Version of Record at: https://doi.org/10.1016/j.puhip.2023.100435

Public Health in Practice 6 (2023) 100435

Contents lists available at ScienceDirect

Public Health in Practice

journal homepage: www.sciencedirect.com/journal/public-health-in-practice

# Threats to public health workers

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A R T I C L E I N F O

*Keywords:*
Public health
Workforce
Threats
Political
Personal
Harassment

A B S T R A C T

Media reports and data from public health professional membership organizations have demonstrated high levels of harassment experienced by public health workers throughout the COVID-19 response. We documented personal and political threats to public health workers across the first 12 months of pandemic response through a longitudinal survey completed in Fall 2020 and Summer 2021. The web-based survey was distributed to respondents using the Qualtrics survey platform. Survey items measured domains including demographic information, public health roles and training, mental and physical health, and work-life balance. Respondents were also asked if they had received any personal or political threats, from whom these threats were received, and completed an open-ended question describing the nature of the threats. Among the 85 public health workers completing both surveys, threats from members of the public and from elected and appointed leaders were most prevalent at both timepoints; however, as the pandemic response progressed, the nature of threats to public health workers changed. While those remaining in the public health workforce may be more resilient to these threats, increased prevalence of personal and political threats has the potential to deter new graduates from entering the field, impacting the public health system's future response capacity.

Public health emergencies are stressful for individuals and communities. During prior responses, public health workers have frequently perceived personal danger. During the 2003 response to the Severe Acute Respiratory Syndrome (SARS) outbreak, public health workers reported a feeling of personal threat that was intensified by uncertainty, shortages of Personal Protective Equipment (PPE), and disease severity [1]. During the Zika virus outbreak of 2016, public health authorities were widely accused of creating and releasing Zika, one of many conspiracy theories that undermined trust in science around the outbreak and the public health response to it [2]. However, the scope and scale of these prior attacks were limited compared to those that occurred during the public health response to the COVID-19 pandemic.

As in these prior public health emergencies, the public health workforce was on the frontline of the response. However, the scope and scale of their activities, the pervasiveness of social media, and the politicization of the pandemic exceeded prior events [3]. Public health leaders frequently appeared alongside elected officials to explain the implementation of non-pharmaceutical control measures (e.g., masking, closures of schools and nonessential businesses, stay-at-home orders) leading some to criticize and ridicule them even when they were previously known as a trusted public servant and member of the community [4]. Politicization, disregarded expertise, threats to personal safety, and a demand for services that exceeded any reasonable ability of the public health system to respond were just some of the stressors public health workers faced.

Leaders were particularly impacted. More than half of local health directors reported harassment of themselves, their staff, or their agencies between March 2020 and January 2021 and more than 1 in 3 retired, resigned, or were fired from their position [5]. Leadership turnover is disruptive at any time, but during a public health emergency response it can have significant negative impacts on effectiveness.

Public health practice and academic professionals in the U.S. recruited through professional networks and vetted social media groups who completed an initial online survey between August 12 and October

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https://doi.org/10.1016/j.puhip.2023.100435
Received 25 May 2023; Received in revised form 23 August 2023; Accepted 5 October 2023
Available online 13 October 2023
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25, 2020, and provided an email address indicating their willingness to complete a follow-up survey were invited to complete a second online survey via Qualtrics (Provo, UT) between June 16 and July 27, 2021. In this commentary, we report findings from six questions used to assess personal and professional threats to public health workers during the COVID-19 pandemic response.

Of 390 respondents who completed the initial survey, 85 respondents from 23 U S. States consented to follow-up and completed the second survey (21.8 %). Of the 85 follow-up respondents, 80 % (68 of 85) reported a master's degree or higher and 58 % (49 of 85) had job roles in communicable disease. Similar to the public health workforce, the majority of respondents were female (81 % compared to 79 % of the public health workforce) and white (75 % compared to 54 %).

Overall, on the initial survey, a quarter of respondents (99 of 390, 25.4 %) reported they or someone in their agency had received personal threats from the public or someone outside their agency. Those who took the second survey were nearly twice as likely to have reported these threats in 2020 (35 of 85, 41.2 %) compared to the respondents who only completed the initial survey (64 of 305, 21.0 %). On the second survey, where additional follow-up questions were asked, the majority of these personal threats were from the public (93.1 %). Nearly 40 % (32 of 85) of respondents to the second survey reported they or someone in their agency had received political threats. Of the 32 respondents reporting political threats, about two thirds (21, 65.6 %) also reported personal threats. In open-ended responses, three primary themes were identified that align to the sources and types of threats that were described.

## 1. Threats from the public

Public health workers have a duty to safeguard population health, regardless of political views or level of adherence to public health recommendations. Public health workers responding to this survey reported receiving death threats from the public, dealing with false claims that COVID-19 was a hoax, and being blamed for the rising number of COVID-19 deaths due to their incompetence. Threats related to public skepticism about the COVID-19 vaccines was also reported. One respondent recalled a member of the public "slapping her hand while administering the vaccine," while another reported a member of the public who was opposed to wearing a mask, "coughing on her prior to calling her a bitch." Doing public health work was something that several respondents mentioned wanting to distance themselves from, due to personal harassment that included being followed home, verbally abused in public for the financial burdens caused by the pandemic, and attacked on social media. One respondent reported being doxed while another received threatening packages that led her to move her residence.

## 2. Threats from internal and external leadership

Pressure on public health staff from internal leadership increased. Specific threats mentioned by respondents included being asked to change data to "make it [data] look better than it seemed" or to "alter data to support lowering [COVID-19 related] restrictions." In other cases, data were released even when staff felt it was of poor quality. There was also increased pressure from external leadership. One respondent reported their jurisdiction's health officer resigned after the Board of Supervisors canceled the emergency declaration and welcomed "public meetings to be flooded with comments from out-of-state groups who were vehemently against COVID restrictions, preventing local callers from being heard." Another reported that public health workers were threatened with job cuts when they were viewed by external leaders as not working quickly enough to contact all the positive cases.

## 3. Political threats

Political pressure increased on public health workers, and these pressures varied across different levels of government. As one respondent put it, "there was political pressure from the Board of Supervisors to stay open during the pandemic but there was also fear of upsetting the Governor" who favored increased restrictions. Pressures from internal leadership were not always separate from political pressures and threats exerted on those in public health leadership positions. Nearly all respondents mentioned pressure from elected officials to take actions that were not grounded in scientific evidence. One respondent stated, "there was near constant pressure [from elected officials] to produce data faster than it could be collected and to have it support different conclusions." Respondents also felt that political threats tended to support the questioning of public health leadership.

The extent, duration, and severity of the personal and professional threats received by public health workers during the COVID-19 pandemic response is cause for concern [6]. Experience of harassment by public health workers during the pandemic were associated with negative ratings of mental and emotional health and with an increased intent to leave the employing organization [7] and there was a dose-response relationship between the number of threats and the likelihood or reporting depression, anxiety, PTSD and suicidal ideation [8]. The public health workforce, already understaffed before the pandemic due to budget reductions, faces a loss of staff more generally – and leadership in particular – post pandemic [9]. These losses may be nearly impossible to recover from [10]. Despite the increased number of students enrolling in academic public health programs during the pandemic, it will take time to replenish the workforce. Further, these graduates will have many other options for employment besides governmental public health [9].

Public health employees need access to different types of support – training, coping, protective services, media management – to deal with threats from the public, from leadership, and from elected officials. The Association of State and Territorial Health Officials is now offering a leadership institute that trains public health leaders in navigating politics and working with lawmakers [8]. More will be needed. One suggestion is that public health workers form more visible alliances with traditional first responders who were potentially less likely to be attacked for their role in the pandemic response, such as nurses, physicians, or paramedics [4]. Additional legal protections for public health workers are also needed. Although 35 states have statutes protecting public health staff during official duties, the National Association of County and City Health Officials and the Network for Public Health Law have asked the U.S. Department of Justice to provide more legal protections and collect more data about threats to public health officials [6].

Although three years into the pandemic nearly every American knows what public health is, this visibility has come at a cost, with public health workers and agencies being scapegoated for many of the COVID-19-related restrictions [9]. At least 25 states passed legislation that limited public health authorities in an emergency, which could limit the ability of public health agencies and professionals to enact important, evidence-based interventions. We must all agree the goal should be public health decision-making guided by science, but we must also accept that public health is inherently political as well. In fact, public health leaders had highlighted the need to be more politically astute as a critical factor to their success well before the pandemic [8]. In a 2017 study of public health leaders, two of their three priorities were to gain a better understanding of political processes and a better understanding of how state government works [10]. In addition, policy makers and elected officials should be better versed in the role of public health in emergencies. In fact, throughout the pandemic, public health practitioners and agencies that had positive relationships with local and state officials felt more supported in, and capable of, carrying out the work necessary for effective and acceptable response. Supported public health

Version of Record at: https://doi.org/10.1016/j.puhip.2023.100435



workers and agencies are essential elements of our frontline response to a future public health emergency.

## Statement of ethics approval

The survey and all other related materials were reviewed by an Institutional Review Board and determined to be exempt.

## Funding

No funding was received for this work.

## Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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