. Claudia Estcourt might have comments to add from an academic perspective.

Professor Estcourt: We have research evidence. As many people will know, Scotland was the first country in the union to roll out a national programme of PrEP, in 2017. I concur with Alan Eagleson that we were game changers at that point and have slid back since then. In those heady pre-Covid days, we did a lot in leading the UK and the world.

Associated with the roll-out, we did some small research studies that were really informative. One that speaks directly to your question was a qualitative study of women of colour in Glasgow and London, which we led from Glasgow Caledonian University and University College London. We asked women of colour about their views and perceptions of HIV and reproductive health and about the services in which they might feel comfortable to discuss HIV prevention. That study was incredibly helpful for us, because it showed that, at that time, women of colour did not find sexual health services particularly amenable places. They felt that they were for people who already had STIs, that they were not environments in which they were comfortable and that, because of historical problems with health service access and racism, they might experience stigma in those environments. It then became very difficult to consider how we might increase the proportion of women from those groups on PrEP if PrEP was offered only in those services.

There are challenges, which I suspect we will come on to, and delivering PrEP in community settings in a way that provides value for money and is also acceptable can become quite difficult. It is where we get a little bit stuck. We know that sexual health services do a fantastic job for certain groups in delivering high-quality HIV prevention and PrEP, but there are other groups who do not feel that such places are acceptable. One of the key findings of the study was that, for women of colour, we needed to wrap PrEP in with holistic reproductive care. In other words, PrEP had to be just one part of the approach to reproduction and contraception, not singled out as some great intervention to be focused on that group, for fear of the adverse implications that might arise from targeting it.

Maggie Chapman: Thank you very much, Claudia. Perhaps I can bring Bridie Howe into this discussion. How does stigma play out with regard to the rural and geographical inequalities that you have highlighted?

Dr Howe: I do not have data as such, just anecdotal stories and situations. In remote and rural communities, people do not have secrets. Everybody knows everybody else’s business, so it is a big deal to go to your GP practice or pharmacy and ask for PrEP or an HIV test or to pick up your medication. It outs you—it outs your sexuality, your lifestyle and your behaviours. It is a big barrier to people accessing care.

Moreover, in some places, such as the Western Isles, there is no access to specialist sexual health services, so the GP is the first port of call for sexual health issues. That can leave people feeling really exposed, because, although we all know that health professionals are bound by confidentiality rules, I have heard countless stories of receptionists talking to neighbours. Indeed, the receptionist might be your auntie, your next-door neighbour or whoever—such things are particularly common in remote and rural settings.

I do not know whether there is data out there, but the remote and rural aspect is, I suppose, underrepresented in such research. The University of the Highlands and Islands has done some remote and rural sexual health studies, but I do not know whether there has been any particular research on stigma.

Maggie Chapman: So far, you have all highlighted the challenge with data. Some of my colleagues will ask about the mechanisms that might normalise testing and so on.

Finally, I want to ask Alan Eagleson about the film that the Terrence Higgins Trust produced, which we saw in Parliament last year. How effective has that been in challenging, tackling and combating stigma? Do you see that kind of intervention having an impact across the different communities, given the different cultural sensitivities, the different access issues and all of the things that we have already heard about with regard to inequalities and the impact of stigma on them?

Alan Eagleson: We would hope that it would help, but it is not an answer on its own. As I said previously, we would hope that it would be the beginning of a conversation and the beginning of work to update public knowledge of HIV now, in the 2020s.

The campaign was viewed by more than 10 million people, either through marketing activity or press coverage, with 4 million impressions on social media and 1.7 million views on STV. Therefore, we know that the reach was good. We also know anecdotally about the conversations that happened at the time among all of us who were working in the sector, our service users and so on. The fact that people were having such conversations was a positive sign.

10:15

I can give you some of the headline figures from the public attitudes survey that we conducted prior to launching the advert. We found that 36 per cent of people in Scotland still believe that people living with HIV have a shorter life expectancy than others and that 30 per cent of people disagreed when asked if they believed that people living with HIV and on effective treatment cannot pass the virus on to others. Only 35 per cent of people said that they would be happy to kiss someone with HIV; 25 per cent would feel worried about receiving medical treatment from a doctor or nurse who had HIV; 55 per cent of people would not feel comfortable having sex with someone living with HIV who was on effective treatment; and almost half—46 per cent—of people in Scotland would feel ashamed to tell other people if they were diagnosed with HIV.

We hear from our service users all the time about stigma in the health and care sector, which is something that I can share personal experience of, as someone who is living with HIV. During the first round of Covid vaccinations, as soon as I disclosed my HIV status at my first vaccination appointment, the person doing the vaccination went off to the other end of the centre in search of a pair of gloves before undertaking the vaccination. That is not an isolated example—we have heard similar stories from others. That was not intentional and I do not think that there was any malice, but it points to the lack of education and up-to-date knowledge that we find within our health and care system, never mind in the wider population.

Maggie Chapman: I could go on, but I will come back in later if I have anything else to ask.

The Convener: Evelyn Tweed is joining us remotely.

Evelyn Tweed: My first question is for Alan Eagleson. You said that Scotland is falling behind, and you mentioned the delivery plan. What do you want to see in that plan? Do we have any idea why that is taking so long?

Alan Eagleson: I imagine that there are lots of reasons why it is taking so long, but it is frustrating that we are behind. England published a funded plan in 2021 and Wales published one in 2023.

The Scottish Government's commitment to end new HIV transmissions by 2030 was made on world AIDS day 2020. By world AIDS day 2021, the HIV transmission elimination oversight group was being formed, and that group presented 22 recommendations to the Scottish Government by world AIDS day 2022. Since then, another group, the HIV transmission elimination delivery group, has been formed and draft plans have been pulled together, but there are various reasons why those have not yet been published.

We want to see funded commitments to expand testing on a number of levels, including the expansion of access to testing through specialist sexual health services and delivery on the commitment to a national STI and blood-borne virus self-sampling service for Scotland. We also want to see testing expanded through meaningful pilots of opt-out testing in emergency departments. We welcomed the Scottish Government's funding of three short pilots of such testing, but we would like to see that go further, with a minimum 12-month pilot and an open bidding process that is fit for all the boards that would like to implement that.

We would also like to see investment in our third sector services to ensure that there is wraparound support for people living with HIV, recognising that, as we get closer to having zero new cases and are identifying those who are currently undiagnosed with HIV, it is likely that those people will have greater support requirements and there will be a greater need for investment. We would like to see investment in education for our health and care workforce and investment in building on the anti-stigma campaign with further targeted education work among the wider public in Scotland.

Professor Estcourt: A lot of work is being done to work out the optimal interventions that will achieve HIV transmission elimination by 2030. They have to be very country and region specific. Scotland is not England-lite, because we are different as a country. We have different numbers of people who are at risk of HIV, and the distribution of the population is very different. We are also very different because England received £20 million to support its transmission elimination strategy, whereas, to my knowledge, no sum of money anywhere near that degree of magnitude has been provided for Scotland.

Achieving transmission elimination requires people to do more work and to do more work differently. A lot of the provision of PrEP is done almost exclusively through sexual health services. I am sure that people in this room are well aware that we are seeing rises in STIs like syphilis and gonorrhoea such as have not been seen for decades. That adds additional pressure for services so that their prevention functions have to take second place to treating people with STIs.

Without additional funding, it is simply not possible to meet the demands of the population who, quite rightly, need access to timely care for their acute STIs and their reproductive health needs. Because of that, very little change can happen. That is markedly different from when PrEP was introduced, in 2017. Introducing PrEP through sexual health clinics seemed a massive deal at the time, but it is actually quite simple compared with what we need to do today, which involves not just sexual health clinics but many different parts of the health system, all of which are under strain.

Although, to my mind, the ideas and the interventions put forward in the plan are the right ones with the correct weighting, it is almost impossible to achieve more than what very hard-working people across our disciplines, the third sector and health services, among others, are achieving already with very small budgets.

Evelyn Tweed: If no one else wants to come in, I will go on to my next question.

The Convener: Gabrielle King has requested to come in.

Gabrielle King: I will keep it very short, because it very much aligns with what Professor Estcourt and Alan Eagleson have touched on. Our concern is the lack of funding and a funding-delivered plan, which raises questions about how we can ensure that nobody is left behind in reaching the 2030 target.

Much as Professor Estcourt said, we know that, as we get closer to 2030, the people we will need to support could require more labour-intensive resources and tailored, person-centred approaches. We already see that through work that Waverley Care does in Greater Glasgow and Clyde around loss to follow-up. That very intensive work supports people who are struggling to engage in care or who have fallen out of the care system to re-engage with treatment and services. There have been marked successes from that work. Between April and September 2023, 63 per cent of people in that process—people with HIV or hepatitis—were able to complete treatment bloods. The challenge of that work is that it is a massive commitment of resources, time and costs for the third sector, and there are concerns that the work could be expected to increase without matched funding.

The Convener: Dr Howe would like to come in on this topic. [*Interruption*.]

Dr Howe: I am sorry—there was an issue with the unmute button.

I will add a remote and rural aspect to what others have said about why we are falling behind in addressing stigma and in the elimination of transmission. In many of the smaller health board areas, there might be one sexual health and HIV specialist—if we are lucky—and they will often be working part time. In some parts of the country there is nobody. How can we move things forward in those areas when there is no expertise there?

Evelyn Tweed: I was concerned to read that 31 per cent of Scots think that they are not the type of person who could contract HIV. That is an issue when we consider the number of heterosexuals who are testing positive. What work is being done to tackle that misconception?

No one is indicating that they wish to respond. Does that mean that no work is being done?

The Convener: I do not have anyone wishing to respond. That is a challenge.

Evelyn Tweed: I think that that needs to be looked at.

The Convener: Yes—absolutely.

Gabrielle King: Waverley Care and the Terrence Higgins Trust might be able to get back to you on that with some evidence. There will be work going on, although none of it springs to mind. We can submit something on that after the evidence session.

The Convener: Thank you, Gabrielle.

We will move on to questions from Marie McNair.

Marie McNair: Good morning, panel—it is great to see youse this morning. Thanks for your time.

I welcome the commitment to the piloting of opt-out blood-borne virus testing in Scotland. The Terrence Higgins Trust has commented on its positive impact on increased diagnosis and reducing the length of hospital stays for newly diagnosed patients. What does the piloting of that testing involve for the patient, and what overall benefits does it bring? Is it a way to reach those groups who are more at risk of late diagnosis?

I pop that out to whoever would like to answer first.

Professor Estcourt: It is really important to look at evidence, wherever that is possible. To my mind, a lot of money and resource could be spent here with very little gain. Approximately 100 people are newly diagnosed with HIV per year in Scotland. That does not count people who have been diagnosed elsewhere and have moved to Scotland. That is a very small number of people, so either we will have to do an awful lot of testing or we will have to be very clever about the places where we offer testing and the people to whom we offer it. It is critical to be precise and to use evidence, wherever that is possible.

As part of a project funded under the sexual health and blood-borne viruses strategy, a group of people in my team are considering possibilities for interactions with the healthcare system by people newly diagnosed with HIV. Are there opportunities in people’s healthcare usage for earlier diagnosis of HIV if somebody suggests an HIV test? That is a really important question.

It is easy for us to get completely the wrong idea from anecdotes. I recognise that from when I am in clinic. I will get an impression of what the clinic population is like and of people’s infections, based on who I see, but that is not an accurate picture. Getting information in this area will really help us.

We could do a huge amount of testing in absolutely the wrong place at cost and with very little gain, so we need to be clever, and we need to consider the prevalence of HIV, very much in the way that England has done, which has been by stratifying into high-prevalence and low-prevalence areas. Even the highest-prevalence areas in Scotland—the major urban areas—have nowhere near the levels of the high-prevalence areas in England. We have to be careful about the resource that we are committing in areas where we think we will have very few diagnoses. There may be an argument for testing in those places, but that would be to reassure us that we are not finding new diagnoses. It is really important to get it right. It is important where we test and to whom opt-out testing is introduced.

The other question is what happens to the healthcare professionals. If I am in a busy accident and emergency department, organising the additional tests adds to my workload, even if most of that is done at laboratory level. If we never find a new HIV diagnosis, it is very easy for the box on the computer screen not to get ticked because I have too many other priorities. Therefore, these tests are not without cost, including to the health service and the individuals responsible, so we have to be very careful.

The evidence is coming. We will have evidence in about six months’ time, because we are analysing the data at the moment. Therefore, I would urge a bit of caution and say that we should proceed in high-prevalence areas, rather than implementing blanket opt-out testing.

10:30

Marie McNair: Are any other potential negatives that we should be aware of?

Professor Estcourt: I imagine that those would be largely related to resource.

Alan Eagleson: We know some things from opt-out testing in England, although I absolutely appreciate what Claudia Estcourt says—we are not England. However, for example, in higher-prevalence areas in Scotland, such as Greater Glasgow and Clyde, which is where the biggest percentage of people living with HIV are and where we would expect to see the largest number of new diagnoses, we would say that opt-out testing meets people where they are. That service is likely to see people who may not have any other touch point with the healthcare system.

That is potentially particularly relevant in Glasgow, given the history of the outbreak of HIV among people who inject drugs, particularly in the street homeless population. Just as an example of what we saw in England, in the first opt-out testing pilots there, 45 per cent of people who were diagnosed with HIV were of black African, black Caribbean or black other ethnicity. That is more than twice as many as the nationwide average of 22 per cent.

Gabrielle King: I echo what Alan Eagleson has covered. Opt-out testing is absolutely not something that we are necessarily asking for across Scotland, for some of the reasons that Claudia Estcourt has already outlined. However, it is one of a plethora of ways of finding people who are living with undiagnosed HIV and, in particular, it is a way of finding people who, due to a range of intersecting inequalities, might engage with A and E as their primary care or be frequent attenders. There is a correlation between people who are frequent attenders at A and E and those with HIV who might be lost to care.

On the negatives, do you want us to speak to the challenges yet or hold that for a later question?

Marie McNair: Feel free to come in now.

Gabrielle King: From our perspective, some of the challenges and concerns are around how the process of opt-out testing has taken place in Scotland. It has been very rapid. We absolutely welcome the announcement of opt-out testing in those three areas, but the process for expressions of interest was incredibly fast and the amount of money that was offered was not substantial enough to enable all health boards to take part.

For example, Great Glasgow and Clyde did not put in a bid. As I am sure that Nicky Coia will speak to later, that was partly due to the very short timeframe for expressions of interest as well as the short duration of the pilot scheme, which was only three months, and the available funding. The funding goes to lab costs but, as Claudia Estcourt touched on, that introduces real challenges, because there is no additional resourcing to support A and E staff who might be doing those tests.

Although opt-out should be as easy as possible, as we have already heard, there is a massive amount of stigma among health and social care professionals and misconceptions that need to be addressed, which requires additional training. The importance of that cannot be overstated. In the prison service and the criminal justice system, for example, opt-out testing for blood-borne viruses should take place but, actually, for a number of reasons, including training resource, that does not happen. Therefore, there is a risk in that regard, unless there is an investment in training alongside the testing.

As well as the investment in training, investment is needed in the additional support that people might need if they receive a reactive result for HIV—or for hepatitis, which is also screened for through opt-out testing. From people who we have spoken to and who we have sought to involve in the Lothian work around opt-out testing, we know that receiving a diagnosis in any setting often sweeps people off their feet when that might not be something that has even entered their minds. Therefore, it is important to think about additional peer support and what additional resources those people might need and to ensure that addressing that need does not fall only on already stretched services and the third sector.

Marie McNair: Does anyone online want to add anything?

Dr Howe: One of the positive aspects of opt-out testing is that it normalises testing for HIV, particularly in settings that might not be used to testing for it, such as emergency departments. However, I am not sure that that is the most efficient way to raise awareness of and normalise testing, particularly in really low-prevalence areas such as Highland, where we are doing one of the pilots. It will be interesting to see what comes out of that.

The Convener: When the series “It’s a Sin” by Russell T Davies was released, there was an uptick in HIV testing. Does our culture industry have a part to play in the matter to support the health sector?

Alan Eagleson: In the testing services that we offer at the Terence Higgins Trust across the UK, we see a direct correlation between any major storyline—for example, “It’s a Sin” or, more recently, one in “EastEnders”—and an uptick in HIV testing through postal and community services. Culture absolutely has a role to play in helping to normalise HIV.

The Convener: That is great.

We move on to questions from Paul O’Kane.

Paul O’Kane (West Scotland) (Lab): Good morning. In the opening remarks and through the conversation, we have spoken about PrEP, which it is important for us to consider further. The Scottish Government has been developing an online PrEP clinic, which would allow people to order the medication without having to go through specialists, as we heard. I ask the witnesses to provide an update on the progress of that.

Professor Estcourt: I will go back to basics, because I am not sure whether everyone is aware of what generally happens when people start on PrEP.

PrEP is an extremely safe medication, but there are some people for whom it might have adverse consequences, particularly in the west of Scotland, where we have a high proportion of middle-aged men who have pretty grotty kidneys that they might not know about. In the Greater Glasgow and Clyde service, 40 per cent of the people on PrEP require more than the annual blood test for kidney function.

Generally speaking, a patient will start on PrEP in a face-to-face visit when all of their other sexual health needs can be met. They will have a check-up for other STIs and be offered vaccinations to protect them against other infections. Their blood tests for HIV and other STIs will be repeated quarterly because there is often a group of people on PrEP who have a higher rate of STIs than others in the community. Once a year, everybody gets their blood tested to check that their kidneys are doing okay. That is a labour-intensive process.

In the Greater Glasgow and Clyde area, approximately 60 per cent of people on PrEP have very straightforward needs. They just need to be seen face-to-face once a year. Then, in between, if they were sufficiently amenable and would like to, they could take their own samples for HIV and other STIs at home and have them tested in the laboratory.

We proposed that they could do an online questionnaire-based medical consultation to check that it was still safe to continue with their PrEP prescription and to pick up whether they had started any new medication. It is important to know that, in a sexual health clinic, we have a completely different electronic medical record system. We are not like GPs. We do not know all of the medication that somebody is on. We just know what they report to us.

My team proposed to the Scottish Government that such a service would be a good development.

If I needed PrEP, I would have a text from my clinic saying, “Claudia, your PrEP follow-up is due. You are going to get a postal self-sampling kit for HIV and other STIs. Log on here. You can answer these health questions online. If your HIV test is negative, and there is nothing untoward, we will send you your PrEP in the post.”

The idea, initially, was to give a subsection of people who were digitally literate and were also quite good at self-managing a way of making PrEP part of their normal life, and doctoral work by Ross Kincaid on my team showed that the acceptability amongst people who were using PrEP, people who were thinking about it, and third sector organizations was really high. We thought, therefore, that the approach might create capacity in the clinic context for people with more complex PrEP needs.

What is very exciting is that, through work with colleagues sitting around the table and behind us, we are taking the mechanism further to see whether it could work for people who have particular barriers to attending sexual health clinics. In other words, we are looking to increase access for those people whom we have already talked about—that is, those who might be geographically remote, who might have stigma about attending services or who are not particularly digitally or health literate.

In fact, last week, we had a great meeting with my colleagues around the table, at which we talked about how we could work together with that prescribing mechanism, but with support from third sector organizations. For example, if I was not very good at doing my postal self-sampling, I could ask for help from THT, or if I was not very good at understanding the healthcare questions, I could go to a Waverley Care peer support worker. It is all about trying to take it into the community.

The work is going really well. Indeed, we have almost completed the first phase, in which we are testing how the health questions that we will ask online compare with the face-to-face consultation. We are just beginning work on the feasibility study, which will start later in the summer; in that study, we will offer something akin to this process to around 200 people using PrEP and then carry out an evaluation, including some early health economics evaluation.

Paul O’Kane: Thank you for that very comprehensive overview for the committee. Members might not always have been fully aware of the issues.

I do not know whether anyone else wants to add anything, but I was wondering, Dr Howe, whether you have a view on rurality and, say, the Highland area and the impact of this approach with regard to getting the service out more widely in a geographically challenging area.

Dr Howe: I am excited to see the developments with ePrEP, which I think will lead to better accessibility for a lot of the remote and rural health-literate population, and it might well reach some of the people who typically do not access traditional sexual health services. There is a particular subset of heterosexual-identifying men who have sex with men, who typically stay away from all health and sexual health services, but because this is online and quite depersonalised, they might feel that they have control over things. It might open it up to those people and probably others whom I am less aware of.

My only main concern is that swathes of the country do not have the kind of expertise within the health area to back up this approach or have the clinical governance oversight or, as I have said, the expertise to manage the complex issues that can occur. For example, Argyll and Bute does not have any specialist sexual health service, and I have already mentioned the Western Isles. Moreover, there are other parts of the country with only part-time expertise—say, one consultant for one day a week—but what if they have to take leave or whatever? There is that kind of part-time patchy cover to deal with, too. That is, I think, my main concern.

In summary, I think that the mechanism is going to be great for some populations, but there is concern about expertise and sexual health provision in certain rural areas of the country.

Paul O’Kane: That was really helpful, and you have, I think, raised an important point about capacity more broadly, and about building the capacity that will underpin these services.

In relation to harder-to-reach groups, Dr Howe mentioned people who feel inhibited to access PrEP for many reasons. I know that the Terrence Higgins Trust has looked in some detail at the transgender community, intravenous drug users, heterosexual men who have sex with men, and black and minority ethnic populations. How do we encourage greater access for those groups?

10:45

Alan Eagleson: There are a few things that we can do. We recognise that, for some people, it is not easy to access statutory sexual health services. We very much welcome the work that is being undertaken by Claudia Estcourt and her team, and we look forward to continuing the conversation about how the third sector can provide support.

That goes hand in hand with exploring how we expand access to PrEP through, for example, community pharmacies, primary care and improving the level of awareness of PrEP in communities that could benefit from it. We welcome the initial commitments to a PrEP pilot involving primary care in NHS Grampian, and we look forward to seeing how that develops. Alongside the ePrEP work, it is vital that any capacity or budget that is freed up in specialist sexual health services is redirected towards assisting those who are currently underrepresented in PrEP uptake to access it.

Gabrielle King: What I was going to say was very much in line with what Bridie Howe and Alan Eagleson have said. It is really important that, when we try to reach those communities, we use suitable culturally appropriate information and education on what PrEP is and the potential benefits of using it. That also applies to some parallel statutory services. For example, some work was done with people who inject drugs in Glasgow, and it was found that there was not a huge amount of awareness of PrEP and its benefits among health and social care professionals, so there were missed opportunities to align people who might benefit from PrEP with some of that work.

It is also important that we invest in members of the community who understand how that community works and the best way to talk about PrEP and accessing it. We should ensure that those people are used, valued and compensated for the work that they can do in going out to communities as PrEP champions.

Professor Estcourt: In relation to other places where PrEP could be delivered, we need to be really careful, because the groups that have been mentioned are all really legitimate, but they might have very different needs. We must be explicit in saying that the needs of somebody who injects drugs might be the same as or might be very different from the needs of a woman of black African origin, so we need to tailor the way in which services are delivered. The costs per capita of keeping somebody free of HIV might well also be really different, depending on which group the person comes from. That is absolutely fine, but we must ensure that the people for whom it is relatively cheap to use PrEP to keep them free of HIV for a year use the cheaper services, and that the more costly services are tailored to the groups who are not currently accessing PrEP. That raises massive challenges.

The devil is in the detail, but we do not need to dig very far. For example, when delivering PrEP in community pharmacies, there are massive structural barriers relating to drug costs, so the Government needs to make changes in that regard before that even gets a look-in.

The costs of a pharmacist conducting PrEP care probably exceed the costs of a nurse on a lower band conducting the care in a sexual health clinic. That is legitimate if the pharmacy reaches people who do not go to a sexual health clinic, but if the pharmacy is just providing a more convenient option for people who would go to a sexual health clinic, we are not running an efficient system.

The issue is really complex, so we need to think carefully across the whole economy about how we provide services to the right people in the right places while maintaining choice.

The Convener: That is a really interesting point.

Meghan Gallacher (Central Scotland) (Con): Good morning, panel. This has been an interesting and informative session. I thank you all for your contributions so far.

I will pick up on the theme of rural communities that has run throughout our discussion. I am interested in hearing about parity among health boards. It seems as though boards outwith the central belt are struggling, not only on tackling the stigma surrounding HIV but on the education aspect. I will put this question to Dr Howe first. Given your expertise, how would you suggest that we tackle and target health boards effectively, in particular if there are depopulation and recruitment issues?

Dr Howe: That is a difficult question. Much of the difficulty relates to workforce issues. For example, if you are the single consultant in your health board area, you have to deal with not only the clinical stuff but the governance, planning and protocol work that is heaped on you. Therefore making developments and sharing education with your colleagues in other areas often go way down your to-do list.

The past five years have brought in many additional factors, such as the Covid pandemic and monkeypox. Although health board areas with smaller populations have lower numbers of people, all the planning and protocol work still has to be done by that lone consultant. Therefore, although we are all enthusiastic, there is just a mountain of things to be done. Education is in there, for sure.

Recruitment is also a problem throughout our small specialty, and our training posts have been underfilled. Smaller and remote health board areas do not even have any training posts, which causes problems with recruitment. If someone has trained in a particular health board area, they are much more likely to take up a job there. If there are no training posts in a board’s area and no one is coming through, it will be less likely to recruit.

I do not have any big answers to those problems, but tackling recruitment and workforce issues must be part of a bigger solution.

Meghan Gallacher: As you said, training is a step into the profession, so that needs to be addressed. We can certainly raise that issue directly with the Scottish Government by asking how it intends to tackle it.

Finally, on the education aspect, how do we close the generational gap in having parity among schools, to ensure that younger people have a greater understanding of HIV and AIDS, which would help to eliminate stigma as we move forward through the generations? Is that being explored? How do we ensure that we are targeting rural schools so that we can have full parity across Scotland?

Dr Howe: I do not know whether that is being considered, but having a systematic approach to including up-to-date information about HIV will be key to addressing such stigma, whether it be done through schools, the secondary and higher education systems or the health and social care systems. It needs to be done systematically rather than by relying on individuals to move it forward.

Meghan Gallacher: Thank you. I am not sure whether anyone else is looking to come in, convener, but I am certainly finished with my questions.

The Convener: Thank you, Meghan. Gabrielle King wants to come in.

Gabrielle King: I very much echo what Bridie Howe has said. We welcome the consultation on the delivery of relationships, sexual health and parenthood education, which took place before Christmas—I want to say that that was in November, but I am not sure—and we look forward to seeing the results of that.

Part of the consultation was about the importance of ensuring that the approach to learning is consistent and that knowledge and information about HIV and sexual health more generally are up to date and challenge misconceptions from an early age. It was also about ensuring that teachers have adequate support in place to enable them to deliver that, recognising that RSHB might quite often be done alongside another job. The approach must also be consistent across all subjects, so that students who have been to an RSHB lesson and then go to, for example, a biology lesson do not get a very different message about sexual health and sexual wellbeing.

The Convener: Thank you—that was really helpful. Alan Eagleson, would you like to come in?

Alan Eagleson: Yes—very quickly. I would agree with all that. On the resources for teachers, consistent support across areas might be helpful. For example, in the health board areas where we are commissioned to deliver health improvement services, with a focus on blood-borne viruses and HIV in particular, we have specialist workers who support teachers to develop education materials and to have the confidence and the language to speak to young people. I do not believe that the picture across Scotland is consistent in that regard.

Annie Wells (Glasgow) (Con): Good morning. I have listened with interest for the past hour or so. The word “stigma” gets used a lot during our discussions on how we reach zero transmissions. Alan Eagleson said that the Terrence Higgins Trust supports a national HIV testing week and the publication of regular data. What is the background to that? Why are those two things important for the elimination of stigma? Do the other witnesses agree that we need to have a national testing week?

Alan Eagleson: First and foremost, as we have said already, Scotland is an outlier in the UK, as the other countries have a national HIV testing week. On its own, a national testing week is not an answer, but it certainly helps us to focus on wider public attitudes, to normalise testing and to increase awareness of HIV. For example, around 22,000 HIV tests are ordered online during HIV testing week each year in England. The week helps to normalise HIV testing, to raise public awareness of HIV and to find new cases of the virus.

Without consistent and comprehensive data, it is difficult to tell where we are in relation to stigma. We have already heard that we do not have robust data on stigma in rural areas versus urban areas.

Annie Wells: Does anyone else have an opinion on whether we should have an HIV testing week?

Professor Estcourt: They are great fun. I was involved in one in London and it was great fun. It was a huge amount of work. It was helpful to do that with healthcare professionals and to get across the message. We have talked a lot about structural stigma and institutional stigma, so it is very helpful in tackling that.

Realistically, in Scotland, we are likely to diagnose a number of people with hepatitis B and hepatitis C who may well not know that they have that infection. We will find some people who have HIV positive tests who already know that they are HIV positive. There will be a small number who know that they are HIV positive but have fallen out of care, and the test provides a good opportunity to re-engage them with care. People who have fallen out of care are likely to have detectable virus, so they may be at risk of passing on that virus.

When it comes to finding the people who have not yet tested for HIV and who have it without knowing that they do, we will pick up a very small number of such cases. If the Scottish Government chooses to go down the route of a national testing week, we should be very clear that we are not going to detect and newly diagnose an awful lot of people with HIV, so we need to be clear about what the aims are. As an exercise to reduce stigma, we also need to know how much it would cost and who would do it, because people in the health services cannot do this as well as their day job, and it will detract from other elements of their service and their work. We need to be clear about what the aims are of a national testing week, how any impact will be evaluated and where that sits within the bigger picture.

11:00

We are talking about destigmatising HIV, but we are really talking about destigmatising sex, which has been stigmatised in human culture since Adam and Eve, for those who believe in them. That fits within a much wider agenda that goes back to some of the previous comments about school and education, about sexual health and wellbeing and about good reproductive health. It is all part of a bigger picture. We tend to focus on our pet blood-borne virus or viruses, but we have to think about people, because this is all about people. We do not sit in isolation; we sit within a much bigger picture. We cannot crack HIV stigma in isolation. We have to think at the societal level about healthy sex and relationships and about what that means for individuals.

Gabrielle King: We absolutely agree that national testing week is not about identifying X number of new cases but about normalising HIV and about tackling the existing stigma. It is one of many different mechanisms that should be put in place.

We can look at delivery models from Wales and England. Wales does it through Public Health Wales in conjunction with charities, and the Terrence Higgins Trust is very involved in the national testing week in England. The week is about normalising testing and empowering people to be aware of their sexual health status, rather than about diagnosing, and it is one of a plethora of ways of tackling stigma.

Annie Wells: That is perfect.

Dr Howe, do you have anything to add?

Dr Howe: I agree with Claudia Estcourt that we are not going to increase diagnosis numbers and that that should not be the focus of a testing week, which should be more about raising awareness. The focus of the week would have to be on public health messaging and on getting the publicity right, rather than on trying to pick up numbers, because there will probably be very few. For example, there will probably be none on my patch. I echo what everyone else has said.

Annie Wells: I have one small question. I think that you have probably answered it, but do you have any suggestions there we have not spoken about already that would help to address stigma and to meet the target for zero new transmissions? Is there anything else that we have not touched on?

Gabrielle King: From our perspective, it is also important to have equitable provision of and access to testing. That might be through a national online portal, giving easy access to testing that people can access regardless of geography. I know that there is work at the moment with Public Health Scotland and I am sure that Kirsty Roy will speak about that during the next panel.

Related to that, we must ensure that we have comprehensive data about what stigma looks like across all the statutory services in Scotland. We know anecdotally that there are challenges in rural areas, as Bridie Howe has said. We should also really invest in education for staff working in those sectors. For example, the National AIDS Trust has produced an HIV confident charter, which supports organisations to have an accreditation that shows they have an up-to-date understanding of HIV and can work to support people.

There are lots of mechanisms to consider, but what is important is that those are properly resourced and funded.

Annie Wells: That is perfect. Thank you.

The Convener: That concludes questions to our first panel. I thank our witnesses for their evidence. There will be a brief pause while the witnesses change over.

11:04

Meeting suspended.

11:09

On resuming—

The Convener: Welcome back. This is the second panel in our witness session. I welcome Dr Dan Clutterbuck, consultant in genitourinary and HIV medicine, NHS Lothian; Nicky Coia, health improvement manager for sexual health, NHS Greater Glasgow and Clyde; Dr Kirsty Roy, consultant in health protection, Public Health Scotland; and, joining us remotely, Dr Daniela Brawley, consultant in sexual health and HIV, NHS

Grampian. I invite each of you to begin with an opening statement.

Dr Dan Clutterbuck (NHS Lothian): I thank the committee for the chance to speak. Briefly, I am an HIV clinician—that is my primary role. My other hats and involvements are that I was involved in the HIV transmission elimination proposal, which, as has been mentioned, was published in 2022; with Professor Nicola Steedman, deputy chief medical officer, I co-chaired a scoping group that sat a couple of times last year to propose a way forward on that; over the past six months, in Nicola's absence, I have chaired the HIV transmission elimination delivery plan short-life working group—my, that is a mouthful—to develop ways forward; and I work closely with the Scottish Government SHBBV team on the strategic work.

I will pick up briefly on comments that were made in the first session and will try not to repeat anything but instead expand on them a little. First, transmission elimination is possible. We need to hang on to that. Numbers are low: there were 77 newly diagnosed infections in 2021 and 108 in 2022. However, make no mistake: transmission elimination is not a given, for reasons that we might want to expand on. It is equally likely that we are at an inflection point and that there will be an increase in infections. I cannot comment on the relative likelihood of that; others may want to speak to that.

Secondly, we are falling behind other UK nations. That is not just a way to get leverage; it is a fact. What happened with PrEP was world leading. It is hard to overstate what an achievement that was and the credit that is due to everybody involved. An article led by Claudia Estcourt, which was published in a world-standard journal, concluded that we were one of the first places to show population-level reduction in HIV incidence due to the use of PrEP. That was driven entirely within and by the sector. There was no resource.

Thirdly, the previous panel addressed really well the issues of stigma, health inequalities and rurality, which are all dear to my heart and are of importance to people across the sector. Things are changing. Earlier, the discussion got into broader issues, which is a great temptation, but I think that we can say that the population is changing, as well as social aspects and the situation with regard to immigration, which is what makes it equally likely that we are at an inflection point rather than in a continuing decline.

Fourthly, even for people who are as long into tooth as me and have been in the sector for a long time, it is easy to forget that, in the 1980s and 1990s, HIV was the sector. At that time, HIV drove the co-working between patients, communities, advocacy services, the third sector and professionals that we now take for granted across health, which is an incredibly tight and small sector. It was not originally taken for granted, and HIV drove that change. It is important to note that we did it again with PrEP: the PrEP programme was driven by the community—admittedly, largely by one particular community, and we have some work to do in broadening it out. However, this time, we in the sector cannot do it without support. It is too complex. Professor Estcourt has touched on that. We should be under no illusions: achieving zero transmission is not going to be like PrEP.

Fifthly, the ambitions that we have stated—the words—need to be met by action. We cannot do that within the sector. It may be that we cannot do it within Government or even within Parliament. It may require a broader commitment, but we need to make that commitment.

11:15

Nicky Coia (NHS Greater Glasgow and Clyde): Thank you for the invitation to participate today.

I am a health improvement manager for sexual health in NHS Greater Glasgow and Clyde, and I co-chair the sexual health promotion specialist group, which brings together my colleagues on the other territorial boards to jointly plan and deliver some national-level interventions around sexual health improvement. Like Dan Clutterbuck, I was involved with several of the iterations of the development of the HIV transmission elimination proposal that he has largely been leading over the past year, and I was also the co-chair of the partnership group that developed the HIV stigma campaign last year into early this year.

All I would want to add at this stage is that, as Dan Clutterbuck has said, we have absolutely all the tools, and we can make this happen, but as far as addressing stigma is concerned, we could have the best tools in the world for eliminating new transmission of HIV, the best PrEP services and the best sexual health services, but if we do not do the work on stigma, certain communities and populations will just not access those services. It has to be part of what we do if we are to eliminate new transmissions of HIV in Scotland.

Dr Kirsty Roy (Public Health Scotland): Good morning, ladies and gentlemen. I am the consultant lead for STIs, including HIV, in the clinical and protecting health division of Public Health Scotland. In that post, I am responsible for the on-going monitoring and surveillance of the HIV epidemic in Scotland, and one of my key roles is to ensure that the data and intelligence from that monitoring and surveillance influence strategies and actions that address the burden of HIV. In that capacity, I will be supporting colleagues across the board, partners, and stakeholders in implementing the recommendations and actions of the proposed HIV transmission elimination strategy.

What else do I want to say? I would probably just say thank you very much for inviting me to give evidence for the committee's considerations. If you have any follow-up questions or queries that relate to my role in health protection or which go further into the public health responsibilities of Public Health Scotland, please do not hesitate to ask for follow-up information.

Dr Daniela Brawley (NHS Grampian): Thank you for inviting me to speak today and apologies for not being able to be there in person.

I am a consultant in sexual health and HIV in NHS Grampian. I am also the local HIV lead, and as part of that role, I am a member of the Scottish health protection network HIV clinical leads group, which I have co-chaired since 2023. In that role, I am also a member of the HIV transmission elimination iteration groups that have been in place since 2022 as well as the most recent implementation group, which is chaired by Dr Clutterbuck. My role is mostly a clinical one as a conduit between clinicians who provide care to people living with HIV but I also play a strategic role both locally and nationally.

As a way of adding to the description of my role, I would just reiterate some of the comments that have already been made by the panel. First of all, transmission elimination is 100 per cent possible; indeed, it has been seen in different parts of the world, with Sydney already saying that they almost approached it in 2023. However, as has been said, we need commitment and, most important, resource not just for sexual health services and within our sector but across the system. After all, the only way in which we can tackle this is through cross-system working.

Secondly, although our numbers have been reducing, we cannot be complacent. Post-Covid, the landscape has changed dramatically and we do not know how things will pan out in the next few years. That is where the data is really important.

Thirdly, although we have low numbers, we still have a significant proportion of late diagnoses, which have a massive impact on the individual as well as a costly health impact. If someone is diagnosed late and is in an intensive therapy unit bed for several weeks or months, that is a lot more for the health system to deal with than if they are diagnosed early, or if we prevent the infection with the preventative measures that we have at our disposal.

Last but not least, I reiterate Nicky Coia's comments that we cannot do any of this unless we properly tackle the stigma that unfortunately still exists around not just HIV but, as Professor Estcourt said, sex itself.

The Convener: Thank you. We will move on to questioning, and I will open the question session. We have spoken quite a bit about tackling stigma, which Dr Brawley just mentioned. I would like to get your personal viewpoints on why it is so important that we tackle stigma. I will go to Dr Clutterbuck first.

Dr Clutterbuck: We have heard an enormous amount of helpful information from colleagues on stigma, and Alan Eagleson gave some quotes. I reiterate that stigma remains a barrier to testing and to uptake of, and particularly retention in, care. We have national and international data, and a really helpful stigma survey is published annually. This week, I was looking at the 2022 figures for another reason, and they show that it remains the case that only about 50 per cent of people living with HIV in 2022 had disclosed that to friends and family or to workers. It is still the case that—this certainly chimes with my experience—around 10 per cent of people have disclosed to no one, apart from the person who provides HIV care. In many cases, that includes people's friends, family, partner, GP or anybody else.

Looking back to when I first started working in the area, I would not have anticipated the fantastic biomedical changes and the changes in prognosis, which have been much better than expected. However, no way would I have expected so little progress to have been made on stigma. I find it astonishing that we have made so little progress in that regard.

The Convener: I will bring in Nicky Coia.

Nicky Coia: Sorry, but can you repeat the question?

The Convener: I was just asking for your views on why it is important that we tackle stigma.

Nicky Coia: It is for all the reasons that others have eloquently described. Stigma affects every aspect of someone's life when they are diagnosed with HIV. It impacts on their mental health and wellbeing, and it affects their ability to enter the workplace or retain employment. For the individual person who is living with HIV, it is important that we address stigma. However, as I alluded to in my opening comments, if we want people to be well educated in terms of safer sex and to use and be able to negotiate safer sex, and if we want people to access PrEP and feel able to access testing at an appropriate level, we will need to address stigma, which very much acts as a psychosocial barrier to those interventions.

Dr Roy: It is difficult to add to what members have heard already today and to what Dan

Clutterbuck and Nicky Coia have just said. From a public health perspective, reducing stigma has an impact on our efforts to reduce transmission because, as a result, people feel more comfortable coming forward for testing and are more comfortable having conversations about risk reduction behaviours. Therefore, it is key that we have a compassionate and well-informed population in Scotland.

Dr Brawley: I reiterate the messages that have been given today. Stigma affects every aspect of the transmission elimination plan. It affects people’s engagement with prevention. If they think that HIV does not affect them or they feel that it is a stigmatising condition, they will not engage with prevention measures and they will not think that PrEP is for them. If somebody stigmatises HIV, they will not go for a test or accept a test. That will often cause challenges around treatment and care.

As Dan Clutterbuck said, people who are living with HIV often do not disclose that to their GP. That creates challenges for clinicians in managing that person’s care safely. They could have other comorbidities, issues and health conditions that we need to deal with. As Dan Clutterbuck said, it is really sad that we have not moved forward on stigma as much as we have on other areas of the sector.

Tackling stigma is important from an individual point of view, a service point of view and a clinician management point of view. Ultimately, however, it is important from the perspective of achieving transmission elimination. That is why we are discussing it today. Unless we tackle that issue, we will not be able to achieve that goal.

Maggie Chapman: Good morning. I thank you for joining us and for what you have said so far.

I want to delve a little deeper into stigma and how we tackle it. You all work within healthcare and work directly with colleagues in the national health service or associated professionals. What challenges, barriers and issues around stigma in health and social care do you see in your daily work? How can we unpick some of that?

As Dan Clutterbuck and others have said, for 20 to 30 years things have not changed as we might have wished them to change. There is something cultural there and, obviously, there is something structural within the profession, too. How do you envisage that changing? What do we need to change in the health and social care profession?

I will start with Dan Clutterbuck.

Dr Clutterbuck: I will leave the question why that is important and mention what we aspire to do as part of the delivery plan.

As Alan Eagleson mentioned in the previous evidence session, the stigma campaign for the wider population was a real win; it is wonderful to have some wins to report. We aspire to build on that with a tiered approach to education. That is not currently signed off or funded, but it is a well-developed idea in which many of the people who have given evidence have been involved.

Our hope is for the entire health and social care sector to have a basic level of knowledge. It might even be possible to go beyond that to other potential key influencers. We might think about nail bars and tattooists, or about other people with a social care background, for example. That would involve the real basics of the “undetectable equals untransmittable” campaign, or U=U. I hope that everyone here is familiar with that. I will not go into it, but it involves the availability of post-exposure prophylaxis and testing. We would build on that with more detailed information.

We have some really good materials for the health and social care workforce. Daniela Brawley and colleagues in NHS Grampian have produced a superb piece of work, and NHS Education for Scotland is developing more work.

One thing that we are not doing that might make a difference is mandating of training. My understanding is that Wales is considering doing that—in fact, I think that it is on the brink of doing it. We mandate transfusion training for clinicians across the NHS, for example, and it would not be out of the question to take that further.

11:30

Maggie Chapman: I will come to Daniela Brawley next. Dan Clutterbuck mentioned the training materials and resources that NHS Grampian has developed. Can you say something about how they are used? If you have an evaluation, can you say whether they have been successful in tackling stigma within the profession?

Dr Brawley: We have put together an e-learning resource that seeks to provide education on HIV and tries to dispel myths. It is aimed very much at health and social care staff. It is currently being used just among healthcare staff, but we are planning to reach out more to social care staff.

I do not have the figures for the evaluation to hand, but I am happy to share that information with the committee later. The informal feedback is that the resource has been very well received. People often say that they were not aware that things had changed so much.

My perspective is that, if an individual has experienced stigma within a health or social care setting, or if someone is not offered a test because it is felt that that is not indicated for that individual, it all comes down to a lack of education and training. That is where we need to use our resource. As Dan Clutterbuck said, whether we mandate that, with much better coverage, is up for discussion, but that is one approach.

There have been initiatives such as HIV Confident—which might have been discussed earlier today—through which organisations can be signed off as being HIV confident and as having awareness and understanding of stigma and of the initiatives around HIV that have been progressed.

Maggie Chapman: Thanks for that, Daniela.

I will come to Kirsty Roy. With regard to your public health role, how is stigma best tackled in terms of connection to communities and the professionals who work in communities?

Dr Roy: One of the challenges in trying to address stigma is that it is complex and multifaceted. We need to address attitudes, beliefs and—which is important—behaviour. We might have the knowledge, but using that knowledge to change behaviour is quite a different thing.

As Dan Clutterbuck has already mentioned, there is an expectation with regard to work on improving awareness and knowledge. It is important to realise that that must be on-going. There cannot just be a one-off effort: on-going work is needed, and it will take time to change behaviours.

We need to monitor stigma continuously, because that is the only way that we will see the change. If we do not see change, we might be able to identify activities that we need to do to address residual pockets of stigma.

Maggie Chapman: I will come to Nicky Coia. From your experience, and given the contact that you have had in working with so many different groups of medical and healthcare professionals around the country, what do you think would work that we are not doing, that we have not thought about, or for which we do not have a well-worked plan? On what Dan Clutterbuck has outlined, perhaps we just need the resources now. What are we missing in tackling stigma?

Nicky Coia: With regard to what is missing, I go back to what Dan Clutterbuck said. Let us take a step back, and think about the population-level YouGov survey that Alan Eagleson shared with us earlier. It showed that half of people said that they would be concerned to tell someone else that they were living with HIV. Those ideas among the general population are largely a reflection of who currently works in our health and care system. It is fair to say that, if someone does not work in the field of HIV, their knowledge of and education on HIV are probably not where they need to be.

One of the challenges that we face is that it is difficult to get staff released to attend any form of face-to-face training. Things like the e-module to which Daniela Brawley referred will therefore be helpful.

I am reminded that, about 10 years ago, in NHS Greater Glasgow and Clyde, we worked with our HIV patients to develop an anti-stigma campaign—at that time, it was a very local one—that was focused on our acute services. We did that because, as is still the case today, the health service is where people who are living with HIV experience most stigma.

We did that campaign 10 years ago, and Dan Clutterbuck is absolutely right to say that nothing has changed since then—we have not shifted the dial. At that time, we worked with patients to capture their experiences, and that was done in a very distanced way because of the nature of stigma. However, patients wanted to share their experiences with healthcare providers, and to say, “This is what I’m experiencing, and this is what’s wrong.” We now need to get to a place where we can think about what “good” looks like, and what good interaction consists of. It is basically about good patient care and what that looks like for people who are living with HIV.

We were able to shift the dial a little in a very short time with the little bit of campaigning work that we did at that point. We put on training and created resources, and we used the internal electronic communication newsletters and channels that we had. That shifted the dial a little bit, but if the campaign is not consistent and nothing follows it, it does not work. The approach needs to be continuous, and it needs to have depth and reach.

Training is part of that, but—as others have said—the general population campaign is just a baseline. I think that a campaigning approach is needed in the health and care system. It is not just about training; it is also about people’s testimonies and people saying, “This is not how I want to be treated, this is how I would like to be treated and this is what patient care would look like for me.”

When we in the partnership group developed the campaign, people living with HIV took part in a number of groups. I will share a quote from one of the groups. It is from a nurse who works in the healthcare system and is living with HIV. She said:

> “I’m a nurse and another nurse whispered to me about a patient ‘be careful with her, she has HIV’. I didn’t have the strength to tell her I do too. None of the nurses wanted to look after that patient.”

There are, in the health service, deep-rooted stigmatising ideas that affect patient care. I do not believe that most people choose to come to work to be unkind to our patients; in the health service, we are focused on doing the best that we can do. However, among most of our staff, we need to increase the level of knowledge of what good patient care looks like for people who are living with HIV.

Maggie Chapman: Thank you. You have clearly outlined why we need targeted action within the profession. As you said, however, the campaign is the baseline in the society that produces our healthcare professionals, so we need to look at that, too.

The Convener: We move to questions from Evelyn Tweed.

Evelyn Tweed: Thank you, convener—it took me a moment to unmute myself there.

It is lovely to see the panel. I thank you so much for your answers so far. I was interested to hear from Dr Clutterbuck and others that we in Scotland are starting to fall behind the rest of the UK. I am interested to know what you are all looking for from the long-awaited delivery plan. Do you have any concerns that you can share with us just now? What do you want to see in that plan? Perhaps Dr Clutterbuck can go first.

Dr Clutterbuck: That is an interesting question for me, because I have lived and breathed that plan for two years, so I hope that what I want to see in it will be in it.

The plan sets out realistic prioritisation of primary, secondary and tertiary interventions—to use the public health spiel. It is, of necessity, extremely utilitarian. It is the bare bones of a plan, because it has been done within the context of appreciating that we are in a very constrained sector with significant financial constraints—there is a lot of cutting the coat according to the cloth. I would be happy to expand on what is in the plan, because I am familiar with it.

One concern is that the plan remains unpublished. I have some insight into why that is the case. In short, it is probably because the constraints that we refer to—I hate to go on all the time about constraints; it would be nice to talk about some of the wins—exist at every level, including within the Scottish Government team, and there are other priorities and pressures. The capacity in the sector is very small.

My other concern, which has been alluded to, is that our collective ambitions are way beyond what we are realistically in a position to deliver, as things stand. Claudia Estcourt mentioned some numbers from the other home nations. That is a dangerous place to go and Claudia's figures were extremely low, but even if we talk about the publicly stated numbers that are available to us, the gap between Scotland and England is enormous and the difference is probably nearer to being a hundredfold than tenfold. It would be difficult to overstate that gap in the financial commitment.

We have worked positively within the constraints, but my concern is about a lot of the discussions, such as those about HIV testing week. There is nothing wrong with having an HIV testing week: it is not a bad idea and it would come at an incredibly modest cost and would not be an expensive intervention, by national standards. However, it does not cross our very high bar, in line with the difficult choices that we have made within the existing funding constraints.

One of my concerns is that, if our ambitions exceed our abilities, we will either not make any significant progress or—as Daniela Brawley said and, I think, I said previously—we might actually see a rise in new diagnoses. In the past ten years, there has in central Glasgow been a significant outbreak in a subpopulation of people who inject drugs; we might see another significant outbreak in a particular vulnerable population.

Marie McNair: Good morning, panel, it is great to see you. I will go back to questions about the pilot of opt-out blood-borne virus testing in Scotland. The Terrence Higgins Trust made a comment about the positive impact that that is having on increased diagnosis and on reducing the length of hospital stays for people who are newly diagnosed. I was also heartened to read about the positive data on that from Croydon university hospital, which found that, when it first started opt-out testing, the average hospital stay was 35 days, and it is now 2.4 days.

Let us come back to talk about Scotland again. To help us to learn a bit more, can you talk us through what the pilot involves for the patient and what the overall benefits are? I will pop that question to you, Dr Clutterbuck, because I really like your name.

11:45

Dr Clutterbuck: I am pretty universally known as Dr Dan, and I am very happy for anybody to use that. My mum does not call me that, but pretty much everybody else does.

Some of the benefits of opt-out blood-borne virus testing have already been covered. There is an enormous benefit to normalising it. There is a discussion to be had about that; we have already had a fruitful and interesting discussion. Claudia Estcourt gave a brilliant overview, from a public health academic's perspective, on what the interventions should be, and Kirsty Roy has great expertise. We have had some healthy discussions.

However, the baseline is that we simply do not know whether opt-out testing or a seroprevalence testing study is the way forward. The essential difference is that if we do opt-out testing, we can find people with infections and we can treat them, whereas seroprevalence testing is not linked to individual patients, which means that we could understand the rate of infection and prevalence, but we would not actually be intervening.

The other thing about opt-out testing that has not come up yet is that—if we take the English example—the biggest number of infections is in cases of hepatitis C and hepatitis B. That is a significant number. There are more than 100 cases, and that is only in the sentinel sites; we do not know the overall number. There are possibly several hundred HIV infections, but there are also many cases of hepatitis C and hepatitis B. From a Scottish perspective, there is an even greater urgency for hepatitis C elimination. Members will be aware that the target for its elimination is 2025, which is very imminent.

Opt-out testing is likely to diagnose significant numbers of undiagnosed hepatitis C infections. To look at the matter from an HIV perspective is to make a slightly false distinction, because the processes are all in place, with the benefits of diagnosing hepatitis C and adding in an HIV test. Again, we could argue about the laboratory costs, but those really are not a massive deal.

To broaden this out, I say that many of the issues—in particular, around stigma—apply to hepatitis C, although the level of awareness about hepatitis C is probably even lower. On the benefits, if we make things routine and systematic, they tend to work better.

Another option that we are exploring is indicator condition-based testing, which is of great interest to me. That involves improving the offer of tests when people have a condition that might be associated with HIV. Frankly, we have been trying to do that for 30 years. We want to be able to do it better, but any time we depend on clinicians adding a test is difficult, and any time we do not, it is easy.

However, as Claudia Estcourt described very eloquently, if we are doing a very large number of tests for a small number of diagnoses, we clearly have to consider the financial implications. We are not quite clear exactly whether the right route in Scotland is opt-out or seroprevalence testing for sentinel monitoring, but actually it has not become an issue. Again, as Alan Eagleson pointed out, we have commissioned just tiny pilots. That is not to diminish the effort and work that have gone into them—they are fantastic things to do—but they will not answer the question for us.

Marie McNair: Thank you for that. It was really helpful. Does anyone else want to come in?

Dr Roy: Opt-out testing can be a proactive approach to diagnosing infected individuals, but as you have heard, it is affected by prevalence. Given that Scotland is a very low-prevalence country, we are unlikely to diagnose individuals through the opt-out pilots, because the likelihood is that the pilots are too small. That said, what they will show us is that the approach and its principles can work, so they will be helpful in proving that you can implement and run schemes, and they will also highlight any barriers. As you have heard, it might be challenging to actually roll out opt-out testing in the kinds of busy environments that we are talking about.

The pilots will have other benefits. Again, as you have heard, diagnosis of hepatitis B and C will be more likely, and the pilots will also go some way towards addressing stigma in relation to healthcare professionals in that environment and the patients who come into that setting.

Undoubtedly, the pilots are costly endeavours to run. However, when we are dealing with resource restrictions and are having to prioritise, normalising HIV testing and making it routine throughout healthcare will have many benefits. It would, for example, address stigma across the wider healthcare setting and the wider population. We need to address stigma, educate people and, as a result, improve the offer of testing as well as improve acceptance of the offer of testing among the wider population who come into contact with the service.

Marie McNair: Thanks. Those comments were really helpful. If no one else wants to come in, I will just hand over—[*Interruption*.] I am sorry. I will bring in Dr Brawley, who is online.

Dr Brawley: I just want to add that in NHS Grampian we are leading on one of the pilots. Obviously, we do not have data, because we are still in the middle of it, but we will be happy to share data with the committee and the wider sector once we get it.

As Dan Clutterbuck said, we still do not know whether we are going down the right road. However, we have seen the success of opt-out testing in, for example, maternity services and sexual health services. There is some background data to look at from those.

I go back to the point that what we are seeing, not just locally within my area but across Scotland, is that there is quite a significant number of late diagnoses. Diagnosing people earlier has a cost-saving aspect, which has to be balanced and taken into consideration when we look at the cost and benefit of opt-out testing.

The last thing to say is that the opt-out testing project that is being run in a couple of board areas and in Grampian is within emergency medicine departments. Because they are often where various populations present who do not have good access to other parts of the healthcare system, the project will focus on people in the priority groups who are most at need. Such issues being looked at, as well as stigma and education for the clinicians who are part of the pilots, is a positive outcome, as is the fact that infections will be picked up through the pilots.

Marie McNair: Thank you.

The Convener: We move on to questions from Paul O'Kane.

Paul O'Kane: Good morning. In the first evidence session, I was particularly interested to hear about PrEP and to hear people's views on the progress of the online clinic proposals. There are wider views about how that online service could enhance the reach of PrEP. We will go on to talk about people who still feel excluded from PrEP or who face stigma.

Who wants to come in first, with an overview?

Nicky Coia: On the populations to whom we struggle to get PrEP, Professor Estcourt described very well in the earlier evidence session that sexual health services are appropriate for some parts of the population, but we know that for some other parts of the population where the prevalence of HIV is likely to be higher, those services are not an optimal location. The ePrEP work and some other work that is coming alongside the implementation plan, on changes to prescribing guidance and exploring other service delivery locations, will be helpful for parts of those populations.

As others have said, PrEP has been an absolute game changer. It has reduced our overall HIV numbers every year since it was implemented in 2017, but it will not necessarily be the solution for everybody in HIV prevention. I want to flag up that although PrEP is at the centre of our primary prevention strategy, other tools are absolutely needed in the toolbox. For other population groups, it is about education and, for example, making sure that anyone who wants to use condoms can access them.

I am from Glasgow, where we had an outbreak among people who inject drugs, so we must also make sure that we still have the more traditional methods, including clean and safe injecting equipment. The safer injecting facility will be a helpful element of that.

We need to work in co-production with the population groups that can most benefit from expanded provision of PrEP, but we also need to be mindful that primary prevention is not just about PrEP. We need to make sure that a range of other primary prevention approaches are still in the mix.

Paul O'Kane: Does anyone else want to comment on either of those issues?

Dr Clutterbuck: Professor Estcourt eloquently described the PrEP pilot. I am optimistic that it will offer us benefits, primarily in efficiency and releasing capacity, which will be very welcome. As has been said, the idea that it might offer access to people who are affected by stigma and who want anonymity is exciting. I think that, in reality, much of the population benefit from HIV reduction through PrEP has already been achieved. That is not to say that there is nothing more to be done, but in relation to the highest-risk individuals, much of the benefit has already been achieved. The things that come alongside that will be important.

Let us hope that the e-PrEP feasibility study is a success. There is every reason to expect that it will be, and it seems to be progressing well. Let us hope that we can move to implementation in existing services, although there will be a question about resource.

12:00

Nicky Coia also spoke about some of the things that go on in parallel with that, in terms of different ways of looking at PrEP for different populations, and in terms of simplification, so dosing is probably where we have more to gain. However, as Claudia Estcourt described quite eloquently, some interventions that involve groups with the greatest disadvantage or the most intersectionality—whatever phraseology you want to use—are often the most resource intensive.

As a note of caution—I seem to come up with caveats every time—I note that, in the current environment, we cannot make the assumption that resource that is released from the ePrEP pilot will go into other PrEP delivery because, in sexual health services, we are all in a very constrained environment in which we are looking at cutting services. Therefore, when we make the case—however compelling it is in this room—for redirecting resource savings that are generated by ePrEP into, for example, PrEP outreach, that will not get a sympathetic hearing from the boards.

Paul O'Kane: That is useful for us to hear, following the earlier conversation. It is something for the committee to consider.

Dr Brawley: Dr Clutterbuck has mentioned some of the comments already; I was not fast enough on the keyboard to come in.

I want to reiterate that the ePrEP pilot is extremely welcome. It will help those who struggle with regard to acceptability of services. It might also help with capacity, although I say that with the caveats that have been mentioned. However, people need to be aware of PrEP before they can use ePrEP, so there is work to be done on education and awareness. That is where some of the very early exploratory work on pharmacy and primary care—and where that might sit in the context of PrEP delivery—comes in.

Large groups of individuals would benefit from PrEP but do not access sexual health services and do not know about PrEP. The only way we will get the messages out there is by widening access, as we did years ago with regard to different types of contraception that were accessible only in sexual health services at the time, but are now accessible in pharmacies and primary care services. However, that will require resource, especially in pharmacies and primary care services, as well as in sexual health services. We will not be able to expand PrEP access and offer it outwith specialist services unless there is resource behind it. We must bear that in mind if we are seeking to widen access to other populations.

Annie Wells: Good afternoon. We have been here that long that it is the afternoon. I know that you were here when I asked the previous panel of witnesses about a national HIV testing week for Scotland and the regular publication of data. From what I heard earlier, the general consensus is that although such a week would highlight the need for people to get a test, it would be resource intensive for the results that we would get—I do not mean that it would not be worth while. On the publication of data, we all agree that we need to collect data.

What else can we do? We have talked about education and working with health professionals to tackle stigma. Having been around in the 1980s and 1990s, I can say that, at that point, I thought that there was a very clear message. We got to the stage of saying, “This is what it is. It’s no gonnae affect you. It’s no gonnae hurt you.” However, I am in my fifties and I know people my age who are HIV positive who still suffer from that stigma. They still do not want people to know. They feel that they are the problem, but it is not them. How do we challenge that stigma? Can we bring anything new to the table to deal with stigma?

Nicky Coia: You have touched on the multifaceted aspect of HIV stigma. We have talked about stigma in quite general terms today. I do not have an easy answer to the question, but it is probably helpful to think about stigma in a few ways. For people living with HIV, there is self-stigma—I think that you were alluding to that in relation to people you know. People who are living with HIV often expect an adverse reaction and withhold information.

It is really interesting. Everybody in this room probably knows somebody or has a family member or friend who has adjusted to some kind of change in their health—they might have some sort of long-term condition. When you have a long-term condition, you look to your loved ones for support. However, for people living with HIV, that support is sometimes not available because of the self-stigma that plays out.

Again, I do not have easy answers, but there is a particularly tricky layer that we need to focus on. It sits between the population level and self-stigma, and it affects the communities that experience or acquire HIV most often: gay and bisexual men, other men who have sex with men, and people who have arrived in Scotland from countries with a high prevalence of HIV, especially those in southern Africa. A lot of the stigma that people who inject drugs experience comes from within their own communities. The examples that we included in the film that is part of our campaign were drawn from the genuine stories of the people with lived experience who contributed. The issue affects those sub-populations, if I can call them that. We need to do much more targeted work in those communities, as well as the work with the broader population.

We need to build on the first year of the campaign. I would like there to be more focused work. We delivered the campaign to those particular population groups in a focused way through social media, but we need to build on that message. We need to expand our anti-stigma work into the health and care system, because when we ask people where they want things to change most, they talk about the health system. There should be a greater focus on the health system and more targeted work in communities.

Dr Roy: From a Public Health Scotland perspective, we see our data as being really important in guiding where some interventions could be targeted. Historically, the HIV data that is published annually is broken down by age and gender. Breaking data down further would give insight into whether certain marginalised sub-groups of the population are not accessing testing. However, there is a risk with that. We must strike a balance, because we do not want to inadvertently cause more stigma by identifying sub-populations.

PHS recognises that there are data gaps. We are working to strengthen the surveillance systems that we have in place, and we are expanding the number of indicators that we can share with our partners and stakeholders so that that information can inform local planning. We have an annual publication, and we are looking to develop an interactive dashboard. Initially, it will include only management information for our local health board colleagues to support their planning, but, over time, we would like to have a public dashboard that will provide transparency in our data reporting and show, I hope, progress towards reaching HIV transmission elimination in Scotland.

We cannot promise to provide all that overnight. Like elsewhere in the health service, we have limited capacity. Public Health Scotland is slightly on the back foot in relation to reporting data, because my entire team was pivoted to support the Covid response and we have not yet filled all our posts. We are at the challenging stage of having to prioritise where we focus our surveillance activities. Unfortunately, timelines have been longer than planned.

Annie Wells: Thank you very much. I look forward to seeing how the interactive dashboard works out.

The Convener: That concludes our business in public. I thank the witnesses for their attendance.

12:11

Meeting continued in private until 12:37.

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