Engaging with communities to encourage adoption of a harm reduction approach to COVID-19

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Abstract

Since the emergence of the Omicron variant in Australia in late 2021 there have been over 5.47 million cases and 4993 deaths, disproportionately impacting on people with social and structural disadvantage. However there has been increasing reluctance by governments to intervene to reduce the impact of COVID-19 transmission and its consequences. This commentary article provides a perspective on the support and guidance required to mitigate individuals and communities risk by using a harm reduction approach to highlight strategies that can reduce COVID-19 transmission and infection.

Key words: harm reduction, COVID-19, CALD Communities

Australia and COVID-19: HERE TO STAY

Since SARS-CoV-2 emerged in late 2019, there have been nearly 500 million reported cases, leading to over 6 million deaths globally from coronavirus disease 2019 (COVID-19).[1] Australia was one of the few countries that initially weathered the pandemic, with 211,000 cases and just over 2,000 deaths recorded between the first reported case on 25 January 2020 and 1 December 2021.[2] However, with the emergence of the Omicron variant, Australia's initial strong control was lost, with over 10.06 million cases and 13,741 deaths reported since the beginning of 2022.[3]

COVID-19 is not going away. Ongoing waves of infection are likely, typical of similar infectious diseases.[4,5] Recent projections suggest increasing COVID-19 cases, alongside influenza cases, during the Australian winter months.[6] New waves of infection will be driven by current variants in the majority of Australians not yet infected, waning immunity from vaccination and past infection, and new variants with unknown levels of transmissibility and virulence, especially given viral propagation in many countries with low rates of vaccination.[2,7] Epidemic waves will continue until we achieve global coverage with vaccines that have sustained and broad levels of protection against a range of variants. Until such targets have been met, Australia must have clear plans to combat the waves of COVID-19 we can reasonably expect in coming years.

Increasing reluctance of governments to intervene

Australia's early response to COVID-19 focused on testing, contact tracing, isolation and quarantine and during waves of infection, government-imposed restrictions that included social distancing, mobility restrictions and working from home. This strategy was highly effective in preventing morbidity and mortality in the pre-vaccine era.[8] When vaccines became available, they were introduced into the mix, creating a *vaccine-plus* approach.[9] The importance of airborne transmission was increasingly recognised, leading to air purifiers being included in the *-plus* and reinforcement of mask-wearing policies (particularly indoors). Modelling and empirical data highlighted the importance of a combination approach to control outbreaks, preventing health systems being overwhelmed and limiting deaths.[10–13]

In Australia and globally, however, a change in narrative occurred in the second half of 2021, with most governments shifting to "living with COVID". In Australia, COVID-19 mitigation strategies have been removed or eased steadily, despite some 10,000 daily infections and daily deaths in the dozens over recent months.[11,12,14] As of October 2022, close contact isolation requirements have been dropped and isolation of COVID cases is no longer mandated, only recommended. Governments have struggled to recognise and implement a "middle ground" strategy to control waves of infections and avoid deaths in

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Table 1: Harm reduction strategies	
Expanded RAT supply	Affordable and accessible RATs for all, with the promotion of prophylactic or preventive testing During significant waves of infection, RATs could be offered to people attending major public events or community events prior to entry
Spill-over policies	Support of spill-over from venues into outdoor settings to minimise risk of overcrowding and subsequent mass transmission
Provision of air purifiers	Subsidised purchase, lending or hire of air purifiers to enable community organisations to reduce risk of transmission during indoor events
Supply of masks	Provision of free masks at large community events Normalisation and community education on the effectiveness of mask wearing

the setting of high community vaccination. Community exhaustion due to the past restrictions—termed 'pandemic fatigue'—and a putative loss of "social licence" are cited as explanations for this failure to act.[15] Instead, responsibilities for mitigating the effects of the pandemic were increasingly handed over to individuals and private institutions, with some institutions unilaterally reintroducing mask mandates and work-from-home policies.

Harm reduction in public health

When governments are reluctant to act, we need to consider what support and guidance is required to support the actions of individuals and communities. A harm reduction–like approach, as occurred with HIV/AIDS in the 1980s, may provide a pathway forward. Harm reduction manifests in policies and practices that aim to minimise negative health and social impacts by acknowledging that potentially dangerous behaviours will always exist.[16] Emerging from and embedded within strong community-led responses, harm reduction principles remain a core part of the global response to HIV. Harm reduction is grounded in social justice and human rights, recognising that some people are unable or unwilling to adopt behaviours that eliminate risk, such as cessation of drug use. People at risk of acquiring HIV are instead supported to adopt protective behaviours, for example, through education campaigns and providing access to condoms and clean needles and syringes to reduce HIV risk. Beyond the prevention "materials" delivered through harm reduction practice, harm reduction is also historically, and remains, grounded in community mobilisation and the harnessing of local social resources and social capital to impact "risk environments".[17,18] In Australia, the mobilisation of the gay community and communities of people who inject drugs to prevent the transmission of HIV in the 1980s are the most notable examples of harm reduction community mobilisation.[19,20]

Focussing on positive change and working with affected communities without judgement, coercion and discrimination, harm reduction is also well suited to reduce the inequitable burden of COVID-19. As with past epidemics such as Ebola, SARS and H1N1, some communities have experienced the direct health effects and indirect impacts of COVID-19 restrictions and social stigma more than others.[21] In Australia, COVID-19 is disproportionately affecting Aboriginal and Torres Strait Islander people. Despite recording no fatalities in the first year of the pandemic, largely through the concerted efforts of Aboriginal Community Controlled Health Organisations and Aboriginal and Torres Strait Islander Public Health leaders and communities,[22,23] the Delta wave saw Aboriginal and Torres Strait Islander people overrepresented, with nearly 1 in 10 infected with COVID-19.[24] Similarly, people from culturally and linguistically diverse communities are experiencing disproportionately higher rates of COVID-19, with a standardised death rate three times that of those born in Australia (6.8 vs. 2.3 deaths per 100,000 people).[25] This is likely attributed to persistent social inequities that limit access to harm reduction strategies, opportunities to enhance health literacy and healthcare.[23]

As Australia shifts from government mandates to individual responsibility and risk perception, promoting a harm reduction approach would allow these communities to determine their own COVID-19 response. The success of Aboriginal Community Controlled Health Organisations in improving the health of Aboriginal and Torres Strait Islander people has relied on multi-level responses that mobilise existing structures, community engagement and social cohesion.[26] Through these engagements, Aboriginal and Torres Strait Islander communities are mobilised by trusted stakeholders to enhance their understanding and willingness to adopt harm reduction strategies.

Whilst it is difficult to predict government willingness to adopt evidence-based public health policies, it is almost certain that vaccination will remain the cornerstone of our COVID-19 response. With the steady roll-back of testing, contact tracing, isolation and quarantine strategies and future restrictions on mobility increasingly unlikely, it seems that communities and private enterprise will bear much of the burden for reducing infection and mitigating risk. Under such circumstances, it is important that governments assume responsibility for providing evidence-based guidance and equitable access to tools and supports enabling communities, particularly those at greatest risk, to adopt a harm reduction approach so they can "live with COVID". Given that disadvantaged communities still face barriers to accessing many of these tools and supports necessary to minimise risk, a concerted effort from government is needed to provide targeted guidance and endorse a harm reduction approach in these communities.

Harm reduction in COVID-19

Federal and state governments have implemented numerous strategies in response to COVID-19, but there remains significant room for expansion within the domain of harm reduction. These strategies are summarised in Table 1.

Prophylactic testing prior to attending large public events, or family and cultural events, is important. There is also a role for testing prior to visiting people at high risk of infection, including immunocompromised and elderly people, particularly if the visitor has recently engaged in activities with high risk of exposure in high-prevalence settings.[27,28] For such an approach to occur, tests need to be accessible and affordable to all. However, the federal government recently ceased funding support to provide free Rapid antigen tests (RATs) to concession card holders.

COVID-19 risk is reduced in outdoor settings. Continued support for private entertainment and hospitality businesses to create outdoor client spaces is needed. Thoughtful policies allowing spill-over from venues into nearby public spaces would also minimise risk in crowded settings. If events cannot be held outdoors, safe COVID-19 practice recommends sufficient indoor ventilation. However, for many cultural and religious community events, the price of air purifiers is prohibitive; strategies such as government subsidies that enable

groups to lend and hire machines at a reduced cost would diminish the disparate experience of culturally diverse communities.

Despite the sometimes negative commentary, there is clear evidence that masks reduce the risk of transmitting or acquiring COVID-19 infection,[29–32] with N95 masks being even more effective. Like RATs, they are not perfect and not always affordable, and some social and cultural reluctance to use masks continues. Whilst governments may be unwilling to reintroduce mask mandates, it is important for governments to endorse subsidisation, community engagement and health promotion on the effectiveness of masks to minimise risk and remedy inequity particularly within communities with poorer health literacy.

Where to from here?

Whilst some strategies, such as air purifiers, mitigate risk regardless of individuals' willingness to participate, others require engagement with community leaders and members to ensure that constituents are mobilised and strategies adopted—a key component of harm reduction. Discordance between public health officials' expectations of the community and the willingness of the community to act is a failure of public policy. We must work to understand the drivers of risky behaviours of individuals and communities in the context of COVID-19 and use that knowledge to identify ineffective messages, facilitate more tailored messaging and efficient allocation of resources and crucially improve broad engagement with public health initiatives to minimise risk.

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Conflicts of interest

The authors have no competing interests to declare.

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