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Quality Care for Women's Health

Public Health Is Women's Health

Denise Link

An analysis of data from the early days of the SARS-CoV-2 (COVID) pandemic revealed a significant decrease in the number of screenings in 2020 compared with prepandemic levels. In women’s health, that decline was manifested as an 80% reduction in the number of mammograms and Papanicolaou tests. Several factors contributed to the phenomenon, including temporary closure or reduced hours in primary care practices and clinics, fewer available appointments, advice to limit visits to health care providers to sick care only, and women’s own efforts to avoid possible exposure to the virus. Concerns were raised about missed opportunities to detect cancer and the possible impact on successful treatment as disease was permitted to advance due to the delay.1

Fortunately, rates of women’s health screenings have improved as clinics implement transmission risk reduction strategies and outreach efforts to encourage women to return for well care. Perhaps there was some crossover impact from the COVID messaging on health promotion and disease prevention on the importance of attending to other risk reduction behaviors. The observation that those managing chronic conditions, such as diabetes and hypertension, and cancer survivors are at higher risk of COVID has been strongly emphasized by the media. While that may also have given a false sense of security to young adults and those without those factors in their health history, well-designed and targeted health promotion messaging could have played a role in encouraging women to catch up with recommended screenings.

Efforts to gain control over the COVID virus have been focused, rightly so, on understanding the biology of the virus, advancing vaccine technology, and clinical research. While all of these cutting-edge-science activities are essential to addressing this global health crisis, it cannot be overstated that the high tech approaches must be accompanied by effective health communication, universal health promotion behaviors, and evidence-based public health policy. These activities must be informed by basic theories about how humans form and act on their health beliefs.

The Health Belief Model has been tested in a wide variety of conditions and populations. The constructs of the model predict that people will be more likely to follow recommendations to engage in certain risk reducing behaviors if they believe that (1) they are at risk, (2) what they are trying to avoid is dangerous, (3) adopting a specific behavior will lower their risk, and (4) they are able to perform the behavior. All of these conditions can serve to raise a sufficient level of concern that can lead to performing the protective behavior. There is a risk of overemphasizing the danger, which can create an unhealthy level of anxiety. In that case, there can be an unintended effect of triggering self-protection in the form of denial and minimize the perception of a threat.2

To find that “sweet spot” along the spectrum of blissful ignorance and panic requires the application of health promotion theories and basic public health approaches to develop effective responses that can be deployed now and sustained for the future. This is knowledge that nurses acquire and apply in community health courses and clinical placements. All the steps and interventions take place in the community and involve established, trusted agencies and the public. Starting with an assessment of both needs and strengths, nurses identify where the gaps are and where the local resources are to close them. There will likely be multiple areas that require intervention, so priority setting is necessary. At every decision point along the way, work groups that are highly inclusive and accurately resemble the demographic mix of the community lead the initiatives.

The application of the concept of intersectionality supports the development of customized, relevant, and effective interventions that will lead to prevention of the spread of disease and improvement of health status. This means examining factors that characterize a particular community and how those factors interact differently among different groups of people to affect their level of risk and their responses. For example, it sounds like common sense that to protect oneself and others from the spread of the virus, hand washing is an effective and simple approach. But not if you live out on the street or in a remote area where running water is not available in 80% of the homes. Spatial distancing and hygiene may not be possible if you live in a crowded multigenerational home, a shelter, a refugee camp, or a slum. Staying at home may be perceived as riskier than going out if you are a victim of domestic violence or if your family is depending on your income to maintain shelter, food, and pay other bills.3

Gender identity, structural discrimination based on race or ethnicity, low income, food insecurity, poor air and water quality, health literacy, physical and intellectual disabilities, cultural practices and beliefs, transportation, and other variables all impact and intersect in different ways with different people in different locations. Failure to consider these interacting factors and involve those most affected when attempting to change behavior can thwart the outcome of the most well intentioned initiatives.

The United States public health infrastructure, which has as its core function the promotion of health and prevention of disease, has been neglected for decades. Right now, application of the basic tenets of health promotion are as critical to our success in
overcoming the pandemic as the highest health technology strategies. Health promotion methods have been effectively applied to reduce noncommunicable conditions (smoking, obesity) and infectious disease (sexually transmitted infection). To build the research base in health promotion science, investigations to identify effective interventions for both types of conditions must increase. Patient centered care, cultural competency, systems thinking, community health, and evidence based practice are core competencies in Doctor of Nursing Practice programs (DNP). DNP graduates are well prepared and qualified to design and implement community-based quality improvement projects that can rebuild the public health system and improve the capacity of women and communities to experience better quality and quantity of life.

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Department Editor Denise G. Link, PhD, WHNP-BC, FAAN, FAANP, is a clinical professor emerita at Arizona State University Edson College of Nursing and Health Innovation in Phoenix. She can be reached at denise.link@gmail.com.