COVID ACTION SCOTLAND

Scottish Parliament Election 2026

Manifesto asks: Background briefing

The following asks were developed through co-production with participants at an online public event hosted by **Covid Action Scotland** on 19th July 2025. A letter setting out the asks with supporting information was then sent to the main parties, with the aim of informing the development of their manifestos: https://covidactionscotland.org/2025/08/09/letter-to-political-parties-ahead-of-scottish-elections/ . This briefing provides some further background information and links to supporting evidence.

The first ask draws attention to the extent of serious long-term effects on health of Covid-19 infection and knock-on consequences for society. The remainder say more on the nature of risks, what needs to be taken to mitigate them and which groups and settings are most impacted.

Covid Action Scotland is a community group of volunteers from different backgrounds united by a commitment to action to reduce the ongoing devastating impact of the Covid-19 pandemic in Scotland. See our website for further information: https://covidactionscotland.org/ . To get involved or join our mailing list please email: zerocovidscotland@gmail.com . You'll also find us on Bluesky and X.

ASK 1: Acknowledge that Covid-19 reinfections cause serious long-term effects on health and advise the population on the need and means to minimise infection risks

Covid-19 is not just an acute illness, nor is long-term damage to health only expressed as Long Covid.

- There is an ever-increasing body of evidence that repeated reinfection with Covid-19 increases the likelihood of long-term damage to health, including Long Covid. This was one of the first major studies showing the increased risk of damage from reinfection: **Acute and postacute sequelae associated with SARS-CoV-2 reinfection,** https://www.nature.com/articles/s41591-022-02051-3 , 10/11/22.
- There is a database of approaching half a million studies related to the wide range of adverse long-term, cumulative impacts of Covid infection: **LitCovid: A literature hub for tracking up-to-date scientific information about the 2019 novel Coronavirus,** https://www.ncbi.nlm.nih.gov/research/coronavirus/.
- Here you'll find hundreds of studies showing how Covid-19 infection is linked to heart attacks and strokes, brain damage, cancer, diabetes, kidney damage, arthritis, visual impairment and so on. It can reactivate dormant conditions including Epstein-Barr and Shingles. Of particular importance is how it damages and dysregulates the immune system, making it harder to fight off other infections.
- It's therefore unsurprising that tracking the incidence of many different illnesses, NHS pressures, labour market inactivity and school absences due to sickness, disability benefit expenditure, etc, etc, all show a step-change compared to pre-pandemic, with similar trajectories soaring upwards (e.g. see: https://threadreaderapp.com/thread/1982148726241005771.html, https://threadreaderapp.com/thread/1979554526131822820.html?utm_campaign=topunroll; https://x.com/_CatintheHat/status/1983131103465517539,
- Public health information about risks and mitigations, so people are empowered to manage and mitigate their individual risk where they can, and are protected from airborne infections where public, collective action is required.

Ask 2: Require and invest in clean indoor air

If there was one thing governments could do to significantly improve public health and thus reduce pressure on the NHS, labour market inactivity due to sickness, work and school sickness absence rates, and disability benefit expenditure, it would be to address unsafe, unhealthy indoor air.

Action to address outdoor air pollution is clearly important. However, air pollution does not stop at the front door. Distinct forms of pollution and allergens are generated indoors, and airborne infections like Covid and flu that accumulate in the air like smoke, are overwhelmingly spread indoors. That is why action to clean indoor air too is so important for health, through dilution, filtration and sterilisation. Each have a role to play. Ventilation (dilution) alone will never be enough if outdoor is also polluted.

There is a great deal of action for healthy indoor air across the globe and the UK, with rapid advances in technology bringing business opportunities too. Access to healthy indoor air is increasingly being positioned as a human right. Yet in Scotland policy solutions seem not to go beyond advice to open a window. Infection Prevention Control completely ignores it other than in relation to a handful of specified procedures.

Global/ international action includes:

- The Global Commission on Healthy Indoor Air that I'm a Commissioner for: https://resources.wellcertified.com/press-releases/global-commission-on-healthy-indoor-air-launches-at-the-united-nations-to-drive-action-to-improve-indoor-air/; https://www.wellcertified.com/global-commission
- Healthy Indoor Air: a global call to action: https://www.airclub.org/ and see pledge positioning this as a human right
- The Safer Air Project in Australia which has done some amazing work, including parliamentary, etc: https://www.saferairproject.com/
- The WHO has issued guidance: World Health Organisation: Indoor airborne risk assessment in the context of SARS-CoV-2 - Description of airborne transmission mechanism and method to develop a new standardized model

for risk assessment (2024), https://iris.who.int/bitstream/handle/10665/376346/9789240090576-eng.pdf

- UN Committee on the Rights of the Child, General Comment 26, 2023: "The places where children learn should be safe from environmental harm": https://www.ohchr.org/sites/default/files/documents/hrbodies/crc/gcomments/gc26/2023/GC26-Child-Friendly-Version_English.pdf

Priority settings for action are health and social care, and schools. Action down south on schools includes:

- **Supporting Healthcare Heroes:** https://shh-uk.org/making-the-invisible-risk-visible-indoor-air-quality-is-a-priority/
- **Safe Air Schools UK:** Improving air quality inside schools for inclusive sustainable equitable education: https://www.safeairschools.org/
- **Clean Air for Kids:** https://www.cleanairforkids.co.uk/
- **SAMHE Schools Air Quality Monitoring for Health and Education:** https://www.samhe.org.uk/
- https://www.london.gov.uk/mayor-invests-ps27m-air-quality-filters-schools-clean-air-classrooms

Ask 3: Commit to stopping hospital and other healthcare-acquired infections:

Lack of action on healthy indoor air, very little mask-wearing, no routine testing for often asymptomatic Covid-19, the fact people will be there precisely because they're ill with airborne infection, all add up to making hospitals and healthcare settings among the most risky places to be.

- Wales is the only UK country that tracks hospital-acquired ('nosocomial') Covid-19 infection. See: https://x.com/gwladwr/status/1981028314077634922 for regular updates on the latest figures from Public Health Wales. Typically, around 75-85% of inpatient Covid cases in Wales are the result of hospital-acquired SARS-CoV-2 infection. Scotland stopped measuring this a couple of months before

masking requirements were removed in health and social care settings (May 2023), making it impossible to track the impact of removing mask requirements on the extent of hospital-acquired infections.

- Some of the worst disinformation has come from the anti-mask lobby on social media - but also from supposed experts who either do not understand or refuse to accept that different kinds of masks protect against different modes of infection transmission. Fluid Resistant Surgical Masks protect against fluid-spread infections and respiratory masks against airborne infections. Research into mask efficacy too often uses methods for testing clinical treatments not equipment, which is what masks are. Studies often don't account for whether masks are properly fitted, the fact infection can happen anywhere and whether used consistently. See
- Studies show the great extent to which people who are clinically vulnerable and people with Long Covid have disengaged from healthcare services. A poll by Clinically Vulnerable Families In March 2024 found that 98% of respondents feel healthcare is unsafe (March 2024, 534 Clinically Vulnerable people). On Long Covid see https://www.alliance-scotland.org.uk/blog/news/accessing-long-covid-services-in-scotland-to-be-believed-listened-to-and-supported/
- This petition sets out key actions needed to make healthcare safer from airborne infections. See submissions for further details: https://petitions.parliament.scot/petitions/PE2071
- People working in healthcare (and social care) have experienced particularly high incidence of Long Covid. See https://spice-spotlight.scot/2023/02/08/long-covid-where-are-we-now/; https://shh-uk.org/ (see #SafeAir4All campaign); https://covidactionscotland.org/2024/05/12/lasting-harm-the-impact-of-long-covid-on-scottish-health-and-social-care-workers/

Ask 4: Increase infection monitoring and support testing:

Testing is crucial for data collection. Without it how can you reliably know what the prevalence is, and take preventative action? How can you identify and treat

illness appropriately, and protect others? How can you track whether subsequent bodily damage, illnesses and deaths originate with Covid infection?

- Collecting and publicly disseminating much **better data** is essential for individuals, healthcare, schools, etc to be able to manage risk. This should include data on current infection prevalence (see https://jamestindall.info/skeuomorphology/ladb_covid/index.html and wastewater monitoring: https://scotland.shinyapps.io/phs-respiratory-covid-19/), the wide range of often hidden long-term damage that can be caused to health, that likelihood is increased with reinfection, the number of people experiencing long-term impacts and hospital-acquired infection.
- There is no routine testing in hospitals for Covid on admission, yet even the National Infection Prevention and Control Manual states: "Individuals are infectious around 2 days before symptom onset to 10 days after." https://www.nipcm.scot.nhs.uk/a-z-pathogens/#s .
- Estimates of the extent of asymptomatic or pre-symptomatic infection generally range from 20-45%. For obvious reasons, this is not straightforward to gauge – particularly without methodical testing.
- There is no obligation on health and social care workers (or anyone else off sick) to test before returning to work, even though they may be working directly with highly clinically vulnerable people and without wearing a mask.
- Governments have responded to concerns about rising sickness absence rates at schools by strongly urging parents to ensure children return to school even if not fully recovered, thereby guaranteeing the spread of infection and further sickness absence.
- It is no longer a requirement to carry out routine asymptomatic testing on discharge from hospitals into care homes: https://www.publications.scot.nhs.uk/files/cmo-2024-06.pdf

Ask 5: Commit to an independent Scottish approach to vaccines, based on science:

Scotland has devolved power over healthcare. It is under no obligation to follow JCVI advice. To do so is a political choice. As such, Scottish Government

needs to explain and be accountable to parliament and the Scottish people for that choice particularly because JCVI advice directly contradicts evidence.

- JCVI advice is much more restricted than World Health Organisation guidelines: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/covid-19-vaccines/advice
- Eligibility for Covid vaccine is even more restricted than in Trump's America.
- Scottish Government has acknowledged that not vaccinating is a false economy: "Primary prevention is 3-4 times more cost-effective than investing in treatment. The return on investment (ROI) for £1 invested was £34 for health protection (for example vaccines and immunisation)" https://www.gov.scot/publications/scotlands-population-health-framework/pages/6/
- Many groups repeatedly proven to be at high clinical risk are excluded from NHS eligibility. The only option is to pay up to £100 – when the JCVI costs vaccine and delivery at £25.
- 'Willingness to pay' appears to have been factored into cost/ benefit calculations for who should be eligible for NHS vaccine https://www.sciencedirect.com/science/article/pii/S0264410X25002452 This is discriminatory, it will increase health inequalities and undermines the founding principle of the NHS that healthcare should be free at the point of use, based on need not ability to pay. We all already pay via taxes.
- The basis for JCVI's cost/ benefit analysis is fundamentally flawed, in that it looks at acute hospitalisation and death only, not at Long Covid or other long-term damage from the virus (see Ask 1), nor at or the resulting wider impact on public health, NHS Scotland's capacity, labour market inactivity and work or school absence due to sickness, and other social and economic impacts: https://actionnetwork.org/petitions/follow-the-science-on-covid-vaccines-broaden-eligibility
- Despite ever-more abundant research evidence that repeated Covid reinfection damages and dysregulates the immune system, that any immunity from infection is short-lived, that the virus continues to evolve into immunity-evasive variants, there is an unfounded assumption that much of the population already has immunity. This is not supported by evidence.

- There is now evidence that vaccine not only protects people from severe acute illness but also from Long Covid: https://www.ecdc.europa.eu/en/news-events/covid-19-vaccination-reduces-risk-long-covid-adults

Ask 6: Commit to support and treatment for people with Long Covid:

People are continuing to get Long Covid due to the fact that any attempt to prevent infection spread has been abandoned. Long Covid is typically a chronic illness of multi-system damage and dysregulation.

- It is unknown how many people in Scotland have Long Covid as data is not systematically collected, very few people test so tracking back to that source is problematic, and medics generally don't understand anything much about Long Covid as a physical illness. How can Ministers claim to be taking Long Covid seriously if they don't even know how many people have got it, trajectory, etc?
- Long Covid seems to have overtaken asthma in the UK as the most common chronic childhood illness: https://www.msn.com/en-us/health/other/why-are-so-many-children-getting-long-covid/ar-AA1Gq5vQ
- Almost one in ten people in England think they have Long Covid: https://www.southampton.ac.uk/news/2025/03/nearly-one-in-ten-unsure-if-they-have-long-covid.page
- Despite the public previously being told that Covid doesn't affect children, Long Covid affects up to 10% to 20% of children with a history of COVID-19. With almost 6 million US children potentially affected, this is higher than the number of children with asthma, the most common chronic health problem in children: https://jamanetwork.com/journals/jamapediatrics/fullarticle/2834486 .
- Scottish Government has committed £4.5mn recurrent funding per year for Boards to deliver services for Long Covid and ME. This is welcome. However, even based on figures available (which are likely to be a significant under-estimate), that works out as around just £7 per person.

- The emphasis for services is heavily on rehabilitation and self-management. But there is a desperate need for research into clinical treatments too.