Dr. Shirley Evers-Manly

Public Health Nursing and the Crisis in Health Care

Dr. Evers-Manly delivered this presentation to the Schiller Institute's international conference "The World at a Crossroad: Two Months into the New Administration," during the fourth panel on March 21, "The Challenge of Famine and Pandemics: The Coincidence of Opposites or Mass Extinction?"

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Dennis Speed: The situation the world finds itself in today is not due to the coronavirus pandemic crisis. That itself is an effect. This is actually a condition that was foreseen back in 1974 by economist Lyndon LaRouche, who stated that such conditions would be the result of the vicious monetary policies being imposed upon the African, Asian, and South American sections of the world by the International Monetary Fund and the World Bank.

LaRouche's concern was that the intolerable conditions of the lack of infrastructure—whether it be water, or power, transportation, medicines—in several of the poorest nations in the world would eventually create 14th Century conditions that would spawn new forms of disease that humanity might not be able to control. Those conditions have now visited *not only* those areas of the world, but parts of the United States.

We've heard about the dirty water in Flint, Michigan and Newark, New Jersey; but we also have conditions in entire states, like Mississippi. We saw the situation in Louisiana [with Hurricane Katrina] only 15 years ago. We are now going to hear a kind of battle report on the state of the fight in the United States by Dr. Shirley Evers-Manly, who is the interim dean for the Alcorn University School of Nursing in Natchez, Mississippi, U.S.A., and is the chairman of the Global Health Committee of the National Black Nurses Association.

Dr. Evers-Manly: Good morning! Thank you for giving me this opportunity to speak at this Schiller Institute conference about nursing and the COVID vaccine distribution. I think this is a very important topic to discuss, as we have witnessed firsthand how COVID-19 screening, and how the COVID-19 pandemic in most of our areas have taken place throughout the world.

Public Health Nursing Infrastructure

It's very important for us to begin to look at our public health infrastructure. When we look at the public health infrastructure—I'm speaking specifically of nurses right now—when we look at the fact that by the year 2030, we're going to need, globally—we'll have a shortage of about seven million nurses. So, seven million nurses globally that have worked in nursing from the beginning of healthcare, providing preventive care, to being at the bedside.

When we look at prevention and healthcare prevention, and we look at our public health departments, I think for the past several years our public health departments have been minimized. Many nurses have been laid off in public health departments, and many times we don't get individuals or nurses to go into the public health setting. We've used public health nurses from back when Florence Nightingale was out looking at the soldiers in the [Crimean] war and preventing disease, and transmission of disease. So, when we have an impact on the public health department, on public health nurses, and we eliminate those, when we have epidemics and pandemics in our community, it creates a major problem in getting accurate health information and education out to the society, in addition to providing hands-on care.

That's what we're seeing now in regard to the vaccine distribution, for example. We're not able to get the vaccine in all of the areas we need to get the vaccine to. We have individuals who lack trust—they lack trust in the government, for example. Federal employees and nurses, who have gone out into the community, who are not from those communities, whereas public health nurses on many occasions work and live in those communities. And individuals see them all the time.

You can take that model, where you have a public health nurse in a community setting, and you can take that from a global perspective as well, because those nurses, whether they're here in the United States in rural Mississippi, or in an urban area like Oakland, California. You can go to Ghana, you can go to Zimbabwe with the public health nurses and public health nursing and community health outreach workers, to help recruit and talk to individuals so that they can be in a trusting environment.

Vaccine Distribution

I have witnessed and have learned that in some areas they're using individuals who are not nurses to administer the vaccine. Now, while that seems simple, a lot of times it's not. I know in one place, they were not drawing up *enough* of the vaccine. In some areas, because we're trying to immunize a large number of people, millions of people every day, the equipment that we receive, or the syringes we may receive may be a different syringe every day. If you don't have the knowledge base of knowing how to look at that syringe and draw the medication up properly, then you'll have a problem with that. But public health nurses, they have that experience; they have the experience to be able to use a variety of syringes, regardless of whether it's a 1-cc syringe or a 5-cc syringe, or a tuberculin syringe, and give that medication out properly and work with the community, again that trusts them. They [the nurses] live in those communities, so they [their patients] know that they're getting care from a person they trust.

I think that's where we've made a mistake a lot in the vaccine distribution. We have made individuals become scientists, and every time we talk about having a 95% efficacy on one vaccine versus another, that makes people upset. So, when they're talking about the difference between the Moderna, the Pfizer, and the Johnson & Johnson vaccines, they put another level of fear and concern on the community, because the community feels that well, if I receive the Johnson & Johnson vaccine, then they're not giving me the best.

That's not what it's about; it's about getting a vaccine in your arm. When we take our children to get their measles immunizations, or we get our flu shots, we don't talk about what the specificity of that immunization is; we don't talk about how effective it's going to be. We're just going to get a vaccine. For the flu shot, it's the flu shot that has all the variants from the year before. So, we'll still get the flu, we just won't get it with as many symptoms than if we had not taken the shot.

Those are the things that I think we need to be educating our communities about. We need to get the vaccine in; we know that it's very similar to a flu shot, and we may have to take it more often. But when we're politicizing healthcare, it makes individuals afraid, and the more afraid they become, the more they push back and go into their homes or communities and don't come out.

Again, being here in rural Mississippi, you have individuals who have to sign up for the COVID vaccine by using their cell phones or their computers. Initially, that's how it started out. Now, they can use their regular phone, but sometimes they don't have a good connection. There is not good connectivity here in some areas, so they still may have difficulty even being on the phone.

Community Health Outreach

I think there should be campaigns where we're taking mobile vans and trusted individuals, and I know we're pulling in the clergy, and they're speaking with athletes. But if we get a grandmother there in that community to receive her shot, or a grandfather, or a relative to receive their shots in those communities, I think we're going to build more trust in that community setting.

So, working with public health nurses, working with community health outreach workers—and that's the same with community health outreach workers. I know we talked about some models in the San Francisco Bay area, in Oakland, and Alameda County. We used our community health outreach workers when we had an epidemic with tuberculosis. Those community health outreach workers would go where the people stayed, and that might have been under a bridge, or in the back of someone's home on a sofa because they were homeless.

But we watched them take that medication—so, direct observation therapy. But we began to build relationships in those communities so that when they saw us coming, they knew that we were coming to help. They knew that we were coming to provide them with medical care and attention, and we didn't care if they had a driver's license or a Social Security number, or those kinds of things.

I think at this point, with COVID, that's where we need to be. We need to just get out and give whomever we come into contact with, who needs this vaccine and wants to take the vaccine, we should give it to them. But if we're saying you have to sign up on your cell phone, you have to call on a telephone, that can be challenging for individuals. Again, here in the South, even trying to

get a ride—in some places, you're still 40 miles away from where they're giving the vaccine. Or, you're coming down a country road and you have to get to the site.

I think we need to look at coming together with a distribution plan that may differ across the United States, because we have different areas—whether we're in a busy metropolitan place like New York or Washington, D.C., or Los Angeles or Oakland, California, compared to being here in Mississippi, or in Texas and some of the other areas.

A Trusting Relationship with the Local Communities

And then, we have to see, what is the relationship, what kind of relationship did the community have with the healthcare providers in the first place? Were they available to them? We know that most people across the country receive their healthcare in the Emergency Department. Some of them don't have primary care physicians. So, we need to know their health beliefs; what was that doctor-patient-community relationship before COVID? There may need to be some bridging of relationships and bridging of gaps that may have occurred prior in those areas.

Another important area that I think we need to look at: we talk about Tuskegee [the "Tuskegee Study of Untreated Syphilis in the African American Male"], and everybody said, we should get over Tuskegee. While I know that we have to build on past history, and that we do need to move forward, we have to understand that there's been different forms of "Tuskegee" happening in communities. You have Henrietta Lacks [an African-American woman whose cancer cells were taken without her knowledge, creating an immortalized human cell line of great use in many scientific developments]; you have individuals now with COVID, where some

Global Cases Increasing; The Virus Appears Ahead

March 27—Over the last five weeks, the daily count of new infections of COVID-19 worldwide has risen from about 350,000/day to roughly 460,000/day. While a few areas (such as Russia, the UK and South Africa) have continued their decline in new cases from January to the present, portions of Europe and of India, and most of Brazil, have exploded. It is assumed that new mutant strains of virus have played a key role in this new wave.

On March 25, Brazil, a nation of about 220 million, set a new record of over 100,000 new reported cases in a day. The COVID-19 P1 variant has spread and has been deadly. Tests show that it is controllable by the Pfizer vaccine—but Brazil has none. Over the last five weeks, new cases per day have increased by more than 75%.

India's case count has tripled, from about 12,000 to over 45,000 new cases/day. (These figures are for 7-day averages. India actually surpassed 70,000 on March 25.) About 20% of the new cases in the state of Maharashtra, the hotbed of COVID-19 activity in India, are from a strange variant born of a strain indigenous to India, E484Q, married to one from California, L452R. If the population of new strains has now grown to the point that there is enough intermingling of variant strains to create a "second-generation" variation, this may mean trouble for controlling the pandemic.

Other countries showing a similar worsening tendency over the last five weeks are: Italy, 12,500 daily cases risen to 23,000; Germany, 7,500 to 16,000; France, 20,000 to 30,000 (most of the increase last week); the Philippines, 1,800 to 7,000; and Ukraine, 5,000 to 13,000.

Chile is also of concern, going from 3,300 to 6,100—not as big an increase, but occurring even with one of the stronger vaccination programs under way. It likely reflects a similarly large increase, but tamped down by the effect of the vaccinations.

Finally, the United States had a big drop starting three weeks into the vaccine rollout, but that improvement stalled a month ago at around 55,000 new cases/day—likely representing a combination of vaccines driving down, and variants driving up the total. Then March 24-25 saw an ominous turn, with 150,000 new cases over 48 hours.

Worldwide, the pace of mobilizing scientific and public health efforts has not yet matched the rate of mutational activity of the SARS-CoV-2 virus.

—David Shavin

physicians are saying, "Well, we're not going to the Pit. We don't go there" [a reference to a "triage room" where severe cases are sent and denied medical treatment]. So, the patients that might be considered in this Pit, they may not be seen.

We don't know what other messages people are hearing of their loved ones or community persons who have been in the hospital who may have suffered from COVID themselves. We know that in some areas, for example, they have put in place universal "Do Not Resuscitate" orders. It might be better [now], and they may not be using that as much anymore.

We know that when COVID first showed up on the scene, we began to see more and more hospitals getting waivers for seeing individuals. All of that brings back a level of mistrust, if you don't understand why they're doing that. COVID is now a pandemic, and it's being treated like it's a war zone. When you're in a war zone, you have to find out: "OK, I can provide care to that person because they're going to live. But this person over here, there's nothing I can do, because whatever we do, we won't be able to save them out on the battleground." So, COVID has been seen as this war; we have this war against COVID.

Now that we have this war, if someone is impacted by COVID, and they have other healthcare conditions and problems, they may not be *treated*. Or, they may not be *treated* the same way another person might be. That's where those universal policies and procedures come in. All of those things, if there's a lack of understanding, brings about concern and more fear and more hesitation from communities.

A Comprehensive Educational Program

So, we need to provide a comprehensive program in regard to educating individuals about COVID, how you get COVID, how it's treated, how you prevent it. I know we're talking about being six feet apart, and we're talking about social distancing and wearing a mask. But sometimes, you have to really pull things back to a level where people can really understand the impact.

For example, my dissertation was around cancer, and in my area, cancer is a major issue. We had a project in Oakland to decrease eight avoidable cancers in the San Francisco area. We went to churches, to social groups, and we talked about cancer, to help people understand how you get cancer, how it forms, how it spreads through the body. Because there were a lot of myths related to cancer. So, we had to understand those myths and those health beliefs in order to help those individuals understand what was not true.

For example, I used to use a banana to say "There's nothing wrong with this banana. But if I open it up, if it has some brown spots, that means this banana is starting to get overripe. The longer I keep it, the more overripe it becomes. It spreads from that one spot throughout the banana." I used to use that in educating about cancer, and how cancer spreads. Because some individuals thought if you have cancer and you have surgery, once you open it up, it's going to cause the cancer to spread. That myth about cancer created a lot of deaths, because it was a misunderstanding.

Addressing Health Beliefs

So, we need to find out what the health beliefs are. What other things are individuals hearing in their small communities? Some of these communities are very, very small when you look at them. In some places, they're less than 100 people, in some of these rural areas. So, we need to find out, what are their health beliefs? Who is the most important person who can work with that, building this community of community health outreach workers, where we're hiring individuals in those communities? It's also going to help with jobs in some of those communities, because there's a lack of employment. So, they would work with public health nurses and public health physicians to go out and educate the individuals about COVID and COVID spread and the importance of vaccines if they haven't received the vaccine.

I think now they're beginning to open up, where it used to just be the first tier of 65 and over; or having medical conditions; being front-line workers. I think more states are beginning to open it up, where more and more individuals can receive the vaccine. If that's the case, again, if we don't have a structured distribution plan, it can become a problem.

One of my mentees in California, who operates a clinic there—she's a public health nurse—signed up to receive her vaccine, and to date, she still has not received it. She works in a community where the majority of individuals are Spanish-speaking persons. Many of their family members have been impacted by COVID. She has a large homeless population, so individuals who will be high spreaders, but she still has not received her vaccine. So, I think we need to come back to the drawing board, and have a national campaign, a national approach.

Vaccinating Globally

When we talk about the global, going to places like Ghana, or the Philippines, or Mexico, or if we were going to Brazil, we have to think about which one of those medications, and the stability of those medications, when we go to other nations. We know we have to have sub-zero refrigeration for Pfizer and Moderna, whereas you don't have to have that for Johnson & Johnson. So, when we're looking at going out into some of these rural areas and really taking the vaccine more global, we have to look at what's going to be stable in those particular environments that we're working with.

It's important for us to look at the vaccine and the environment that we're going to, because when you're going to some of those countries, electricity can be a problem. And so, if you don't have electricity and you're not able to maintain those vaccines, then you actually have to—if you were having a clinic—you may have to throw some of those vaccines away which would be sad. So, I think those are the things that I would begin to think of in regard to rebuilding our public health programs starting in public health schools, starting in nursing schools.

As I mentioned earlier, by 2030, there will be a shortage of 7 million nurses across the globe. So, we have to begin to look at how we can expand those providers, and we know the same thing with physicians. Now, there's more nurses than there are physicians, but we already know in some areas there's one doctor to maybe five or ten-thousand people.

Access to care will continue to be a major problem if we don't begin to look at this healthcare delivery system and how to use other areas and other disciplines in healthcare to be able to help to deliver care through this pandemic. And, we will have another one. We've lived through several epidemics in my time. We've lived through some epidemics—at least I've lived through some epidemics. This is my first pandemic. But I'm sure there will be other pandemics. We should take this as a historical standpoint in time, to begin to rebuild our public health system.

I think we got very comfortable. And I know at one point they were saying, "Public health and public health nursing is a dinosaur." And I know in some states, in some cities, you have to fight your mayor or whoever's given that city's budget or your county, to say public health nursing and public health is still important. But if you look across several public health departments over the last several years, I'm pretty sure their budgets are not as strong as they were several years ago. Public health nurses and public health officials have been laid off. I don't know if some areas even have public health nurses. In California, the nurses become public health nurses. If you earn a bachelor's degree or higher in nursing, you automatically become a public health nurse. In the state of Mississippi, they don't have that public health nurse structure.

Public Health Structures and Education

So, we can look at what kind of public health structures are being used across the country. Are there public health nursing and public health nurse certificates for individuals who want to go in that area so that, when you have an epidemic, a pandemic, or even a major disaster in a city, public health nurses can be pulled who have that knowledge base? If something happens right now, today, I know how to set up a shelter, I know how to get the medications. I know how to triage individuals in regard to care. That's where we are now.

However, in doing all of that we still have to keep our public educated. In educating the public about how you provide care in a time of disaster and public health crises, I think it's important that we keep people informed. But we cannot make them scientists because they won't understand it. I have nieces and nephews coming to me and talking about one vaccine being better than the other. Well, they look at that like a sports team. My sports team got 99 points playing basketball, and the other one only got 76, so they lost.

If we're not looking at the health beliefs of individuals, then we don't know how they're taking that information and interpreting it in their own belief system. And so, I think again it's important, in understanding health beliefs, to really think about how we are delivering information. You can go to the internet; you can go on almost every news channel: they're constantly comparing the medications. I think if we remove that dialogue and state [instead], "We need to be vaccinated. We need to be vaccinated, and if we start vaccinating people—you still have to stay safe," we're going to begin to see numbers go down.

It has to be a collective program. We all have to be on the same page. We can't have one state saying, "We're going to lift our masks," and another state saying, "No, we're not going to lift our masks." We can't say in one state, "Okay, you can take the vaccine,"

and in other states, "No, you don't have to take the vaccine," because again, it starts pitting individuals.

We've seen people fighting over vaccines, because even if they make an appointment, they still think its supply and demand. So, if you make your appointment to go and receive your vaccine at one of the vaccination clinics, and we say that we've made 200 appointments that day, we have 200 vaccines to give. We're not going to run out. It's not on a first-come, first-served basis. But that's what a lot of people in the community believe, that it's a "first-come, first-served basis" even though they've made an appointment and they've received an appointment. So, that's the other fear.

A National Standard for Public Health Nursing Care

Another level of fear is that people don't believe there's enough vaccine, and they've heard about fighting in the lines, they've heard about individuals pulling guns in the line. So, they say, "I'm going to stay home in my safe environment." We know that some of the individuals that stay at home, though, need a safety check. They need somebody to go out and check on them. They may have other illnesses—they have not been able to have their blood pressure professionally checked, or have their cholesterol checked, or have their levels checked for taking heparin; they may be taking too much and have bleeding and a stroke.

There are several things that public health nurses in the past would do. We made those safety visits to prevent avoidable deaths. We went home to home to check on new mothers and babies, and to make sure that they were thriving. And I think that's what we need to look at for COVID-19, for COVID screening, for COVID vaccination. Then, when we get into the hospitals, we have a clear COVID trajectory on how we're going to treat the patients, and it should be the gold-standard treatment just like we have if someone's diagnosed with breast cancer or colon cancer or hypertension.

There's a gold standard. Right now, we're doing a little bit of everything. One hospital may be practicing in one way, another hospital may be practicing in another way. I think if we come up with a standard, individuals will regain their trust in the American nurse, physician, and hospital setting across the board, and across the country, and across the world.

Speed: Thank you, Dr. Evers-Manly. We want to point out right now that we *can't pretend* that people don't know that sections of this country, perhaps as many as 100 million people in the United States, are being sent the message—not because of COVID—but because of the economy and because of what's been done for the past 30-40 years in this country to de-industrialize it; they are being sent the message that they are living lives that are not worthy to be lived. It may be important to point out that to pretend in this situation that we really know exactly what we're doing—whether it's about COVID-19 or it's about what we want to do in our health system, or how to handle this situation—is the worst thing we could do.

There are many people working in various different ways to try to actually wrap their minds around the truth of this circumstance that we are involved in. There are many questions, as was already referenced by Dr. Evers-Manly about the vaccines. There's a stigma about working with certain nations, for example Cuba, which has one of the most important and successful medical programs in the world; Vietnam, which has had under 100 deaths, I believe even as of now, from COVID; and of course, China. This has to be overcome.