selection after cryptogenic stroke, and atrial fibrillation risk stratification in broad populations.

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*Peter A Noseworthy, Zachi I Attia, Rickey E Carter, Xiaoxi Yao, *Paul A Friedman*
friedman.paul@mayo.edu

Department of Cardiovascular Medicine (PAN, ZIA, PAF) and Department of Health Sciences Research (XY), Mayo Clinic, Rochester, MN 55905, USA; and Department of Health Sciences Research, Mayo Clinic, Jacksonville, FL, USA (REC)

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Dismantling racism in research

The widespread dissemination of how George Floyd was murdered prompted people around the world to demand structural reform. We agree with the points raised in the Editorial about the need to "find ways to use science as an instrument for social change".[1] Here we highlight approaches for dismantling racism within research.

First, we must recruit and retain a diverse research workforce. As reported by Heilig and colleagues,[2] African Americans represent 12·7% of the US population, and Hispanics and Latinos represent 12·7% of the population, yet they make up 4·1% and 4·6% of tenured faculty, respectively. The tenure track not only affords academic freedom and stability but the opportunity to shape research agendas and priorities as chairs and directors.

Second, we must transform how we do research. Through community-based participatory research (CBPR),[3] we can move from treating community members as research subjects and commit to a partnership of equals wherein they are respected for their expertise of lived experience. CBPR provides a way for community members to take ownership of the ways in which research of their communities is constructed, conducted, and disseminated, thus reversing the power imbalance currently present in traditional research practice.

We applaud the open acknowledgement of our community's role in contributing to an antiquated oppressive system and explicit stance on Black Lives Matter. To move forward, we must look within and question the approaches upon which our scholarship is built, so as to ensure that we are part of the solution of creating an anti-racist society.

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**April Joy Damian, Melanie Gonzalez*
adamian2@jhu.edu

Johns Hopkins University Bloomberg School of Public Health, Department of Mental Health, Baltimore, MD 21205, USA (AJD); and Weitzman Institute at Community Health Center, Middletown, CT, USA (AJD, MG)

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Australia's First Nations' response to the COVID-19 pandemic

Kaitlin Curtice and Esther Choo[1] described the well known risks for infectious diseases among First Nations internationally and the serious concerns that COVID-19 poses for them. These risks include their levels of chronic disease, poverty, poor living conditions, and racism in mainstream services with resulting lack of trust using them. They also highlighted the problem of data not being available specifically for First Nations so that authorities are blind to the situation and hence how best to help them.

In Australia, we have seen an extraordinarily different outcome. We do have data identifying Aboriginal and Torres Strait Islander populations.[2] Since the beginning of the pandemic here, we have observed only 60 First Nations cases nationwide; this represents only 0·7% of all cases, a considerable underrepresentation, as First Nations make up 3% of our population. If rates for First Nations were the same as non-Indigenous people, we should have seen 215 cases, and the incidence should have been higher given their risk status. Only 13% of First Nations cases needed hospital treatment, none have been in intensive care, and there were no deaths. Most cases were in urban centres, and none in remote or very remote communities. There is much debate every year about the continuing gap in health, education, and other outcomes in Aboriginal and Torres Strait Islander people, yet the gap here seems completely reversed, with our First Nations doing better than everyone else. How did this happen?


Luis Álvarez/Getty Images

First Nations health leaders, chief executive officers of the Aboriginal Community Controlled Health Services, and others responded rapidly to the news of the pandemic, having been badly affected by the 2009 H1N1 influenza epidemic. They lobbied governments (federal, state, territory) to close remote communities, to help with personal protective equipment, testing and contact tracing, prepared sophisticated videos for social media about COVID-19 and what people should do (which was better than

anything in the non-Indigenous space), trained their staff, organised the homeless in safe accommodation, and focused on the elders and those with serious illnesses. They established partnerships with government departments and relevant non-governmental organisations to ensure services were implemented and culturally appropriate. The result of this First Nations-led response has shown how effective (and extremely cost-effective) giving power and capacity to Indigenous leaders is. This response has avoided major illness and deaths and avoided costly care and anguish. It is nothing short of a triumph as we sadly read about the situation mentioned by Curtice and Choo.[1]

There is debate in Australia about the Uluru Statement from the Heart, a document prepared 2 years ago, via a series of national dialogues with First Nations peoples. They have asked for a voice enshrined in the Constitution, discussions about treaty, and acknowledgement of history. The response to the pandemic is surely the best evidence we have for giving our First Nations people such a voice and hastening progression towards authentic Indigenous self-determination.

For the **Uluru Statement from the Heart** see https://www.referendumcouncil.org.au/sites/default/files/2017-05/Uluru_Statement_From_The_Heart_0.PDF

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*Sandra Eades, Francine Eades, Daniel McCaullay, Lesley Nelson, Péta Phelan, *Fiona Stanley*
fiona.stanley@telethonkids.org.au

Curtin University, Perth, WA, Australia (SE); Derbarl Yerrigan Health Service, Perth, WA, Australia (FE); Edith Cowan University, Perth, WA, Australia (DM); South West Aboriginal Medical Service, Bunbury, WA, Australia (LN); Melbourne Poche Centre for Indigenous Health, University of Melbourne, Carlton, VIC, Australia (PP); and Telethon Kids Institute, Nedlands, WA 6009, Australia (FS)

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COVID-19 vaccine affordability and accessibility

The need to ensure the affordability of any future COVID-19 vaccine is gaining increasing attention.[1] Although there is support for bulk purchasing, making vaccines affordable is fraught with difficulties, particularly for the so-called missing middle countries that are not eligible for aid from Gavi, The Vaccine Alliance or other aid but lack the resources to produce their own vaccines or afford patent-protected drugs.

For these countries, price controls—regulations that would cap or set prices—provide an effective approach to vaccine affordability and thus accessibility. This has led to the adoption of price controls in Chile and some other low-income and middle-income countries (LMICs). However, if only LMICs impose price controls, vaccine manufacturers might opt to not sell or supply adequate quantities, prioritising high-profit markets instead.

Although price controls only apply to domestic producers, they provide leverage for LMIC governments to negotiate lower prices. Since many of the COVID-19 vaccine developers are in the USA, a US price control would have a big impact. These price controls could enable LMIC governments to purchase the vaccine, ensuring faster access for all those who need it and not just for those who can afford it.

However, the US Government currently prioritises profits, stating "the priority is to get vaccines and therapeutics. Price controls won't get us there".[2] This stance will hinder efforts to control the pandemic, both within the USA and globally. Multiple approaches, including price controls, are needed to ensure an effective vaccine is widely affordable.

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Safura Abdool Karim
safura.abdoolkarim@wits.ac.za

SAMRC Centre for Health Economics and Decision Science, Wits School of Public Health, University of Witwatersrand, Johannesburg 2050, South Africa

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COVIDSurg Collaborative. Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study. Lancet *2020;* **396:** *27–38*—In this Article, in the Summary, the proportion of all deaths that were in patients with pulmonary complications has been corrected, as well as the total number of deaths denominator, to "81·7% (219 of 268)". Also, the appendix has been corrected. These corrections have been made to the online version as of June 9, 2020, and the printed version is correct.