


CURRENT CONTROVERSIES

COVID-19 restrictions should only be lifted when it is safe to do so for Aboriginal communities

Paul A. Komesaroff ¹, Donna Ah Chee,² John Boffa,² Ian Kerridge³ and Edward Tilton²¹Monash University, Melbourne, Victoria, ²Central Australian Aboriginal Congress, Alice Springs, Northern Territory, and ³University of Sydney, Sydney, New South Wales, Australia**Key words**

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CorrespondencePaul A. Komesaroff, Monash University, Melbourne, Vic., Australia.
Email: paul.komesaroff@monash.edu

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Abstract

The NSW Government has proposed a blanket lifting of COVID-19 restrictions when the proportion of fully vaccinated people rate reaches 70% of the adult population. If implemented, this would have devastating effects on Aboriginal populations. At the present time, vaccination rates in Aboriginal communities remain low. Once restrictions are lifted, unvaccinated people will be at high risk of infection. The risks of serious illness and death among Aboriginal people from a variety of medical conditions are significantly greater than for the wider population. This is also the case with COVID-19 in First Nations populations around the world. The vulnerability of Aboriginal people is an enduring consequence of colonialism and is exacerbated by the fact that many live in overcrowded and poorly maintained houses in communities with under-resourced health services. A current workforce crisis and the demographic structure of the population have further hindered the effectiveness of vaccination programmes. Aboriginal organisations have called on state and federal governments to delay any substantial easing of restrictions until full vaccination rates among Aboriginal and Torres Strait Islander populations aged 16 years and older reach 90–95%. They have also called for additional support in the form of supply of vaccines, enhancement of workforce capacity and appropriate incentives to address hesitancy. Australia remains burdened by the legacy of centuries of harm and damage to its First Nations people. Urgent steps must be taken to avoid a renewed assault on Aboriginal and Torres Strait Islander health.

While many people in Australia are looking forward with hope and optimism to the nation reopening after its COVID-19 lockdowns, many others are approaching this prospect with dread. This is because a blanket lifting of restrictions when the proportion of fully vaccinated people reaches 70% of the adult population¹ will have devastating effects on indigenous and other vulnerable populations.

The first year of the pandemic was, in many ways, a triumph for what can be achieved in a country whose history of colonisation has led to systemic inequity and

disadvantage. By March 2021, fewer than 100 Aboriginal people had become infected by COVID-19 and not a single one had died of the disease. This was the result of strong indigenous leadership, especially from the Aboriginal community controlled health services sector and land councils, decisive action to restrict travel and isolate communities, and co-operation between governments and Aboriginal community controlled health services, leading to the establishment of the Aboriginal and Torres Strait Islander Advisory Group on COVID-19.

However, ongoing protection of communities still vulnerable to the pandemic required continuing, sustained and collaborative action to redress inequities, support under-resourced health services, build capacity (including the ability to deal with surges in infections) and implement vaccination strategies. Despite warnings from Aboriginal community controlled health services and other Aboriginal organisations, this failed to happen.

An earlier, shorter, version of this article appeared in *The Conversation* on 16 September 2021; see: <https://theconversation.com/vaccinations-need-to-reach-90-of-first-nations-adults-and-teens-to-protect-vulnerable-communities-167800>.

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Aboriginal people, who were supposed to have been prioritised in Phase 1B of the vaccination strategy, simply were not vaccinated at scale.

When the most recent delta variant COVID-19 outbreak began, in NSW and subsequently in other states, vaccination rates in indigenous populations were extremely low. This is a problem because once restrictions are lifted low vaccination rates are likely to translate into high rates of infection in unvaccinated groups. International data show that under such circumstances the risk of serious illness and death among First Nations populations from COVID-19 and other diseases will be up to four times that of the wider population.^{2,3}

This is not an unfamiliar circumstance. The effects of many medical conditions are worse among people with lower socioeconomic status and especially among Aboriginal and Torres Strait Islander people.⁴ There are multiple reasons for this, including the impact of inter-generational trauma and the greater likelihood of underlying conditions, including diabetes, and chronic cardiovascular, kidney and lung diseases, and reduced access to appropriate healthcare. This was clearly demonstrated in 2009, when H1N1 influenza rates among Aboriginal and Torres Strait Islander people were more than five times those of other Australians.² It is also consistent with experience overseas, where racial inequalities greatly affect health outcomes. For African Americans, death rates from COVID-19 are more than triple those for White people and among Navajo people, death rates are more than 4% (compared with 1.6% for the whole population).⁵ Other First Nations groups in the United States⁶ and elsewhere⁷ experience similar outcomes.

The vulnerability of Aboriginal people is exacerbated by the fact that many live in overcrowded and poorly maintained houses in communities with too many under-resourced health services, the product of years of government neglect. These conditions make it more difficult for them to isolate and quarantine and limit their access to intensive care, ventilation and newer agents that may prevent disease progression, such as sotrovimab. This has been further compounded by the workforce crisis caused by the border controls and other measures implemented due to the pandemic. At the time when we most need health professionals, they are the hardest to come by. As an additional, perverse irony, the poorer outcomes of Aboriginal people following a diagnosis of COVID-19 may generate a form of 'double jeopardy' in which discrimination is magnified by prognostic scoring systems used to ration intensive care unit resources that do not explicitly take into account cultural and other inequities.

Therefore, there is a basis for genuine alarm and the impact of infectious diseases is still in people's living memory. Many Australians may not appreciate that the early effects of British colonialism⁸ led to a high proportion of the population – some say more than 50% – dying from introduced infections.⁹

On 9 September 2021, the New South Wales government announced¹⁰ its intention to lift lockdowns and other public health measures when the state reaches a full vaccination target of 70% of the adult population, which equates to a little over 50% of the state's population overall. NSW will reach this target in less than a month¹¹ and the nation as a whole will do so by 30 October 2021. Further details of the 'roadmap' were released on 27 September 2021.

If such a policy of a blanket lifting of restrictions is implemented the consequences for Aboriginal and Torres Strait Islander and other vulnerable populations will be severe. This is because vaccination rates in Aboriginal and Torres Strait Islander communities are lagging badly behind the remainder of the Australian population, with fewer than 20% fully vaccinated in many places in NSW, Western Australia, Queensland and the Northern Territory.¹²

The problem is made more difficult because of the demographic structure of indigenous populations. Aboriginal and Torres Strait Islander communities are significantly younger than the wider population.¹³ As a result, to achieve the same vaccination rate as 80% for the entire population older than 16 years, Aboriginal and Torres Strait Islander communities will need full vaccination rates of 90–95%.

Younger members of the population cannot be ignored. Across Australia, infections with the delta variant of COVID-19 among children and adolescents now account for nearly half of all new infections and generate a high proportion of new cases of viral transmission. This fact in itself highlights the importance of both modelling data and policy decisions considering vaccination rates among the entire population and not just the adult section of it, as has widely been the case.

Aboriginal organisations have called on state and federal governments to delay any substantial easing of restrictions until full vaccination rates among Aboriginal and Torres Strait Islander populations aged 12 years and older reach 90–95%. The organisations calling for such a target include the National Aboriginal Community Controlled Health Organisation, the Aboriginal Medical Services of the Northern Territory and the Central Australian Aboriginal Congress. They have argued that the higher rate is justified simply in terms of achieving equal vaccination coverage at a population level let alone equitable coverage to allow for the additional

burden of chronic disease, overcrowding and other issues.

The Northern Territory Government has responded to these calls with a plan for COVID-19 management at Stage 3 of The National Plan, which will maintain some of the strongest protections in the nation for vulnerable Aboriginal populations. This includes a commitment to ensure that key public health measures are not relaxed until there is 80% full vaccination coverage equally in all regions of the NT as well as across all age cohorts. Even when the NT does reach this progressive 80% target there will still be a requirement for people coming into the NT to undertake quarantine if they have been in red zones, that is, areas where there are significant COVID-19 infections. Unvaccinated people will not be allowed into the NT except from green zones, where there is no community transmission of COVID-19. In other words, there will still be significant border controls to keep COVID-19 out of the NT without an overreliance on vaccination until there has been adequate time and resources to get vulnerable people vaccinated. A similar commitment is urgently needed from other jurisdictions, including from the Federal Government.

An immediate, well resourced and determined effort will be needed to achieve these vaccination rates. Many Aboriginal community controlled health services are already conducting urgent vaccination campaigns with existing resources, but much more needs to be done. The recent Australian Government's announcement of A\$7.7 million to fast-track vaccinations in 30 priority areas across the country¹⁴ will be of assistance, as will the additional pledges of support for modest increases in the numbers of Aboriginal health workers. However, these initiatives will not be sufficient if they are not expanded to all areas with significant Aboriginal and Torres Strait Islander populations. To achieve such an expansion three conditions will need to be satisfied. First, there will need to be a guarantee of a sufficient and reliable source of vaccines to Aboriginal and Torres Strait Islander communities. Second, adequate capacity and an appropriate workforce will need to be provided to health services to enable them to carry out intensive outreach vaccination programmes, including culturally knowledgeable Aboriginal and Torres Strait Islander workers able to engage with communities, and clinicians and to address vaccine hesitancy.

Third, steps must be taken to overcome vaccination hesitancy. These must take into account the complex underlying causes, which include a historical and understandable distrust of the health system and confusion and fear caused by misinformation spread on social media or through fringe religious groups. Here, the role of indigenous health workers to engage in respectful

dialogues with community members is central and this needs to be resourced. Effective health education in Aboriginal languages developed by local Aboriginal community controlled health services must be made available through the media daily. In addition, government support is required for financial incentives in the form of food vouchers or other benefits, a strategy that has been applied successfully for vulnerable groups in other countries.¹⁵ Non-financial incentives requiring full vaccination for travel, entering pubs, clubs, restaurants, sporting venues and so on need to be foreshadowed now with commencement dates in the near future.

To achieve adequate protection for Aboriginal people it will be necessary for all levels of government to work in partnership with community controlled health services. Until the 90–95% target is met, rigorous restrictions should remain in place. This is consistent with modelling from the Burnet Institute¹⁶ and the Doherty Institute¹⁷, which inform the NSW and national policies about reopening. As the Burnet Institute has stated:

We agree with the calls made by the Aboriginal Controlled Health Organisations around the country that under the national transition plan, the country should not move to Phases B and C until vaccination coverage in each jurisdiction's Aboriginal and Torres Strait Islander communities is as high, or even higher, as in the general community. We support incorporating this metric into the official version of the plan as soon as possible.¹⁸

Similar considerations undoubtedly apply to some other vulnerable groups in the population.

The current situation unfolding in Aboriginal communities around Australia is a reminder that public health strategies (and their implementation) must build in equity at the outset and must maintain a focus on this throughout. In relation to the 'road-map' out of the pandemic this means that we must treat equals equally and unequals unequally. Given how much we know about the compounding disadvantages experienced by Aboriginal people and other disadvantaged groups this means that we cannot cling to broad public vaccination 'targets' that may simply further entrench inequity and create further harm.

Australia remains burdened by the legacy of centuries of harm and damage to its First Nations people. We are facing the possibility of a renewed assault on Aboriginal and Torres Strait Islander health. The difference today is the outcomes are foreseeable and we know what needs to be done to avert them.

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