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The Role of the Public During the Decision-Making Process in Preparation for and in Response to a Pandemic

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Abstract

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MBA, Capella University, 2014

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Of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Many advances have been made in technology and medicine; however, humanity remains vulnerable to existing, emerging, and re-emerging infectious diseases that have a profound negative impact on our society. This study investigated how individuals balance socioeconomics, demographics, and religious views with their actual behavior in response to public health guidelines during an epidemic/pandemic. The participants' perceptions and experiences of a practical problem, how the public was asked to respond, and how the public ultimately responded to public health guidelines were explored. The theoretical model for the study, the polarity of democracy model, has been explored as a possible decision-making tool in achieving a unifying strategy and guide the discussion between opposite points of view to minimize risk and maximize benefits during the decision-making process. In this exploratory qualitative pragmatic study inquiry, a random sampling strategy was used. An open-ended semistructured online survey was used to address the posed research question, thirty individuals participated. The questionnaire contained open-ended questions with targeted key components directly related to the research questions. The completed questionnaires were collected electronically via Survey Monkey. The gathered data were analyzed using content analysis and coding. From the collected and analyzed data, it was clear that people's perception behavior is influenced by their situation and the desire to stay healthy physically and mentally through the pandemic. The data suggested positive social change may result from better involvement of the public and a multidisciplinary approach might bring better public health guidelines, and long-lasting response to an epidemic/pandemic.

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Dedication

To all aspiring students and visionaries:

“Do the things that interest you and do them with all your heart. Don't be concerned about whether people are watching you or criticizing you. The chances are that they aren't paying any attention to you. It's your attention to yourself that is so stultifying. But you have to disregard yourself as completely as possible. If you fail the first time, then you'll just have to try harder the second time. After all, there's no real reason why you should fail. Just stop thinking about yourself.”

— Eleanor Roosevelt, You Learn by Living: Eleven Keys for a More Fulfilling Life

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Chapter 1: Introduction to the Study

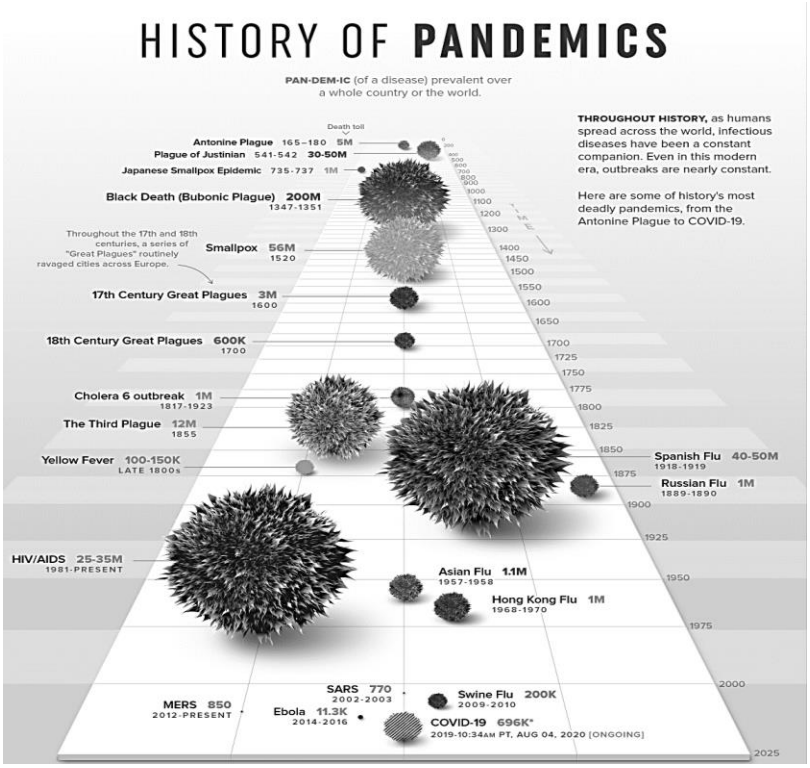
Many advances have been made in technology and medicine; however, humanity remains vulnerable to existing, emerging, and re-emerging infectious diseases that have a profound negative impact on society. An epidemic occurs when an infectious disease spreads rapidly across a population. Outbreaks of infectious diseases are happening more frequently and spreading faster and further than ever before due to biological, environmental, and lifestyle changes (Huremović, 2019; WHO, 2018; Wu et al., 2014). Contagious diseases are exceptional in the way they apply from animal or insect to human and from human to human, making the human factor the mutual denominator of infectious diseases (WHO, 2018). Currently, there is a combination of newly discovered and re-emerging diseases. Typically, an array of forces can affect the burden of infectious diseases in a given population, making infectious diseases an unpredictable threat to human health and global stability (Bloom & Cadarette, 2019; Huremović, 2019; Wu et al., 2014).

Background of the study

The World Health Organization (WHO) periodically tracks the general burden of epidemics globally (Figure 1) and consistently ranks infectious diseases in the top 10 causes of death worldwide (WHO, 2020a).

Figure 1

History of Pandemic and the Death Toll



Note. Retrieved from Visualizing the History of Pandemic by LePan (LePan, 2020).

An influenza virus or a coronavirus has caused most epidemics and pandemics in the 20th and 21st centuries. Influenza killed 80,000 people in 2017 in the United States alone (Huremović, 2019; LePan, 2020) . The COVID-19 disease which is brought by the SARS-COV-2 virus killed nearly 5 million people worldwide by 20th of September 2021 (Worldometer, 2021), and it is often compared with previous flu pandemics (Ashton, 2020; Belongia & Osterholm, 2020).

1.1 million people were killed by the Asian flu from 1957 to 1958, close to the 1 million people thought to have been killed by the Hong Kong flu pandemic of 1968 to 1970. Approximately 50 million people (one-third of the world's population) worldwide were killed by the Spanish flu in 1918 caused by the H1N1 influenza A virus, estimated 770,000 people have died from AIDS-related illnesses (CDC, 2014; Huremović, 2019; LePan, 2020).

Figure 2

The burden of COVID-19

Note. Retrieved from (WHO, 2020b).

Globally, as of 4:56 pm CET, 28 December 2020, there were 79,515,525 confirmed cases of COVID-19, including 1,757,947 deaths, reported to WHO. The map below shows the most impacted region in the darkest color: The United States, Russian Federation, India, Europe, Brazil, Argentina, Peru, Colombia, and others.

Problem Statement

There has been a problem in public engagement in the decision-making process during an epidemic/pandemic. Despite the need for a whole-of-society approach to an epidemic/pandemic, the public is often not included in the initial decision-making process (De Santo, 2016). Whole-of-society approaches are a form of collaborative governance that emphasizes all stakeholders' significant roles in the mitigation and response process. They aim to engage the private sector, civil society, communities, and individuals.

While the government, scientists, health care workers, and healthcare policy analysts play a vital role in creating a response plan, there is a gap addressing the public involvement in the initial decision-making process. This approach creates a gap between how the public is asked to respond and how the public responds. The world of infectious disease and public health management heavily depends on individual human behavior (Weston et al., 2018). Thus, if the public does not follow the public health care recommendations, the pandemic's mitigation and response may not be effective.

A possible cause of this problem is that the public is a passive recipient of information about the new rules and guidelines and is expected to follow them. As seen in 2020, during the COVID-19 pandemic, the public often does not follow the guidelines and feels oppressed by those guidelines. For instance, Thailand became the first country to confirm the first case of COVID-19 outside China. That was on 2020, January 13. On 2020, March 26, the government of Thailand came up with national Emergency Decrees which restricted movement. However, data showed that by end of November the country

saw the case rise to 3998, 38303 recoveries, and 60 deaths. This meant a recovery rate of 95% and fatality rate of 1.5% (Saechang et al., 2021).

Thus, I proposed a qualitative research study investigating venues of public engagement (opportunities to share ideas, provide feedback, ask questions, etc.) in the initial decision-making process and development of guidelines by using the polarity of democracy model (PDM). PDM consist of 10 concepts organized in five polarity pairs that could be used to guide the discussion between opposite points of view to minimize risk and maximize benefits during the decision-making process.

Purpose of the Study

The purpose of this study was to understand public participation in the decision-making process arising from, planning for, and responding to an epidemic/pandemic to create a whole-of-society approach in implementing the public health guidelines. The central phenomenon was how individuals balance socioeconomics, demographics, and religious views with their actual behavior in response to public health guidelines during an epidemic/pandemic. In this study, I explored the gap between how the public is asked to respond and how the public is ultimately responding to public health guidelines.
In this qualitative pragmatic study, I used an online structured anonymous interview survey via the Survey Monkey platform. The study was open to the public and I did not generalize; I investigated and analyzed concepts and emerging themes within a group of participants from the public. I explored if opposite concepts and opinions can be transformed into collaborative forces via the PDM.

Research Question

The primary research question for this study was: How does an individual balance socioeconomics, demographics, and religious views, with their actual behavior in response to public health guidelines during an epidemic/pandemic?

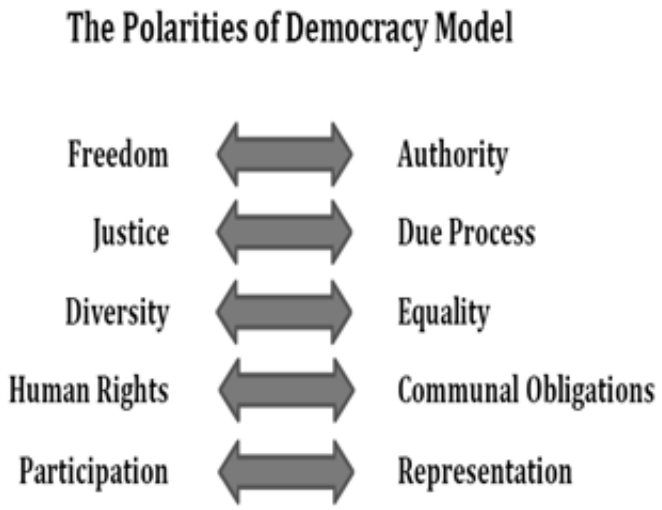
Theoretical Framework

A theoretical framework in qualitative research is used to connect the study to existing knowledge and understanding, expose relationships between concepts, and identify the research project's strengths and weaknesses (Chenail, 2011; Stake, 2010). I applied the PDM in the decision-making process arising from, planning for, and responding to a pandemic to create a whole-of-society approach (Benet, 2013). Benet's (2013) polarities of democracy model consist of 10 concepts organized in five polarity pairs: freedom and authority, diversity and equality, human rights and communal obligations, and participation and representation (Benet, 2013).

My goal for this research was to apply PDM to explore the decision-making process during a pandemic and serve as a balancing and unifying approach between opposite points of view to minimize risk and maximize benefits during the decision-making process in preparation for and response to a pandemic. For example: seeking a balance between the individual need to work and the public health need for social distancing and exploring, evaluating, and weighing different realities against each other to find a solution that would protect people's source of income and health.

Figure 3

The Polarities of Democracy Model with the Elements Arrangement in their Polarity Relationship



Note. Retrieved from (Benet, 2013).

Nature of the Study

In this study, I explored participants' perceptions and experiences of a practical problem, how the public is asked to respond, and how the public is ultimately responding to public health guidelines. In this exploratory qualitative pragmatic study inquiry, I used a purposeful and non-probability sampling strategy. I analyzed the data using frequency distribution and coding. I used a qualitative pragmatic methodology to understand the perception of experience through a detailed description of the people's perspective. I focused on people's subjective experiences and interpretations of the world (Creswell, 2006; Patton, 2015). I used an open-ended semistructured online survey to address the

posed research question. The survey was open to the public because the research question in its context concerns society as a whole.

Qualitative pragmatic research was appropriate for this study because the central question was complex, currently not well-defined, practical, and highly contextual. There was also a need to explain relations or mechanisms that cause the public to behave in specific ways during a pandemic. I used PDM to explore opposing points of view during the decision-making process to prepare and respond to a pandemic. For this study, I used only three out of five pairs of concepts of democracy:

1. Diversity and equality,
2. Human rights and communal obligations,
3. Participation and representation.

Using COVID-19 as an example of the most recent pandemic, there was mounting evidence suggesting that minorities experience a greater incidence and worse cases of diseases than White Americans. Key risk factors, such as age, sex, race, socioeconomic status, dense living conditions, and comorbidities, are linked to worse outcomes during COVID-19 infection (CDC, 2020).

International human rights law guarantees everyone the right to the highest attainable standard of health (Leary, 1994; Potts & Hunt, 2008). It obligates governments to prevent threats to public health and provide medical care to those who need it (Turner & El-Jardali, 2020). However, due to the nature of the infectious disease, this is impossible to achieve without considering individual responsibilities to follow health guidelines and communal obligations (Gostin & Wiley, 2016).

Combating an epidemic/pandemic requires a whole-of-society approach. Thus, all stakeholders' equal participation was a fundamental human right and fundamental recruitment to a successful response. Equal participation in the decision-making process is necessary to provide a balance that reflects society's day-to-day needs more accurately. I explored the public's perception based on their socioeconomics, demographics, and religious beliefs using the three polarity pairs outlined above.

I did not seek a unifying point of view. I did not use a preselection of variables, adjustment of variables, prior commitment to any theoretical aspect of a target phenomenon, or previous focus on a specific population. I did not generalize; I explored, researched, and analyzed concepts and emerging themes within a group of participants from the public.

Definitions

Epidemics: a widespread occurrence of an infectious disease in a community at a time (CDC, 2019).

Perceived barrier: The belief that certain factors prevent an individual from making constructive and eloquent health care decisions (Glanz & Bishop, 2010).

Perceived severity: The belief that individuals are at risk of developing the disease, and the likelihood of disability or death from the disease, in the presence or absence of treatments.

Perceived susceptibility: The perception of the individual that the disease can be transmitted from one source to another .

Pandemic: (of a disease) prevalent over a whole country or the world (CDC, 2020).

Self-efficacy: The ability of the individual to make positive decisions and to act to implement those decisions (Glanz & Bishop, 2010).

Socioeconomic status: The combination of education, income, and overall financial situation.

Assumptions

Qualitative pragmatic research assumptions are about the fundamental perception of the phenomenon being studied and its relation to a practical problem (Patton et al., 2015; Patton, 2005). Such qualitative approaches encompass an in-depth understanding of human behavior and the insights that guide human behavior (Creswell, 2013; Creswell & Poth, 2016).

I assumed that the public is interested and willing to participate in the decision-making process arising from planning for and responding to a pandemic. I assumed this based on the assumption that behavior during a pandemic is shaped by individual experiences and understanding of the ethical and moral challenges that could emerge during a pandemic.

I also assumed that various points of view were being collected by opening the survey to the public. Creswell (2006) described four philosophical assumptions:

1. *Ontological* refers to different points of view, multiple forms of evidence, and various individual perspectives and experiences.

2. *Epistemological* is the approach that involves the most accurate ways to obtain the necessary data based on personal opinions and perceptions from research conducted in the field.
3. *Axiological*, which means that researchers make their values known in the study and actively reports their values.
4. The methodology includes all the methods used in the process of research.

Ontology and epistemology are two different ways of viewing the challenges within a pandemic. Ontology is used to frame the known facts about pandemic mainly through medical and scientific facts. Epistemology is used to explore the system of beliefs and perceptions of an individual about the ethical and moral challenges that arise during a pandemic. Methodological assumptions consist of the researcher's expectations concerning the methods used in qualitative research and the study process (Creswell, 2006; Patton, 2015). I assumed that an exploratory qualitative pragmatic study represented the best approach to address the research question. I further believed that the participant's selection, research methods for data collection, data analysis, and interpretation are the best fit for the study. By opening the research to the public, I assumed that the answers would reflect the public's diverse points of view.

I assumed that the polarity of the democracy model is the correct model for this study, and it has the power to analyze and evaluate opposite points of view into unifying guidelines. I also assumed that the model can be used to determine the given decision-making process's positive and negative views. I assumed that certain positive and

negative factors are universal. I further assumed that the selected three pairs of the polarity and democracy model are the most fitting for a pandemic:

1. diversity and equality
2. human rights and communal obligations,
3. and participation and representation

The main practical assumptions that I had in this study were that all questions were answered honestly and accurately. I assumed that the written answers and descriptions would allow for more accurate data interpretation. I assumed that all the data collected through anonymous surveys were valid, accurately represented, suitably coded, and analyzed.

Scope and Delimitations

Using a qualitative pragmatic methodology, I aimed to understand public participation in the decision-making process arising from, planning for, and responding to an epidemic/pandemic to create a whole-of-society approach. This exploratory research study was open to the public via Survey Monkey. I sought diverse individual points of views and did not expect a unifying answer. The survey included questions that I used to investigate the personal perceptions and experiences of a practical problem that concerns society.

This was an exploratory research study with no preselection of variables, no adjustment of variables, and no prior commitment to any theoretical assumptions about reality that could form the questions and influence how answers might be evaluated. I

collected responses to 10 demographic questions at the end of the survey to retrospectively understand the demographics of participants who volunteered for this study.

I explored only three out of five pairs of PDM: diversity and equality, human rights and communal obligations, and participation and representation, interrogating challenges that seem to be most prominent during the COVID-19 pandemic. I established transferability by providing evidence that the research findings could apply to other contexts, situations, times, and populations. The outcome of this study is specific to the participants who opted into the study and their individual situations.

Limitations

A study's limitations are those characteristics of design or methodology that impact or influence the interpretation of the survey findings (Andrade, 2020). Qualitative research results cannot be verified, and the results are not statistically representative (Creswell, 2013; Creswell & Poth, 2016). Methodological limitations relate to issues with sample and selection. My decision to engage the public in this discussion via an anonymous survey limited this study because it was impossible to predict who would participate. I defined the participants retrospectively based on answers to the demographic questions in the last section of the survey.

In this study, I may not have described all factors associated with the decision-making process to prepare and respond to a pandemic. The study data represent only the views limited to those who chose to participate. Because the study was open to the

general public, it is possible that some participants might not have fully understood the scope of the topic and might not have provided an answer to all questions. Limitations of transferability and dependability include but are not limited to evasive answers, unanswered questions, incorrect information, lack of credibility validation, differences in understanding and interpretation of subjects, difficult to convey feelings and emotions, etc.

The study design included an open-ended online survey to address the posed research question. The open-ended questions were limited to the initial response because there was no interviewer to direct and follow up on the answers. Only participants with computer access were able to participate. Only participants comfortable with Survey Monkey volunteered for this study. The Survey Monkey platform had many limitations such as simple, standardized templates requiring questions to fit the template, inability to upload complex structure, place a time limit on questionnaires, etc. none of which impacted the research study.

Furthermore, because this was a novel exploratory study, I used a newly developed questionnaire. More research is needed to determine if this questionnaire is enough to address the posted research question and establish valid data collection sufficiency to answer the research question. The survey's full validity will be evaluated based on data collected and the respondents' views. Measures to address limitations were limited. I used only data from completed questionnaires in the study. My goal was to collect 30 complete surveys. Examples of possible bias were mostly related to data

analysis, such as clustering illusion, selective perception of emerging themes, and confirmation bias.

Significance of the Study

This study's significance is that I explored public engagement in the decision-making process during an epidemic/pandemic. Despite the need for a whole-of-society approach to the pandemic that emphasizes the significant roles of all stakeholders involved in mitigation and response to a pandemic, the public is often not included in the initial decision-making process. This approach creates a gap between how the public is asked to respond and how the public ultimately responds. A possible cause of this problem is that the public is often a passive recipient of information about the new rules and guidelines and is expected to obey them. As seen in 2020, during the COVID-19 pandemic, the public often does not follow the guidelines and feels oppressed by those guidelines.

Despite the need for a whole-of-society approach to an epidemic/pandemic, the public was often not included in the initial decision-making process. In the study, I investigated venues of public engagement (opportunities to share ideas, provide feedback, ask questions, etc.) in the initial decision-making process and guidelines developed by utilizing the PDM which was applicable to this situation. PDM consists of 10 concepts organized in five polarity pairs that can be used to guide the discussion between opposite points of view to minimize risk and maximize benefits during the decision-making process.

In 2020, we saw the rise of COVID-19 due to a lack of social distancing, premature business reopening, or not wearing masks. Many businesses had to make a difficult choice to open prematurely or lose the business. In the study, I explored if, by engaging the public in the early decision-making process, some of the hardship could have been prevented by seeking an alternative to a complete shutdown for those unable to work remotely. Socioeconomic status, religion, and demographics are associated with multiple health dimensions and are inextricably linked to race and ethnicity. Socioeconomic status and demographics affect where we live, what we eat, what type of job we have, and whether we have access to health insurance, health education, and healthcare. Religion is associated with different preferences and beliefs related to health. All of this, in turn, determines the public health.

Benet (2013) points that polarities of democracy model might bridge the current gap by exploring the decision-making process and serving as a comprehensive tool to reconcile opposing views and options to reduce risk and maximize benefits day-to-day. Such model provides a set of interrelated concepts, definitions, and propositions that aims to balance opposing points of view to minimize risks and maximize benefits. This study is significance when it comes to social change relied on developing potential real-world solutions based on real-world evidence for more realistic management of the pandemic. Therefore, I explored the boundaries of where the public duties start and end during a pandemic, aiming to determine the public's level of engagement during the policy-making process and understand the guidelines that the public can follow during a pandemic.

Summary

Despite many advances in technology and medicine emerging, re-emerging infectious diseases represent a real threat to humanity. In this chapter, I initiated a discussion regarding the public's engagement in the decision-making process during an epidemic/pandemic. Furthermore, I explored the gap between how the public was asked to respond and how the public was ultimately responding. The world of infectious disease and public health management heavily depends on individual human behavior. Thus, if the public does not follow the public health care recommendations, the pandemic's mitigation and response are insufficient.

The purpose of this study was to understand public participation in the decision-making process arising from, planning for, and responding to an epidemic/pandemic to create a whole-of-society approach. The central phenomenon stood on how individuals balance socioeconomics, demographics, and religious views with their actual behavior in response to public health guidelines during an epidemic/pandemic. In this chapter, I incorporated a brief background of the study, problem statement, and purpose of the study, theoretical framework, assumptions and scope of delimitation, limitations, and significance. In Chapter 2, I took a comprehensive review of the literature on the decision-making process during a pandemic, economic, cultural, and public health impact, and policy development and implication in preparation for and response to a pandemic. I also included a discussion of the literature surrounding the theoretical framework.

Chapter 2: Literature Review

My goal for this research was to understand the public's level of engagement in the decision-making process during a pandemic. I explored whether engaging the public in the early decision-making process can yield a whole-of-society approach to infectious diseases. In this chapter, I explored the historical impact of epidemics and discussed the individual and the community's role, academic and private institutions, media etc. in fighting the pandemic. I addressed the challenges posed by individual families and communities' ethical values and norms that need to be considered when guidelines and services are being developed.

Literature Search Strategy

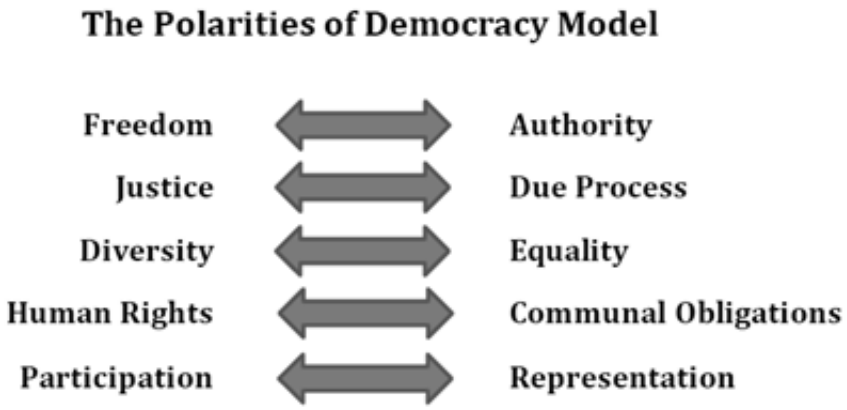
The literature that I reviewed in this study includes topics and central concepts relevant to a pandemic, such as a history, evolution, transmission, biology, epidemics, decision-making process, public health guidelines, public policy development, evolution, and execution implementation of public health guidelines and bioethics. The literature searches were done using several databases: Quest, Medline Plus, PubMed, and Google Scholar. I conducted literature search electronically, using the standard query terms such as: *infectious diseases pandemic, epidemic, public health decision-making process, public policy development, public health concepts during a pandemic, bioethics, pandemic, public health guidelines, evolution, execution,* and *implementation of public health guidelines and bioethics.*

Theoretical Framework

In this study, I utilized Benet's (2013) PDM as shown in Figure 4, which consist of 10 elements organized in five polarity pairs: freedom and authority, justice and due process, diversity and equality, human rights and communal obligations, and participation and representation (Benet, 2013).

Figure 4

The Polarities of Democracy Model



Note. Retrieved from (Benet, 2013, P. 31).

In pointing the five polarity pairs, Benet (2013), gives the following points;

1) Freedom and authority refer to people's right to choose or freedom of choice to exercise full bodily autonomy. Authority involves a moral right to control, command, or determine a specific process or action. A clear understanding of who has the authority and which organization or institution demands/needs

power. The public needs a set of guidelines that can be agreed and followed without questions and doubts, but trustfully.

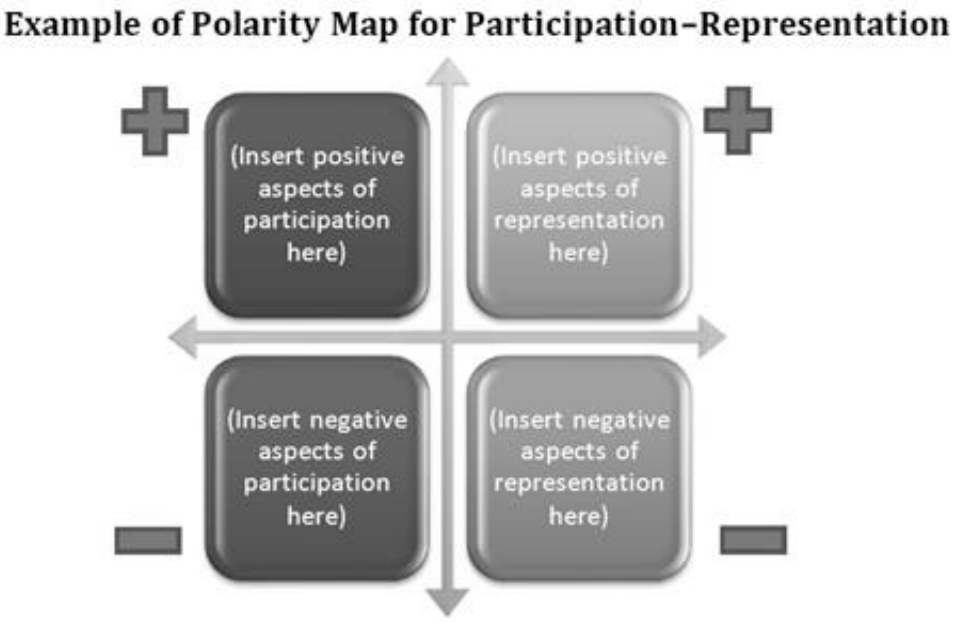
2) Justice and due process is rooted in the Fifth and Fourteenth Amendments in the United States Constitution of 1992. Due process deals with the administration of justice. Every person has the right to life, liberty, or property. The constitution reinforces self-control that reminds people that they all have the right to life, and that such action is in a way that it will not jeopardize others' lives.
3) Diversity and equality are about considering the differences between people and groups of people. Equality is about making sure that everybody has an equal opportunity and is not discriminated against.
4) Human rights and communal obligations are based on individual beliefs and culture. Community responsibilities are an individual's duties or obligations to the community and include cooperation, respect, and participation.
5) Participation and representation are two fundamental elements and principles of democracy, balancing the people's voice with those representing them in the office.

The PDM has been used to help build healthy, sustainable, and just communities (Benet, 2013). Benet (2013) presented the 10 elements as essential components of the workplace and societal democracy and emphasized that democracy is a useful tool in achieving positive change; a unifying theory is needed to connect the differences between diverse points of view. Each of the 10 elements can have either a positive or negative

effect, and the goal is to increase each component's positive impact (Figure 5). The elements are ultimately minimizing the negatives and maximizing the positive within the decision-making process.

Figure 5

Example of a Polarity Map for Representation



Note. Retrieved from (Benet, 2013, p. 34).

Pandemic management success depends on some aspects such as: when, where, and how to deploy available interventions (Institute of Medicine - IOM, 2007; WHO, 2020) . The current public health pandemic decision-making process relies on the government's actions, expert's recommendations of the optimal response, and the Code of Ethics (Bishop, 2013; Vaughn, 2010; WHO, 2018b). The Code of Ethics stands on four

biomedical ethics principles defined by individuals' autonomy, nonmaleficence, beneficence, and justice (Vaughn, 2010). Although these principles represent a good foundation for the public health decision-making process, they do not go far enough to address challenges during a pandemic. For example, the autonomy principle recognizes the individual's right to have an opinion, make choices, and take actions based on individual values and beliefs (Bishop, 2013; Vaughn, 2010; WHO, 2018b). However, challenges that arise during a pandemic must balance individual human rights with communal obligations by determining the positive and negative factors that induce the decision-making process. For example, wearing a mask and practicing social distancing could be viewed as a communal obligation, not a factor that is limiting human rights.

Vaccination could be viewed as both a positive and negative factor. Vaccination helps slow down the transmission and prevents severe symptoms, however, mandatory vaccination could be viewed as an action interfering with human rights and body autonomy (van Aardt, 2021). Furthermore, social distancing might be viewed as a reasonable measure to limit the spread of a virus while it can have a negative impact on several businesses (Dalton et al., 2020). It is up to the community to use a situational approach and valuate different factors against a given situation.

The PDM can guide and enhance the decision-making process during a pandemic to ensure more effective processes, procedures, and outcomes. It can improve the decision-making process by understanding and examining the different points of view, maximize the positive aspects of conflicting opinions making sure that no decision is

made based on a single idea. It can serve as a unifying framework for the challenges seen during the COVID-19 pandemic.

Wynia (2005) noted that protecting human rights fosters healthy behaviors, while restrictions on liberty drive destructive behaviors and suggest that if social order was maintained, people were more likely to follow the law if agreed upon between the people and the authorities before implementation. Smith et al. (2019) stressed that infectious diseases in today's globalized world require robust public-private partnerships and communication for optimal health and economic security. Trostle (2005) acknowledged the importance of cultural factors and various institutions' influence on the decision-making process during medical emergencies.

While the five pairs of the PDM (Benet, 2013) represent two sets of opposite concepts of democracy, they can be used as collaborative forces that strive for the best possible outcome in each situation. For example, the communal obligation could outweigh individual human rights during a pandemic to protect the most significant number of people by reinforcing several restrictions such as social distancing, curfew, or limited store hours. However, despite such restrictions people should be able to meet their needs, such as earning a salary. A guideline and policy's potential to fail is high when these opposite forces are not recognized and managed. In this case, either people would feel oppressed because their human rights are taken, or the community will be exposed to a higher risk of infections than necessary.

History of Epidemics/Pandemics

An epidemic occurs when an infectious disease spreads rapidly across a population. A pandemic occurs when an infectious disease spreads over a whole country or the world. Both epidemics and pandemics of infectious diseases are occurring more frequently and spreading faster and further than ever before due to biological, environmental, and lifestyle changes (Bloom & Cadarette, 2019). Contagious diseases are exceptional in the way they spread from animal or insect to human and from human to human, making the human factor the mutual denominator of infectious diseases (Barreto et al., 2006).

Currently, the world is faced with a combination of newly discovered and re-emerging diseases. Typically, there are several general forces that can affect the burden of infectious diseases in a given population: change in abundance, virulence, transmissibility; increase in the probability of exposure of individuals; increase in vulnerability of people to infection and the consequences of the disease; access to health care in a given population, the population's understanding of the issue, mitigation and response plans in place, and the public adherence and acceptance to these plans (Woolhouse et al., 2012). WHO periodically tracks the general burden of epidemics globally and consistently ranks infectious diseases in the top 10 causes of death worldwide (WHO, 2020b).

Table 1

History of Pandemics and the Death Toll

Name	Time period	Type / Pre-human host	Death toll
Antonine Plague	165-180	Believed to be either smallpox or measles	5M
Japanese smallpox epidemic	735-737	Variola major virus	1M
Plague of Justinian	541-542	Yersinia pestis bacteria / Rats, fleas	30-50M
Black Death	1347-1351	Yersinia pestis bacteria / Rats, fleas	200M
New World Smallpox Outbreak	1520 – onwards	Variola major virus	56M
Great Plague of London	1665	Yersinia pestis bacteria / Rats, fleas	100,000
Italian plague	1629-1631	Yersinia pestis bacteria / Rats, fleas	1M
Cholera Pandemics 1-6	1817-1923	V. cholerae bacteria	1M+
Third Plague	1885	Yersinia pestis bacteria / Rats, fleas	12M (China and India)
Yellow Fever	Late 1800s	Virus / Mosquitoes	100,000-150,000 (U.S.)
Russian Flu	1889-1890	Believed to be H2N2 (avian origin)	1M
Spanish Flu	1918-1919	H1N1 virus / Pigs	40-50M
Asian Flu	1957-1958	H2N2 virus	1.1M
Hong Kong Flu	1968-1970	H3N2 virus	1M
HIV/AIDS	1981-present	Virus / Chimpanzees	25-35M
Swine Flu	2009-2010	H1N1 virus / Pigs	200,000
SARS	2002-2003	Coronavirus / Bats, Civets	770
Ebola	2014-2016	Ebolavirus / Wild animals	11,000
MERS	2015-Present	Coronavirus / Bats, camels	850

(table continues)

COVID-19	2019-Present	Coronavirus – Unknown (possibly pangolins)	19,800 (Johns Hopkins University estimate as of 9am PT, Mar 25, 2020)

Note. Retrieved from "The History of Pandemics" (LePan, 2020).

An analysis is done to the following outbreaks between 2011 to 2017: avian influenza A(H5N1), A(H7N9), A(H7N6) A(H10N8), A(H3N2), A(H5N6), A(H9N2), chikungunya, cholera, Crimean-congo hemorrhagic fever, Ebola virus disease, Lassa fever, Marburg virus disease, meningitis, MERS-CoV, monkeypox, nodding syndrome, nipa virus infection, plague, Rift Valley fever, shigellosis, typhoid fever, viral hemorrhagic fever, West Nile fever, yellow fever, and zika virus disease. The spread of new diseases such as HIV/AIDS, hepatitis C, dengue hemorrhagic fever, and the resurgence of diseases long since considered under control, such as malaria, measles, tuberculosis, and meningococcal disease, cholera, and sleeping sickness, have raised concerns.

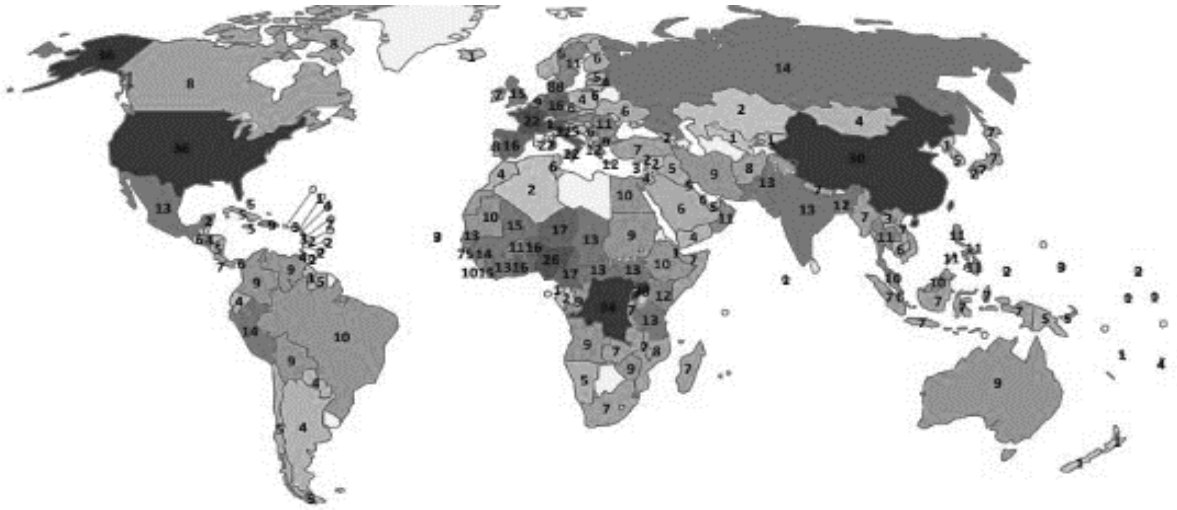
Infectious diseases cause 63% of all childhood deaths and 48% of premature deaths (CDC, 2020).The CDC (2019) created the Crisis and Emergency Risk Communication/ Emergency Preparedness Model (CERC), outlining decisions made, steps taken, and resources allocated by officials and organizations (CDC, 2014). No response to an epidemic can be completed without the public's active and willing participation (Vaughn, 2019). The complex challenges associated with the threat of infectious diseases are magnified by population growth, insufficient health systems,

urbanization, globalization, climate change, civil conflict, and the changing nature of pathogen transmission between humans and animals (Bloom & Cadarette, 2019).

Several studies examined the socioeconomic impact of epidemics such as Ebola, SARS, H1N1, or RVF on various sectors: tourism, agriculture, government, overall financial impact, and travel and stressed the importance of more collaborative work between the public and private stakeholders at local, national and international levels to ensure sound strategies for prevention and preparedness where possible and assess optimal intervention strategies when necessary (Woolhouse et al., 2012).

Figure 6

Burden of Epidemic: Epidemic events globally, 2011 – 2017: A total of 1,307 epidemic events, in 172 countries



Note. "Managing epidemics: Key facts about major deadly diseases," (WHO, 2018a).

Today, there has been an elaboration of global health systems in place against known and unknown infectious diseases such as various organizations that serve different stakeholders; have varying goals, modalities, resources, and accountability; and operate at different regional levels. The global health system has evolved into a strong protection network. However, emerging and reemerging infectious disease such as Ebola, zika, dengue, Middle East respiratory syndrome, severe acute respiratory syndrome, HIV or influenza remain a significant threat to the world (Barreto et al., 2006), including COVID-19 (WHO, 2020a).

The two primary global leading entities in the fight against infectious disease are the Eastern Mediterranean Region (EMR) and the WHO. WHO collaborates with member states to improve public health preparedness, surveillance systems, outbreak response, and address critical knowledge gaps. A regional network for experts and technical institutions has been established to facilitate and support an outbreak's international response (Buliva et al., 2017). Health-care providers and government information are the most critical determinants of intention to practice prevention measures (Abu-Rish et al., 2019).

The CDC (2014) created the Crisis and Emergency Risk Communication/ Emergency Preparedness Model (CERC), outlining decisions made, steps taken, and resources allocated by officials and organizations during health emergencies (CDC, 2014). However, no response to an epidemic can be completed without the public's active participation (Probert et al., 2018).

Public Health Ethics

Public health ethics focuses on the nature and moral justification of human rights and the right to health, a human right to the essential resources for promoting and maintaining basic health, including adequate nutrition and health education (Liao, 2019). Public health ethics are standing on the four principles of biomedical ethics defined by the autonomy of individuals, non-maleficence, beneficence, and justice (Vaughn, 2012). Historically, bioethics and public health ethics have been based on various moral philosophy schools and theoretical foundations.

The four most influential are 1) Utilitarianism, 2) Kantian ethics, 3) Liberal individualism, and 4) Communitarians (Vaughn, 2019). The fundamental premise of Utilitarianism is to aim for maximum utility, which is usually defined as creating happiness or satisfaction. Utilitarianism holds actions as right or wrong according to the balance of their good and bad consequences (Vaughn, 2019). Utilitarianism has a distinct approach to ethical reasoning in public health despite suggestions of unfairness prioritizing resources to those who make the most significant contributions to society rather than those in the greatest need (Beauchamp & Childress, 2001).

Kantian ethics are concerned with the inherent moral character of actions and whether an effort can be universal so that any rational agent would act in a consistent way across the population (Vaughn, 2019). It promotes equal resource allocation and universal rights to health care (Nunes & Rego, 2014). This philosophy is inclined to social medicine but does not account for different beliefs, ideas, and perceptions among diverse groups. Liberal individualism promotes human life protection by advocating the

right to treatment, privacy, autonomy, and confidentiality. It emphasizes the dignity and human rights (Nunes & Rego, 2014; Vaughn, 2019). Communitarians strive to promote shared values and interests while maintaining the connection between an individual and the community. It emphasizes individuals' responsibility to the community and family (Vaughn, 2019). Similarly, to the Liberal individualist or Communitarians' ethics, the democracy model's polarities strive for moral justice in protecting individuals from political and scientific injustices.

The four principles of bioethics represent a crucial building block of the decision-making process in health care. An individual has the right to decide about treatment and preventive measures. The autonomy principle is closely connected to Kant's (Allison, 1990). observation that all persons deserve respect as rational beings. According to these beliefs, autonomy might imply that the patient's wishes are to be followed even if there could be a reason to go against the patient's wishes due to the communal obligation. The principle of collective responsibility stresses not to inflict harm on others. It strives for equality. However, duties that pursue the patient's benefits may conflict with this obligation (Nunes & Rego, 2014).

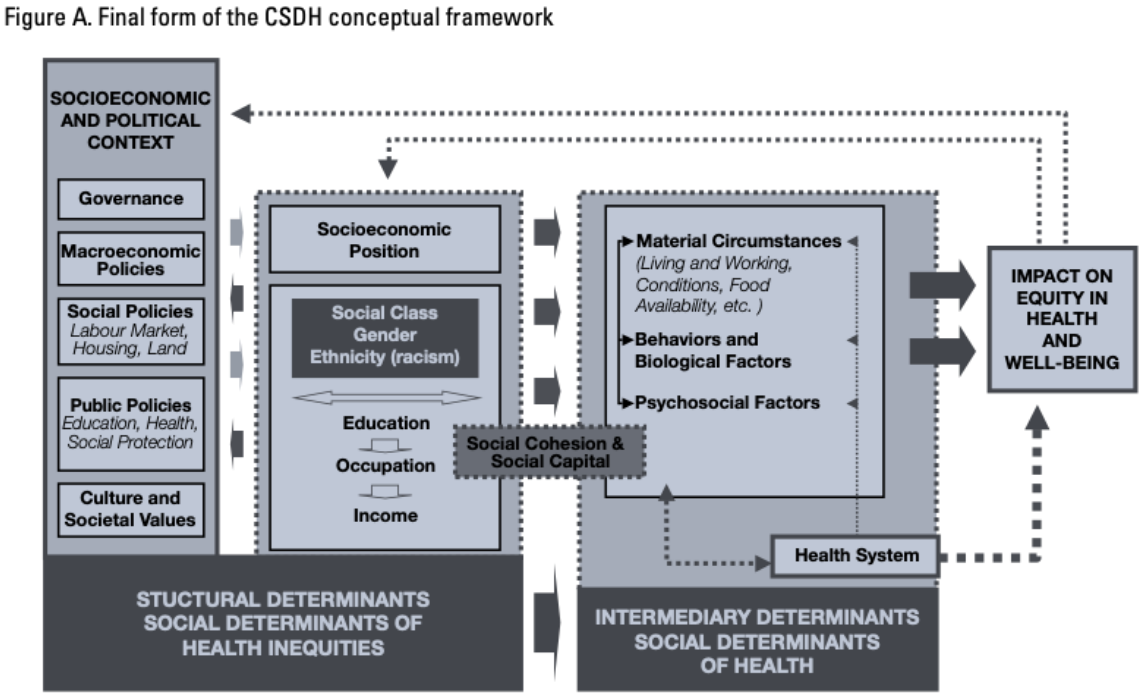
WHO (2010) developed a Commission on the Social Determinant of Health (CSDH) as a general conceptual framework to measure and predict the quality of health within a population (Figure 7). This model shows how different cultural variables shape the health status and the perception of health rights, obligations, responsibilities, and vulnerability to health-compromising conditions. The model outlined the key factors: income, education, occupation, social class, gender, race/ethnicity, etc. The main

categories of an intermediary determinant of health are material circumstances, psychological circumstances, behavioral and biological factors, and the social system itself. The CSDH provides a useful lens into the fundamental forces influencing people's health and their health-related decision-making process.

The current decision-making process stresses multiple determinants and multiple levels of determinants of health and health behavior (Karen Glanz & Donald B Bishop, 2010).

Figure 7

Conceptual Framework for Action on the Social Determinants of Health



Note. From "A Conceptual Framework for Action on the Social Determinants of Health," by WHO (2010)

Attitudes, principles, and actions inspired by what is presented to the public by relations and information, received from the society, and the surroundings Individual's families, educational systems, media exposure, religious groups, political affiliation, where one lives, where one study and work, what type of health care system is available might influence how people express their attitudes, beliefs, and behaviors toward others (Trostle, 2005).

Decision-Making Process

The public health policy decision-making process stands on government decisions, expert recommendations, and bioethics. The public is often not included in the early decision-making process (Blackett et al., 2019; Richards et al., 2017). Reynolds (2006) stressed that decision-making measures need to be based not only on valid scientific evidence but also on the affected community's ethical and moral views to reduce the likelihood of harm. Müller (2001) argued that public health decisions must account for different perspectives to be effective.The Centre of Excellence on Partnership with Patients and the Public (CEPPP) outlined the importance of early inclusion of the public in the decision-making process to assure a good engagement through building trust and keeping people safe in the long run (CEPPP, 2021).

Policy decision-makers are responsible for forecasting, directing staffing, logistics, selecting public health interventions, communicating to professionals and the public, planning future response needs, establishing strategic and tactical priorities along with their funding requirements, rapidly synthesizing data from different experts across

multiple disciplines, bridging data gaps, and translating epidemiological analysis into an operational set of decisions for disease control (Probert et al., 2018; Chattu, 2014). However, Richards et al. (2016) observed that he current process does not include the public in the decision-making process.

During an epidemic/pandemic, the decision-making process optimizes population health measures (total infections averted or real expected gains in quality-adjusted life-years) while satisfying resource constraints (such as budget or vaccine). These processes use real-time epidemic data (disease incidence) and the information on the availability of resources at each decision point, such as transmission-reducing intervention (such as school or public space closure). Inside all the efforts, there is still an urgent need for greater demand and more significant support from communities and policymakers for rights-based, evidence-informed prevention strategies (CDC, 2020; WHO, 2020)

The Ethical and Legal Consideration in Mitigating Pandemic Diseases (IOM, 2007) examined how to overcome obstacles associated with outbreaks through research, policy, legislation, communication, and community engagement. It was noted that even after reviewing a broad range of infectious diseases, the legal and ethical dilemmas seems to vary from an outbreak to an outbreak struggling to balance individual human rights with communal obligations, the vulnerability of health workers and the duty to treat, ensuring equal and just medical resources, each countries responsibilities to prevent international spread while preserving trade (Cvetković et al., 2021; Chattu, 2014; Javed & Chattu, 2020; Chattu, 2014).

WHO and CDC have developed a comprehensive pandemic preparedness plan that includes essential steps to assure a whole-society pandemic readiness. The model (Figure 8) clearly shows an equal role between the health care community, the public, and other sectors. Yet, during the 2020 COVID-19 pandemic the public was excluded from the decision-making process. The public was expected to follow and obey the rules (Richards & Scowcroft, 2020).

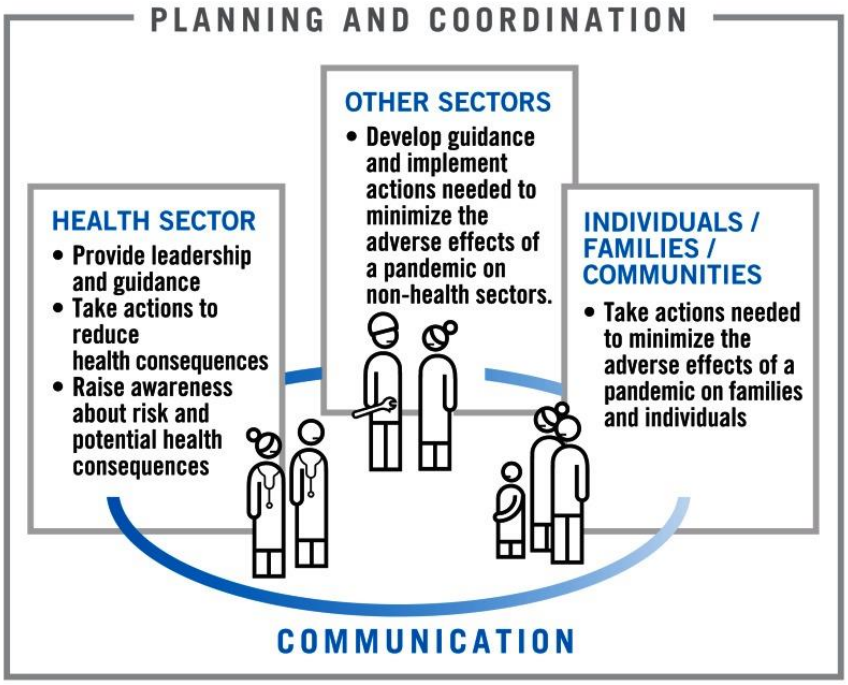
Public health guidelines may have unintended and often undesirable consequences, such as adverse economic effects or the restriction of civil rights and civil liberties (Cvetković et al., 2021; IOM, 2007). Agreement within the professional community is very unlikely to succeed without the population's collaboration. Researchers stressed out the despite the general understanding that a whole-society approach is needed to mitigate any health crisis, patients, families, and front-line workers are often excluded from the decision-making process. The polarity of the democracy model could provide the missing tools to close the communication gap between the professional community and the public and help balance the opposing forces within the decision-making process (Richards & Scowcroft, 2020).

Yang (2020) stressed the challenges of achieving evidence-based decisions and evidence-based management (EBM) during a pandemic. He pointed out that a pandemic is characterized by uncertainty, high potential loss, time constraints, and competing forces, posing challenges to EBM. He identifies three key issues: what is evidence, how do we access evidence during the decision-making process, and what role evidence plays in ethical judgments in a pandemic (Yang, 2020).

A whole-society approach to mitigate the predictable adverse effects of service reconfiguration and lockdown and accentuated the need for clarity on which services would be suspended or remain accessible. The proper inclusion of all stakeholders might prevent at least some of the excess morbidity, mortality, economic hardship, or mental health impact associated with pandemic responses, particularly among older adults, those with long term conditions, and those in lower socioeconomic (Richards & Scowcroft, 2020; Wizemann et al., 2013).

Figure 8

Pandemic Influenza Preparedness and Response: A WHO Guidance Document



Note. "Pandemic Preparedness. Pandemic Influenza Preparedness and Response: A WHO Guidance Document," retrieved from https://www.who.int/influenza/preparedness/pandemic/en/

Summary

Infectious diseases have spread across the world. Even in this modern era, outbreaks regularly occur, though not every outbreak reaches the pandemic level as COVID-19 has. The current public health policy decision-making process stands on government decisions, expert recommendations, and bioethics. The role level of participation by the public is sporadic. However, a successful response to an epidemic stand on individual human behavior. Thus, in this research, I explore the boundaries of

where personal rights, responsibilities, and obligations start and end during a pandemic. I examine the level of engagement of the public during the decision-making process in response to an epidemic.

Furthermore, I explore if the polarity of the democracy model could provide the missing tools to help balance the opposing forces within the decision-making process. In the next chapter below, I specify the study's methodology, including the rationale, selection of participants, data collection, and analysis. I used qualitative pragmatic methods to explore individual engagement in the decision-making process during a pandemic.

Chapter 3: Research Method

In this study, I explored the engagement of the public in the decision-making process during a pandemic. In this chapter, I included the following sections: Research design and rationale, in which I described the pragmatic methodology in exploring perception and experiences of the participants.

Methodology is a roadmap, I therefore applied the qualitative research inquiry, qualitative pragmatic methodology and nonprobability sampling strategy. I also described the role of researcher, stressed the obligations of the researcher to collect and analyze the data. In this case, no pre-selection of variables, no adjustment of variables, and no prior commitment to a specific population applied. Concerning the instrumentation section, I emphasized the importance of open-ended questions in the survey.

Additionally, I demonstrated the procedure for recruitment, participation, and data collection section. I explained the method of recruitment via survey Monkey. I collected the data through administration of open-ended questions in the survey. Furthermore, I demonstrated the trustworthy issues section concerned, showing the researcher ability to demonstrate transferability, dependability, confirmability, and credibility. In the ethical procedures section, I investigated ethical nature of the study and the conduct of the researcher to the respondent; and finally, in the summary sections, I demonstrated all the all the chapters' main points and arguments.

I applied a qualitative pragmatic methodology in this research because it is essential, to consider all the epidemiological research components. Health care research

in general qualitative methodologies can provide insight into the perceptions, values, opinions, and community standards during a decision-making process (Patton et al., 2015; Patton, 2005). Such methodological approaches are suitable for interpretative, naturalistic approach to the studied topic and enables developing an all-inclusive perception of the phenomenon in question (Denzin & Lincoln, 2011).

Research Design and Rationale

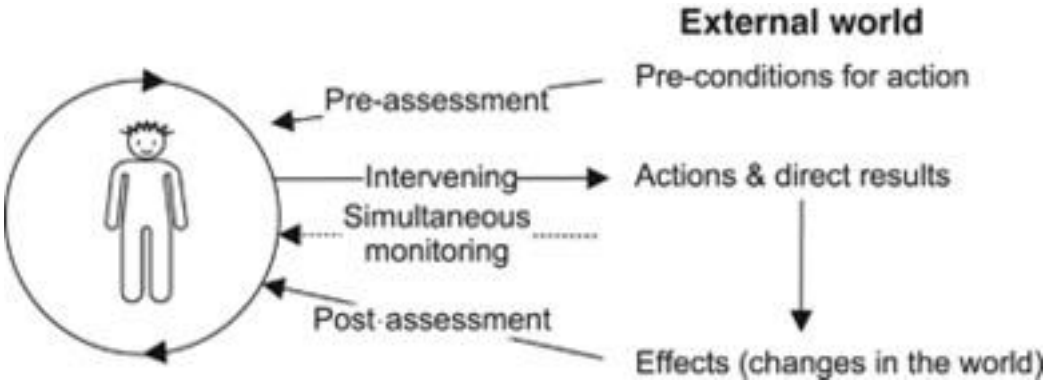
I sought to answer how individuals balance socioeconomics, demographics, and religious views, with their actual behavior in response to public health guidelines during an epidemic/pandemic. I further explored participants' perceptions and experiences of a practical problem, how the public was asked to respond, and how the public ultimately responded to public health guidelines. In this exploratory qualitative pragmatic study inquiry, I used a random sampling strategy, and I also used an open-ended semistructured online survey to address the posed research question.

I selected qualitative pragmatic methodology for the study to explore participants' perceptions and experiences of a practical problem (Goldkuhl, 2012). Grounded in the social sciences, the qualitative research approach assisted me to explore participants' life experiences within their social context, aiming to understand complex relationships while recognizing each situation and context (Denzin & Lincoln, 2011). It helped me to explain human experiences and provide insight into people's individual experiences seeking a pragmatic solution above philosophical discussions (Patton, 2015). The qualitative pragmatic methodology facilitated my understanding of human action in a world that is

continuously changing. It also helped me to study humans' behavior as the driver to all human relationships and overall existence (Figure 9). There is an assumption in qualitative approaches that the world is changed through reason and action, and there is an inseparable link between human knowing and human behavior. One of the foundational ideas within pragmatism is that the meaning of a statement or a concept is the practical consequences of the idea/concept influence the purpose of specific action steps people take (Goldkuhl, 2012).

Figure 9

A Cyclic Model of Human Action



Note. "Pragmatism vs interpretivism in qualitative information systems research," retrieved from Goldkuhl (2012).

Role of the Researcher

In qualitative studies, the researcher is an instrument of data collection and analysis (Denzin & Lincoln, 2011). I followed a protocol for data collection,

documentation, and analysis. Just as Pannucci and Wilkins (2010), I define bias as any tendency or systematic error introduced into sampling or analysis by selecting or encouraging one outcome or answer over others. Bias can occur at any phase of research, including study design or data collection, as well as in the process of data analysis and publication.

In this study, I used an anonymous open-ended structured questionnaire instead of an interview. I collected data through a standardize process through Survey Monkey. I collected the participants' data and stored under respondent's ID generated by Survey Monkey. The survey was open to the general public and all adults who are 21 years of age or older. I defined risks and outcomes in the consent form. This study's data collection type aimed to minimize bias by collecting written answers and encouraging the participants to answer these questions in their own time and space, which might place less pressure on the respondents. Written surveys represent convenient data gathering with little observer subjectivity and higher uniformity of data collection. I designed the questionnaires to allow free expression within the questions being asked. No identifiable information was collected. In applying the written answers approach, I was able to collect accurate transcription and interpretation of the data, a thorough comparison of individual responses among participants, and provide an audit trail of my analysis.

Methodology

The pragmatic methodology approach helps the researcher to transcend the distinction between knowledge that is *context-dependent* and experience that is *universal*

and generalizable (Patton, 2015). Such approach helps the researcher to focused on discovering who, what, and where of events or experiences and gaining insights from individuals regarding a phenomenon (Onwuegbuzie & Leech, 2005). A broad range of data may be used to describe the phenomenon in the form of words, stories, and experiences analyzed into a formal structure (Sandelowski, 2000; Sandelowski, 2009).

In this exploratory qualitative research inquiry, I applied what Samar (2017) calls a qualitative pragmatic methodology with a purposeful and non-probability sampling strategy. The aim of using a purposeful sample is not primarily to achieve (external) validity but to understand the perceptions and experiences of the individuals in-depth (Creswell, 2013; Creswell & Poth, 2016; Rodríguez-Espíndola et al., 2018), such aim applied in the study. Using such approaches helps the researcher to understand how individuals from the public currently understand and view their engagement in the decision-making process.

Participant Selection

A research population is a collection of individuals. All individuals within a specific community usually have a standard, binding characteristic or trait (Creswell & Poth, 2016). However, since this was an exploratory study, I selected the public with no pre-selection of variables, no adjustment of variables, and no prior commitment to a specific population. I used an open-ended semistructured online survey in the study to address the posed research question. The survey was open to the public via Survey Monkey. I created a URL link to the survey, posted it on social media such as LinkedIn

and Facebook, and sent it via email and WhatsApp to individuals and groups. inside and outside of my network. Interested candidates accessed the survey via the URL link.

Qualitative samples tend to be small because of the emphasis on intensive contact with participants, and the findings are not expected to be generalizable. According to Creswell and Poth (2016), 25 participants could be used for a qualitative study and achieve saturation. Some qualitative studies use a sample size range of five to 25 based on diversity (Bradshaw et al., 2017). In this study I aimed to collect 30 surveys. Furthermore, I used open-ended semistructured online surveys to address the posed research questions that should produce a deeper understanding of the phenomenon. Data saturation was determined after I collected the data and analyzed it. I achieved the data saturation, as it reflected in the type of feedback and people who participated in the survey.

The principle of data saturation has become an accepted standard to determine sample size within some qualitative designs. Data saturation can be considered to apply to the point where no new information emerges from the study participants during data collection (Bradshaw et al., 2017a) when the ability to obtain further information has been attained and when additional coding is no longer feasible or when enough data is gathered to replicate the study (Gugiu et al., 2020).

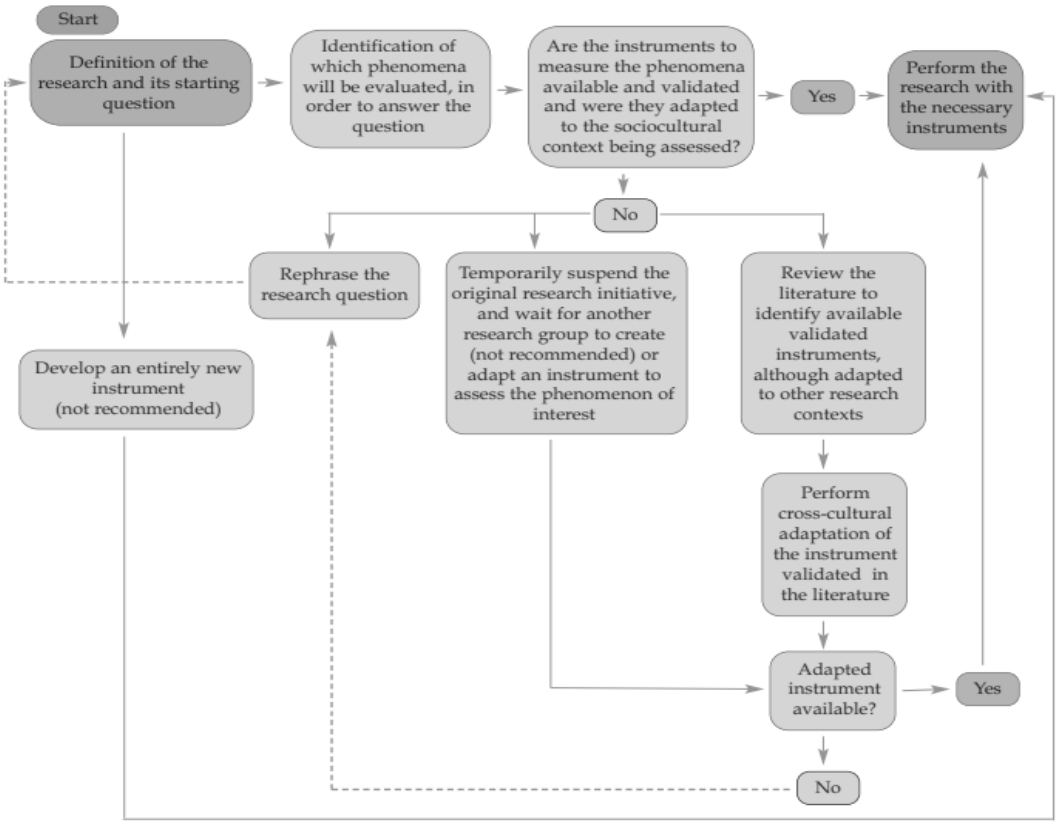
Instrumentation

Creswell and Poth (2016) stressed the importance of questions, in which the investigator poses general, broad, open-ended questions to obtain in-depth information

from the participants within their natural setting. I applied open-ended semistructured online survey to address the posed research question. The survey I developed is based on existing knowledge from the literature review outlined in Chapter 2 and a pilot study conducted during a class at Walden University. Moreover, as Bastos et al. (2014) demonstrate in data collection, I applied the decision tree guide (Figure 10) to guide the process of choosing an instrument to collect scientific research data in this study and ensure that all aspects of the construct being measured have been covered.

Figure 10

Decision Tree to Guide the Process of Choosing an Instrument to Collect Scientific Research Data.



Note. From "Field work I: selecting the instrument for data collection," by Bastos et al. (2014)

The questionnaire had 25 questions. It included 14 subject questions, 10 demographic questions, and open input. Open-ended questions helped me to gather more detailed information because participants were free to express themselves more while answering the questions. The questionnaire targeted key components directly related to

the post-research question, such as the participant's understanding of the pandemic, the decision-making process, and the participant's interpretation of key terms from the PDM.

This methodology has the potential to:

1. Capture a description of the experiences that individuals have with the COVID-19 pandemic and their understanding of the decision-making process.
2. Identify and explain the opposite forces that influence the decision-making process in planning for and responding to a pandemic.
3. Ground the individual experiences and perceptions within the context of the COVID-19 pandemic.
4. Explore the type and level of engagement individuals would like to participate in during a pandemic.

In a novel exploratory study like this, the questionnaire contains an open input section that lets participants include any thoughts, ideas scenarios that were perhaps missed by the questionnaire; for example, the quote below was used in the questionnaire

> Please feel free to share any additional thoughts about the decision-making process and your role in the decision-making process during an epidemic/pandemic. Would you like to share any other views, ideas, or scenarios arising from, planning for, and responding to an epidemic/pandemic that was not fully addressed or missed by the questionnaire? Considering the challenges experienced during the COVID-19 pandemic, would you like to share any other ideas on how the

pandemic's response could have been handled differently by individuals, communities, health care intuitions, and the government?

Procedure for Recruitment, Participation, and Data Collection

The survey was opened to the public via Survey Monkey. A URL link to the survey was created and posted on social media. I sent a customized email invitation to all my contacts through Survey Monkey. Such email method helps to achieve vast number of participants (SurveyMonkey, 2021). Interested candidates accessed the survey via the URL link. I analyzed the survey daily before its completion. All participants received a brief invitation (see Appendix A), a full questionnaire (see Appendix B), and the Adult Informed Consent Form. The Adult Informed Consent Form described the inquiry parameters, the study's purpose, selection criteria, potential risks, and benefits. A confidentiality clause informed the participant that their names or any other identifying information were not collected and that they had the right to withdraw from the study at any time.

I collected the completed questionnaires electronically, and I stored the individual surveys under a randomly assigned research project number. Participants exited the study by completing the one survey described above. In the survey I did not include any follow-up procedures, such as requirements to return for follow-up interviews. The written answers allowed me to get accurate transcription and interpretation of the data and a thorough comparison of individual responses among participants. The duration of data

collection events will vary depending on participation and data saturation. Therefore, in this research, I aimed to collect a minimum of 30 completed surveys.

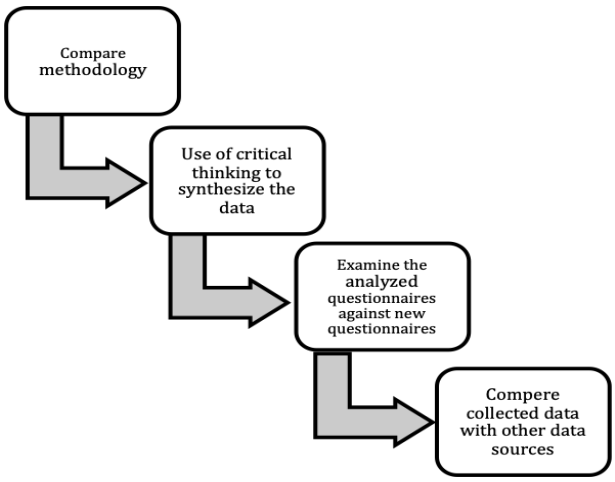
After receiving each completed questionnaire, I collected the data, transcribed, and with application of MS Excel, I coded systematically and thematically identifying relationships between specific answers. I did the coding process line by line, statement by statement, identifying and documenting phrases and comments of each of the participants. I categorized and aligned the emerging themes with the theoretical framework of Benet's (2013) PDM.

As I already mentioned above, I was guided by a qualitative pragmatic methodology, including concurrent data collection and analysis (Goldkuhl, 2012). Thus, each of the research process elements, including data collection, coding, data analysis, key theme construction, and conceptual description development, occurred somewhat simultaneously throughout this study. I condensed the raw data into a brief, summary format, establishing clear links between research objectives and summary findings derived from raw data. Alignment was established between collected data and the three pairs of the polarity of the democracy model.

Data Analysis Plan

Figure 11

Four Steps of the Data Analysis Plan.



Note. From "Managing the polarities of democracy: A theoretical framework for positive social change, by Benet Benet (2013).

After receiving the completed questionnaire, I collected the data, transcribed, and coded it systematically and thematically. I established clear links between research objectives, summary findings derived from raw data, and links established between collected data and the three pairs of Benet (2013) PDM. As previously discussed, this study was guided by qualitative description methodology, which includes concurrent data collection and analysis. Thus, each of the elements of the research process including data collection, coding, data analysis, key theme construction and conceptual description development occurred somewhat simultaneously throughout the course of the study.

Creswell and Poth (2016) stressed the importance of sorting collected data into a story, patterns, categories, or themes. This system used in the study to identify

relationships between specific answers/participants to gain a better understanding of the type and level of engagement individuals might find helpful during the decision-making process. I did the coding line by line, statement by statement, identifying and documenting phrases and comments from each of the participants. Emerging themes and categories were aligned with the theoretical framework of Benet's (2013) PDM

Open and thematic coding followed the principles of Constant Comparative Analysis (CCA). CCA is well suited for this study because it is an inductive data coding process used for categorizing and comparing qualitative data for analysis purposes. Previously analyzed data are compared and reanalyzed against new data (Boeije, 2002). Theme development was the primary function of the questionnaire data in the data analysis phase of this study. Audit included detailed description of sources of data, collection and analysis, interpretations, decisions taken, and codes assigned.

Issues of Trustworthiness

Qualitative researchers have used the concept of trustworthiness to support the argument that qualitative research, including qualitative descriptive studies, is as critical as quantitative studies (Creswell & Poth, 2016). The researcher in any research study is obligated to demonstrate rigor and consistency in the methods and steps used in the study (Creswell & Poth, 2016). Four components are usually implemented to address trustworthiness in qualitative research (Onwuegbuzie & Leech, 2005). These four components, which include, transferability, dependability, confirmability and credibility were addressed in the study to ensure the rigor and trustworthiness in qualitative studies

(Onwuegbuzie & Leech, 2005). Transferability refers to the applicability of one finding to another setting. These principles (Figure 13) are an essential framework for all qualitative researchers to validate their research quality, including qualitative description research (Bradshaw et al., 2017).

Patton et al. (2015) explained that researchers could ascertain a qualitative study's transferability by the degree to which the findings could be generalized. However, in this study, I did not aim to generalize. I analyzed emerging themes within the general public. In quantitative research, the researcher's concern is how the data are applied to the general or broader population, but since qualitative research usually involves specific environments or small groups, the concept of generalizability is less of a concern. Patton et al. (2015) stressed that qualitative research's dependability is achieved through consistent and sound processes and procedures. Cooper et al. (2009) noted the importance of maintaining a clear and detailed audit trail with the descriptive qualitative methodology.

I established dependability in this study by preserving all electronic records and detailed analysis and coding processes. Additionally, I recorded participants' responses electronically via an anonymous open-ended survey, thus, not being influenced by my interest, bias, and motivation. Besides, in the questionnaire, I avoided the leading questions. Also, the participants could review the responses and results complied in the survey.

Credibility is a concept that corresponds to internal validity, and it refers to the way the data are collected (Cooper et al., 2009). An audit trail provides the necessary

materials for confirming research or identifying differences. I preserved all questionnaires, analyses, and transcripts, before reviewing them. The qualitative descriptive methodology aims to keep the interpretation near the participants' meaning as possible by using their own words aligned with the research question and the data collected (Bradshaw, 2017).

Confirmability has to do with confidence that the data collected is based on the participant's own words, not potential researcher bias. To establish the credibility and confirmability of qualitative study is the construction of an audit trail (Amankwaa, 2016). In this study, the audit trail record provides evidence that collected raw data have gone through a vigorous analysis. It allows to trace the textual sources of data back to the interpretations and the reverse.

Ethical Procedures

The format of the study was an anonymous online open-ended questionnaire. I maintained the ethical standards throughout complete anonymity, and I did not collect any specific information enough to identify the subject. Furthermore, I stored each participant's data under a subject number. Participants were invited, not required, to answer all questions. Being in this study did not pose a risk to their safety or physical wellbeing. However, there was a potential risk to emotional and psychological well-being since the survey seeks information about the COVID-19 pandemic. For that reason, I did the data collection in the safety and comfort of the participant's choice to minimize the impact of these questions. I provide the contact for mental health support in the consent

form. There were no direct benefits to participants. I designed the survey to benefit society, such sentiments are also highlighted by Weijer (2000).

Summary

In this chapter, I outlined the research methodology, the rationale for the research, and the population's selection from which I collected the data. I apply a qualitative pragmatic design with a semistructured questionnaire. Participation was open to the public via Survey Monkey. I collected the data, transcribed, and manually coded. The study's significance was to explore the public's engagement in the decision-making process during a pandemic. I examined the public's role in a whole-of-society approach that emphasizes all stakeholders' significant roles in mitigating the effects during a pandemic. In the next chapter, below, I focused on the data analysis conducted for this study. The research results are provided in Chapter 4, followed by an interpretation of findings in Chapter 5.

Chapter 4: Results

The purpose of this study was to explore how individuals balance socioeconomics, demographics, and religious views with their actual behavior in response to public health guidelines during an epidemic/pandemic.

I organized the chapter into several subsections, such as setting, participant demographics, and data collection. Furthermore, the chapter entails data analysis using frequency distribution and coding, participant's reflection on the PDM, aligning the emerging themes and categories. Lastly, the chapter demonstrates trustworthiness, ascertains the validity and credibility of the data, the result that answers the research question according to the themes, and the summary section.

Setting

I collected the data using Survey Monkey, and I also shared the URL via social media such as WhatsApp, Facebook, and LinkedIn. A total of 30 participants from all around world took part in this study. I defined the participant demographics retrospectively and described them in in the following section.

Participants Demographics

This section is devoted to defining the demographics of the sample (Table 2). Of the 30 participants who entered the study, 16 were women and 14 men. Twenty-nine participants provided a specific age ranging from 30 to 84. One participant gave her age as a range stating that she is in her 20s. Out of 30 participants that entered the study, nine

participants are in the age range 60 to 69 years old, nine participants are in the age range 50 to 59, one participant is in the age range 40 to 49, and eight participants in the age range 30 to 39 years old. Apart from the age, I also identified the participants with their ethnicities, I identified 23 participants as White/Caucasians/European origin, one African, four Indian, two of mixed ethnicities. Of the 30 participants that entered the study, 22 confirmed that they identify themselves with a religion, seven participants stated that they do not identify themselves with a religion, and one participant did not provide an answer.

The frequency distribution of higher education (Table 2) and occupation close to the health care profession was higher among participants. Ten participants reported having a bachelor's degree, 10 a master's, and four participants reported having a doctoral level of education. Four participants had some college-level education, and two participants had a high school level of education. Sixteen participants worked in the medical/research field. Out of the total 30 participants, 27 stated they own a house. All participants reported having a job and health insurance.

Out of the 30 participants, 24 reside in the United States, two in Europe, three in India, and one in Latin America. The population reflected most participants that reside in well developed areas where they can easily access technology devices and the internet. Twenty participants indicated that they are married, six divorced, two single, and two widowed (Figure 18). The majority practice civic engagement in their community.

Table 2

Participants Demographics

Age	Gender	Ethnicity	Religion	Education	Occupation	Residence
55	M	Boring white	Catholic	BS	Drug Development	USA
35	F	African	Yes, Christianity	BS	scientist	USA
58	F	Italian	Jewish	MA	Sr manager clinical trial material	USA
38	M	Caucasian	Yes - Protestant (Lutheran)	College	Pharmaceutical Project Manager	USA
37	F	White	No	MA	Software engineer	USA
60	M	White	Christian	MD	Physician in the pharmaceutical industry	USA
60	F	Caucasian/Balkans	No	College		USA
31	M	Caucasian	Nope	College	Clinical Supply Chain	USA
65	F	White	Christian	MA	Regulatory Lead	USA
33	M	Belgian	Hindu	MBA	Entrepreneur	Belgium
30	F	Belgian	Hindu	PhD	Senior Scientist	Belgium
57	F	Caucasian	yes	MA	Administrator	USA
20s	F	White	Jewish	BA	Nonprofit	USA
57	F	White	Catholic	BS	Registered nurse	USA
62	F	white	Christian	College	Executive Assistant	USA
35	M	White	Yes	University	Tour guide	Brazil
53	M	White		HS	Firefighter - EMT	USA
57	F	Indian	Hindu	MS	teacher environmentalist	India
62	M	White	No	BA	Public/Media Relations Consultant and Environmental Activist	USA
63	M	White, Caucasian	Roman Catholic	MD	R&D Scientist in Biotech	USA
56	M	White	No	HS	Dancer	USA
52	M	Caucasian	No	MA	Mid-level manager	USA
36	M	White	Catholic	BS	Procurement	USA
60	F	white	Christian	BA	Executive Assistant	USA
57	F	Indian	Hindu	MS	Dentist with a private practice	India

60	F	Mix of Indian and Black	A child of God	BA	Clinical Supply Chain at a Pharmaceutical Company	USA
84	F	Indian	Hindu	MS	retired teacher	India
70	F	Descent from Spain and Portugal	no	College	retired - x Executive Assistant in Pharma	USA
62	M	Indian	Hindu Jesuit	MD	Safety physician in the pharmaceutical industry.	USA
44	F	White	Believer	MBA/MS	Manager	USA

Data Collection

Data collection started on December 31, 2020 via Survey Monkey. I used an open-ended semistructured online survey to explore the research question. The survey was open to the public via social media because the research question in its context concerns society as a whole.

In the data collection process, there were a few technical issues with Survey Monkey. For example, some participants reported that they received a message informing them that they had already taken the survey and could not move forward in the survey. I resolved technical challenges by resending the URL link with added instructions that the survey needs to be completed at one sitting and cannot be saved and finished later. It was unclear if participants that experienced technical difficulties were able to go back and retake the survey. Otherwise, the study progressed as expected.

Thirty participants completed the study and as it is on the retrospective analysis of participant's demographics, participants seem to have a similar socioeconomic and demographic backgrounds. And despite different religious backgrounds, they share similar views on the challenge's experience during the recent pandemic.

Data Analysis

Applying, qualitative pragmatic methodology, I did understand the perception of experience through a detailed description of the people's perspective. Such approaches on qualitative methods are also pointed out by Roy and Sinha (2020). Qualitative pragmatic research was appropriate for this study because the central question was complex, currently not well defined, practical, and highly contextual. Such facts are also pointed out by Szymkowiak et al. (2021). There was need to explain relations or mechanisms that cause the public to behave in specific ways during a pandemic.

I used in vivo coding to analyze the data. This is because such coding techniques helps to derived information from the data itself. The terminology and language used by the participants are applied as they are, not researcher derived, furthermore, a single word or short phrase is assigned to a section of the data. This makes it easier for the codes to reflect the perspective of the participant's actions and perceptions.

I analyzed the gathered data using frequency distribution and coding. I also carried out the process through an inductive and in vivo coding process. I divided the qualitative data sets into small samples and carefully read, identifying the passages in the text, and coded. Furthermore, I did the coding line by line, statement by statement. Additionally, I coded phrases and comments for each of the participants, then stored the collected raw data into conceptual categories based on the PDM concerning the different types of impact the COVID-19 pandemic had on individuals, families, and

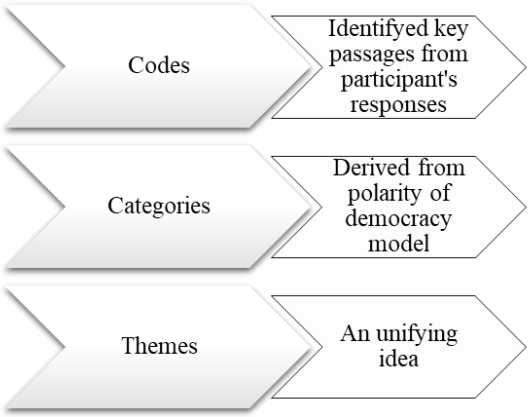
communities. With the direct quotes, I reported the exact words of participants to capture the meaning, feelings, and the language of the original statement.

I created the codes to help define what the data collected are about. Individual passages and codes were re-read, and I applied the codes in attempt to search and identify concepts and finding relations between them. Then I noted the frequency of each code, I recorded the response again. In other words, I repeated the steps until all data were fully coded.

Categories were derived from the PDM: "freedom and authority, human rights and communal obligations, and participation and representation" (Benet, 2013, p. 26). I assigned these categories to identify a basic meaning to codes and align them with the theoretical framework, and I also added the frequency of individual codes among participants to capture the number of occurrences of a repeating answer.

Figure 12

Data Analysis Scheme



The Survey

The survey had 25 questions. It included 14 subject questions, 10 demographic questions, and open input. Subject survey questions were grouped into five groups. In conducting findings and analysis, I use two methods, general and cross-tabulation analysis, mainly based on five topics:

- Impact of the Pandemic on the Participants Group
- The Decision-Making Process During a Pandemic
- Rights, Responsibilities, and Obligations during a Pandemic
- Participants Reflection on the Polarity of Democracy of Model
- Participants Reflection on the Response to Pandemic

Table 3

Breakdown of The Survey Questions Into 5 Topics

Topic	Survey Question
Impact of the Pandemic on the Participants Group	1. Describe in your own words what a pandemic is.
	2. What are the ways the pandemic impacted you?
	3. What are the ways the pandemic impacted your family?
	4. What are the ways the pandemic impacted your community?
The Decision-Making Process During a Pandemic	5. Based on your understanding, who are the people that are participating in the public health decision-making process during a pandemic?
	6. Who creates public health guidelines and laws in your community?
	7. Where do you get information about the COVID-19 pandemic?

(table continues)

	8. If you could, would you like to be part of the decision-making process that develops public health guidelines and laws during a pandemic?
	9. Describe ways you could be a part of the public health decision-making process during a pandemic. How do you see yourself doing that?
	10. Do you practice civic engagement and actively help your community?
Rights, Responsibilities, and Obligations during a Pandemic	Question 11
	Describe the responsibilities to yourself during a pandemic
	Describe the responsibilities to your family during a pandemic
	Describe the responsibilities to your community during a pandemic
	Describe the rights to yourself during a pandemic
	Describe the rights to your family during a pandemic
	Describe the rights to your community during a pandemic
	Describe the obligations to yourself during a pandemic
	Describe the obligations to your family during a pandemic
	Describe the obligations to your community during a pandemic
Participants Reflection on the Polarity of Democracy of Model	Describe in your own words what these word pairs represent to you during a pandemic
	Diversity – Equality
	Individual Rights -Communal obligations
	Individual participations – Representations
Participants Reflection on the Response to Pandemic	Question 12 and open input sections were combined to highlight participants reflection on the response to the pandemic.
	12. If you could, would you change anything in the current response to the COVID-19 pandemic?

All 30 participants appear to have similar socioeconomic and demographic background and share similar view on the challenge's experience during the recent pandemic, despite the differences in spiritual beliefs. Therefore, the data collection has reached conceptual sufficiency for this study.

Evidence of Trustworthiness

To assure all four components of trustworthiness I addressed the transferability, dependability, confirmability, and credibility in the study to ensure the rigor and trustworthiness in qualitative studies. To ascertain the validity and credibility of the data used for this research, I applied survey monkey in the data collection. I exported the data from Survey Monkey to an Excel spreadsheet and analyzed into codes, categories, and themes.

The transferability refers to the applicability of one finding to another setting since the findings could be generalized and the emerging themes within the general public could be analyzed. However, this study does not aim to generalize. It seeks to analyze emerging themes within the public. In quantitative research, the researcher's concern is how the data are applied to the general or broader population, but since qualitative research such as this involves specific environments or small group of participants, the concept of generalizability is less of a concern.

The dependability of this research has been achieved through the consistent and sound processes and procedures employed in data collection and analysis. In this study,

participants' responses were recorded electronically via an anonymous open-ended survey and thus not influenced by my interest, bias, and motivation. Besides, all electronic records have been kept and analysis followed straightforward coding processes code-category-theme. The description of all codes is included in this study.

For credibility of this research, all the questionnaires, analyses, and transcripts have been preserved and ready for peer review. The participants own words were used in the code's description. Confirmability has been achieved since the data have been linked to the sources from which the data was obtained and ready for review and participants own words have been used waterer possible (code descriptions, themes, direct quotes).

Results

Impact of the Pandemic on the Participants Group

Based on this study, the participants protective behavior was often associated with their perception of the risk posed by health threats and their capacity to deal with the challenges. People's perceptions of risks influenced their responses to different threats, like the COVID-19 pandemic. Participants had a good understanding of what a pandemic is. They were overwhelmingly seeking answers and guidance from official sources such as the CDC, WHO, NIH, and the government.

The pandemic had a profound effect on people's life. Participants reported poor quality of life, negative impact on professional life, loss of livelihood, loss of access to service and care, and a new way of learning and working via virtual platforms (Table 3 & 4).

Table 4

Impact of the pandemic on the participants group (Participant's responses)

Code	Participant's responses
Impaired quality of social life	inability to see family and friends, inability to travel for family holidays, inability to do normal activities, inability to travel and inability go on a vacation. No large gatherings, limited dining, not getting out and being adventurous.
Negative impact on professional/business life	working for home, inability to see colleagues, inability to make business decision and meet business partners, working more hours
Negative impact on mental health	anxiety and cautious around doing normal activities, stressful work environment, isolation, high stress from other people, inability to grief or celebrate
Loss of livelihood	unemployment, use of emergency fund
Following public health guidelines	wearing masks, gloves,
Only urgent medical care	seek only urgent medical and dental care
Using virtual platform	online teaching, working online
Negative impact on individual decision-making process	inability to make intelligent personal decision

Table 5

Impact of the pandemic on the participants group (Analysis)

Code	Category	Theme
Impaired quality of social life	Diversity and equality Human rights and communal obligations	Impaired quality of personal life
Negative impact on professional/business life	Diversity and equality Human rights and communal obligations	Impaired quality of professional life
Negative impact on mental health	Diversity and equality Human rights and communal obligations	Impaired quality of personal & professional life
Loss of livelihood	Diversity and equality Human rights and communal obligations	Impaired quality of personal & professional life
Following public health guidelines	Human rights and communal obligations Participation and representation	Impaired quality of personal & professional life
Only urgent medical care	Diversity and equality	Impaired quality of personal & professional life
Using virtual platform	Diversity and equality	Impaired quality of personal & professional life
Negative impact on individual decision-making process	Diversity and equality	Impaired quality of personal & professional life

Negative social impact, negative financial impact, and negative impact on mental health were the three main factors that impacted this study's participants. The negative social impact was due to the inability to meet family members, friends, and colleagues. Travel cancelation led to missed family holidays and gatherings. Social interaction was also negatively impacted by wearing gloves, masks, and social distancing. Negative business impacts ranged from the inability to meet business partners, work effectively, lose business, lose a job, and adjust to the virtual world. Negative mental health impact ranges from anxiety around doing normal daily activities, stress while working as a first responder, or isolation.

The four highest impacts reported by participants on oneself were

- Inability to meet family and friends (27/30)
- Negative impact on daily activity (22/30)
- Negative impact on professional/financial life (17/30)

The four highest impacts reported by participants on the family were

- Inability to meet family and friends (26/30)
- Negative impact on daily activity (22/30)
- Negative impact on professional life (16/30)
- Negative impact on mental health (4/30)

The four highest impacts reported by participants on the community were

- Inability to meet family and friends (28/30)
- Negative impact on daily activity (28/30)
- Negative impact on professional/financial life (17/30)

- Limited access to services (7)
- Negative impact on mental/physical health (6/30)

Participant three shared:

> The pandemic has impacted everyone in many various forms. Some have financially benefit, some it has financially devastated. Some seem to learn better remotely while others who were superstars in the classroom are now failing. I believe it has caused various levels of depression, frustration, and anger.

Participant four said: "I no longer go into the office for work, my spouse is very stressed, I have known over 20 people who have contracted the virus."

Also pointing the concern on the impact of the pandemic, participant seven pointed out:

> The neighborhood became a ghost-town with very few humans on the streets. The police would stop us on the road and allow us only to join the queue to the grocery stores but wouldn't allow us to visit family and friends. It was harsh.

In further showing the concerns on the impact of the pandemic, participant 10 shared:

> My second son was born during the corona pandemic and only my wife and I were allowed to see him in the hospital. My family and I were unable to leave the country for vacation. During the peak of the corona pandemic, we couldn't meet the family and my kids couldn't meet their grandparents.

Furthermore, participant 11 added: “My family and I had to stay at home and couldn't meet families and friend. We had to cancel our holidays to be with my father in USA.” Participant 15 also pointed out that “People have become ill, some severely, and some have died. Public facing businesses have suffered from loss of income and in some cases had to close.” Additionally, participant 29 also pointed out the impact of the pandemic on the public:

> I couldn’t meet family and friends. Cancelled all my vacations with family. My family had to cancel their plans and trips to visit me. I couldn’t be there to meet my 3rd. grandkid when he was born as travels had to be cancelled.

The Decision-Making Process During a Pandemic

This study focused on understanding public participation perceptions in the decision-making process arising from, planning for, and responding to an epidemic/pandemic. Out of 30 participants only two clearly stated that they are not willing to participate in the decision-making process that develops public health guidelines and laws during a pandemic. The rest of participants indicated the desire to help from their line of expertise, offering more specific advice about what options to consider based on pre-existing experience, formal qualification, or type of their line of work. They have indicated that they would like to be part of the effective response to a pandemic and help foster an effective communication.

Direct Quotes from Participants Regarding the Decision-Making Process during a Pandemic

Participant three also pointed out:

> We pay taxes so that qualified people do their job of making proper public health decisions during a pandemic. I am not qualified expert in the field of pandemic, but as a leader of my company I use common sense to protect my family and my employees. The public health decisions by the government must make sense.

Also, in showing concern on public participation in public policy, participant six suggested that "Maybe they should create a jury where people can expose or report the activities in the neighborhood so the town would be more aware of it."

In showing concern on the same, participant 18 pointed out:

> I may reach out to the CDC to suggest my views. Although, I am not sure if they are prepared or bothered to listen to me. As this is a pandemic situation, the policy makers have already made up their minds and they shall stick with it.

Furthermore, participant 19 added: "I don't see where the state's political, social and economic climbers/powers that be, would ever give credence to those who are more directly affected by adversity. Maybe a start would be to simply ask the "common man."

Three participants, despite the negative response, offered a few ways to see themselves participating in the process. Participant two demonstrated: "I think the best way would be pushing for changes that would cut down on the transmission of viruses." Also, participant 25 pointed out that "Collect epidemiological data for my country." Furthermore participant 27 pointed out that "I believe my role is in helping to raise consciousness to an independent thinking state, which is what I am doing. I am not one of those tasked to actually legislate."

Rights, Responsibilities, and Obligations During a Pandemic

For this study, participants were asked to define their rights, responsibilities, and obligations to themselves, the family, and the community during a pandemic. The participants shared that they had were having three dominant responsibilities/aims during a pandemic (Table 4); maintaining good mental health, spirit and physical health. These data suggest that participants were aware that an effective response to a pandemic started with each of them. They had also recognized their responsibility to protect and support their families and communities in any way they can do so. There seemed to be apparent acceptance and respect of the current public health guidelines. Participants identified as the two most dominant responsibilities to themselves to care for themselves. To protect and care for the people we love, we must first take care of ourselves. Right to information, vaccine, treatment, and services dominated the participants' answers.

Table 6

Participants Responsibilities to Oneself (Participant's Responses)

Code	Participant's responses
Maintain good mental health/spirit	take care of myself, do not get depressed, rest, following public health guidelines
Maintain good physical health	Prevent infection, get vaccinated, and follow public health guidelines: wear a mask, gloves. Keep physically active
Educate myself and others	stay informed, take inform decision for my family and my employees, take proper decision for my family, develop guidelines and policies
Responsible living	Taking responsibility for my health, stay on track with life goals, keep going. Do not engage in risky behavior. Provide a good example. Follow guidelines. Pandemic is about all of us, protect, help, & support, being respectful to others, be good citizen.

Table 7

Participants Responsibilities to Oneself (Analysis)

Codes	Category	Theme
Maintain good mental health/spirit	Diversity and equality Human rights and communal obligations	Responsibility of myself and care for myself.
Maintain good physical health	Diversity and equality Human rights and communal obligations	Responsibility to stay healthy and care for myself.
Educate myself and others	Human rights and communal obligations Participation and representation	Responsibility to educate myself and others using official source
Responsible living	Human rights and communal obligations Participation and representation	Responsibility to stay healthy to live for others

In giving their concern regarding their responsibility to oneself desiring the pandemic, different participants pointed out the following: participant five demonstrated that "To avoid getting depressed, to stay on track with life goal." While participant 11 pointed out that "I must first protect myself so that I can protect and care for my family." Furthermore, participant 15 pointed out:

> To take care and responsibility for my health by using caution when in the public. Masks and gloves when needed, avoiding crowds. Often not going into stores if they are too packed. Social distancing. Trying to eat right, exercise and get adequate rest.

Additionally, participant 25 pointed out that "Getting vaccinated when available. Practice social distancing, except while seeing patients. While seeing patient we wore the highest grade of PPE."

Table 8

Participants Responsibilities to Family & Community (Participant's Responses)

Code	Participant's responses
Stay disease free	Access to vaccine and to treatment, right to offer free test, take precautions not to get infected
Responsible living	Taking responsibility for my health, stay on track with life goals, keep going. Do not engage in risky behavior. Provide a good example. Follow guidelines. Pandemic is about all of us, protect, help, & support, being respectful to others, be good citizen.
Educate myself and others	stay informed, take inform decision for my family and my employees, take proper decision for my family, develop guidelines and policies

Table 9

Participants Responsibilities to Family & Community (Analysis)

Codes	Category	Theme
Stay disease free	Diversity and equality Human rights and communal obligations	Responsibility of myself and care for myself.
Educate myself and others	Human rights and communal obligations Participation and representation	Responsibility to educate myself and others using official source
Responsible living	Human rights and communal obligations Participation and representation	Responsibility to stay healthy to live for others

Participants demonstrated their responsibilities to the family and community during the COVID-19 pandemic. For example, participant 10 showed concern by taking responsibilities by saying “To make sure I am doing everything to protect my family and my employees who are part of the community.” Participant 11 pointed out that “Ensuring that my family is protected is critical. My husband and I are wearing masks but my infant daughter keeps tearing out her mask. It is difficult for her to understand.” While participant 16 pointed out that “Follow all the procedures recommended by the experts who have been dealing with a pandemic directly.” Most participants echoed that a response to a pandemic is less about human rights and more about communal obligation and to act in the best interest of all, indicating the desire for education and information from official sources, support of vaccination, public health guidelines, and determination to place a community's needs above individual human rights.

Table 10

Participants Right to Oneself (Participant's Responses)

Code	Participant's responses
Stay disease free	Access to vaccine and to treatment, right to offer free test, take precautions not to get infected
Self-preservation	Right to be happy, take care of mental health, do whatever needs to be done to achieve self-preservation, to access services, conduct business at acceptable risk
Responsibility to others	Pandemic is about all of us, protect, help, & support, being respectful to others, be good citizen.
Stay informed	Be fully informed by the professional community, maintain good communication
Preserve rights to decide	Right to decide how to deal with a pandemic and how to respond to guidelines. Preserve the same rights regardless a pandemic

Table 11

Participants Right to Oneself (Analysis)

Code	Category	Theme
Stay disease free	Diversity and equality Human rights and communal obligations	I have the right to do everything that prevent me from getting sick
Self-preservation	Diversity and equality Human rights and communal obligations	I have the right to be safe and be happy
Responsibility to others	Human rights and communal obligations Participation and representation	Individual rights should not interfere with communal obligations
Stay informed	Human rights and communal obligations Participation and representation	Education is essential to stay healthy and protect others

The participants also shared their understanding of their rights during the pandemic. For example, participant one outlined rights: “To get access to a vaccinated after higher-risk people have gotten vaccinated. To be able to conduct business and access services in a way that is higher risk than it needs to be.” Participant three pointed out that “A pandemic isn't about individual rights. Everyone needs to do what is in the best interest of All of us.” While participant four affirmed that “I have the right to make sure that I'm happy, whether that means taking a mental health day from work or ordering takeout all week.” Lastly, participant seven demonstrated that “To be fully informed of the pandemic situation to take necessary steps to protect myself.”

Table 12

Participants Right to the Family (Participant's Responses)

Code	Participant's responses
Stay disease free	Access to vaccine and to treatment, right to offer free test, take precautions not to get infected
Self-preservation	Right to be happy, take care of mental health, do whatever needs to be done to achieve self-preservation, to access services, conduct business at acceptable risk
Responsibility to others	Pandemic is about all of us, protect, help, & support, being respectful to others, be good citizen.
Stay informed	Be fully informed by the professional community, maintain good communication
Preserve rights to decide	Right to decide how to deal with a pandemic and how to respond to guidelines. Preserve the same rights regardless a pandemic

Table 13
Participants Right to Family (Analysis)

Code	Category	Theme
Stay disease free	Diversity and equality Human rights and communal obligations	I have the right to do everything that prevent me from getting sick
Self-preservation	Diversity and equality Human rights and communal obligations	I have the right to be safe and be happy
Responsibility to others	Human rights and communal obligations Participation and representation	Individual rights should not interfere with communal obligations
Stay informed	Human rights and communal obligations Participation and representation	Education is essential to stay healthy and protect others

Direct Quotes from Participants Regarding Their Rights to the Family During a Pandemic

Participant three pointed out that “Rights are not a factor during a pandemic. We're not being asked to allow "rights" to be violated.” While participant five demonstrated that “My family has the right to be safe during the pandemic.” Furthermore, participant six pointed out that “Once I have the right information, I can apply the rights to my family to protect them from the pandemic.” and participant 11 pointed out that “The rights of my family are to be respectful of others and expect people to also be respectful with masks, social distancing.”

Table 14

Participants Right to the Community (Participant's Responses)

Code	Participant's responses
Community-preservation	Ensure the health and safety of the community. Pandemic is about all of us, protect, help, & support, being respectful to others, be good citizen. Be kind.
Stay informed	Be fully informed by the professional community, maintain good communication. Make sure my family is informed
Preserve rights to decide	Right to decide how to deal with a pandemic and how to respond to guidelines. Preserve the same rights regardless a pandemic

Table 15

Participants Right to the Community (Analysis)

Code	Category	Theme
Community-preservation	Diversity and equality Human rights and communal obligations Participation and representation	Ensure the health and safety of the community.
Stay informed	Human rights and communal obligations Participation and representation	Education is essential to stay healthy and protect others
Preserve rights to decide	Human rights and communal obligations Participation and representation	My rights and decision-making should never be affected

Direct Quotes from Participants Regarding Their Rights to the Community During a Pandemic

Participant 1 shared that "To have public officials who are capable of leading during the pandemic, and who set good examples and do outreach to all parts of the community."

While participant 25 also pointed out that

> To be able to review the guidelines and interact with the authors and government policy makers. Rights to vaccination against the pandemic Rights to complete treatment and follow-up, including rehabilitation, if infected. Compensation for job loss, if any.

Lastly, participant 11 confirmed that

> The rights of the community are to follow the advice of the government even if they don't like it. Many voices their opinion that they are forced to wear masks and it is all a big conspiracy which is appalling. I believe they should be able to gather for civil rights events if they are properly masked and social distanced.

Table 16

Participants Obligations to Oneself (Participant's Responses)

Code	Participant's responses
Self-preservation	Care of myself, keep working, moving forward with life, stay healthy. Keep going
Responsibility to others	Pandemic is about all of us, protect, help, & support, being respectful to others, be good citizen.
Panel of experts	Proper representation of experts that will keep the community safe, experts should guide the public
Stay disease free	Access to vaccine and to treatment, right to offer a free test, take precautions not to get infected

Table 17

Participants Obligations to Oneself (Analysis)

Code	Category	Theme
Self-preservation	Diversity and equality Human rights and communal obligations Participation and representation	I have the right to be safe and be happy
Responsibility to others	Human rights and communal obligations Participation and representation	Individual rights should not interfere with communal obligations
Panel of experts	Human rights and communal obligations Participation and representation	Proper representation of experts that will keep the community safe

Direct Quotes from Participants Regarding Their Obligations to Oneself During a Pandemic

Participant one pointed out that: “I feel obligated to keep working full time, since I'm a little nervous about the economy in the future.” While participant 6 shared desire to: “To exercise my rights as stated above: To have the right information; and to vaccination if proven safe and effective by the Belgian Government and Medical Insurance.” Additionally, participant 11 shared that:

My obligation to myself is to learn to take better care of myself. For example, while working get up and take more breaks and walks. Try to call and encourage others that are older and shut in too.

Table 18

Participants Obligations to the Family (Participant's Responses)

Code	Participant's responses
Taking care of my family	Care and support my family. Set a good example.
Stay informed	Be fully informed by the professional community, maintain good communication. Make sure my family is informed
Panel of experts	Proper representation of experts that will keep the community safe
Stay disease free	Access to vaccine and to treatment, right to offer a free test, take precautions not to get infected

Table 19

Participants Obligations to the Family (Analysis)

Code	Category	Theme
Taking care of my family	Diversity and equality Human rights and communal obligations Participation and representation	
Stay informed	Human rights and communal obligations Participation and representation	Education is essential to stay healthy and protect others
Panel of experts	Participation and representation	Proper representation of experts that will keep the community safe

Direct Quotes from Participants Regarding Their Obligations to the Family During a Pandemic

When it comes to their obligation to family in the pandemic period, participant 25 outlined several obligations: "Contacting my family regularly. Follow the CDC, NIH, WHO & local guidelines. Guiding them to these official sites to get information on pandemics, rather than go to social media. Getting vaccinated when available to end the pandemic."

While participant 11 shared: "Try to encourage them that we will make it through this tough time. Call and chat and try to lift their spirits." Additionally, participant six

pointed out that "Obligations to my family is to ensure they are protected from the pandemic."

Table 20

Participants Obligations to the Community (Participant's Responses)

Code	Participant's responses
Responsibility to others	Pandemic is about all of us, protect, help, & support, being respectful to others, be good citizen. Set a good example. Be kind. Help to stop the spread.
Panel of experts	Proper representation of experts that will keep the community safe. Seek official information.

Table 21

Participants Obligations to the Community (Analysis)

Code	Category	Theme
Responsibility to others	Human rights and communal obligations Participation and representation	Individual rights should not interfere with communal obligations
Panel of experts	Participation and representation	Proper representation of experts that will keep the community safe

Direct Quotes from Participants Regarding Their Obligations to the Community During a Pandemic

In showing obligation to the community during the COVID-19 pandemic, participant six pointed out that "To do everything necessary by the law/guidance to control the pandemic to protect the community, my family and my employees." While participant 11 pointed out that

> To be respectful by wearing a mask, social distancing and being kind as many people are on the edge and about to lose it at any moment. Be a good role model. I think if it is possible to donate to local food pantries and clothing for those in need, it is important.

Furthermore, participant 24 added "Be especially kind, patient, and friendly."

Participants Reflection on the Polarity of Democracy of Model

Emerging themes and categories were aligned with the theoretical framework of Benet's (2013) polarity of the democracy model. For this study, only three out of five pairs of concepts of democracy were used:

1. Diversity and equality,
2. Human rights and communal obligations,
3. Participation and representation.

Table 22

Three pairs of polarity of the democracy model (Participant's Responses)

PDM	Participant's responses
Diversity	Different people, background, & different situations
Equality	Equal rights, opportunities, equal treatment, views
Individual Human Rights	Must be preserved, at times on hold for the greater good of the community,
Communal Obligation	Support and protect the community, do what is best for all
Participation	Individual participation is required during a pandemic
Representation	Must align with the need of people, protect especially those that can't protect themselves

Participants were asked to give their thoughts on the six PDM terms and what they meant to them, especially in the decision-making process context, during pandemic, their perception of the word pairs selected from the PDM (diversity & equality, individual rights & communal obligation, and personal participation and representation) suggested participants awareness for communal obligation during a pandemic.

Direct Quotes from Participants Regarding the PDM Pairs

The participants gave their thoughts concerning the PDM such responses focused on different aspects. First, diversity among people and circumstances should not affect people's equal rights. Secondly, a collective obligation is superior to human rights during

a pandemic. Lastly and third, expert representation is essential, especially for those that can't represent themselves.

Direct Quotes from Participants on Diversity – Equality

Furthermore, the pandemic also highlighted diversity and equity. For example, participant nine pointed out "The missing piece of a real pandemic response and necessary for effective decision-making." Participant 11 shared that "People from all backgrounds and walks of life - They all should be treated equally (even though we know they are not." In mentioning diversity, participant 25 shared that:

> Diversity: Educational differences, Socio-economic differences, Religion, Ethnicity Equality: in trust is a must. If trust is lacking, then building it… rapidly (pandemic will not wait for humans to fight it). It takes time to build equality to fight a pandemic, then more humans suffer in the meantime. Use the strengths of Diversity and Equality to confront, control and eradicate the pandemic as it was done for Small-Pox and Polio.

Direct Quotes from Participants on Individual Rights - Communal Obligation

In demonstrating individual rights, participant two pointed out that "Individual rights are concerning the rights of the individual; Communal Obligations refers to tasks to be carried out for the community to control the pandemic." Similarly, participant three pointed out that "During a pandemic individual rights are realized when Communal

Obligations are practiced." Furthermore, participant 25 said: "Individual Rights: Are important but make sure rights of all individuals synergies to fight the pandemic. Communal Obligations: This is important to fight the pandemic without losing the Individual Rights."

Direct Quotes from Participants on Individual Participation - Representation

Concerning individual participation and representation, participant one shared: "Individuals can be very influenced by strong leaders, and by the examples they set. When leaders don't step up during a pandemic, they are not doing a good job at representing the interests of the people."

Participant six highlighted: "Individual participation is when you have a say in the society with your participation. Those people who can't participate -- elderly, children, mentally handicapped etc. need Representation to exercise their rights/ participation."

While participant 21 pointed out that "Individual participation: Individual participation is mandatory in controlling a pandemic. Representation: Representation is necessary when communities are too diverse or need more time to be educated."

Participants Reflection on the Response to Pandemic

Participants reflection on the response to the COVID-19 Pandemic showed an array of feelings from the desire to be included in the decision-making process and be well informed to frustration and disappointment with the way the response to the pandemic was handled.

Direct Quotes from Participants on the Response to Pandemic

The participants also demonstrated concerns on the response to the pandemic. For example, participant one pointed out:

> Just tell me the facts! Explain to me the reason behind decisions that are being made. Don't lie to me. Have our leaders put all of their efforts into helping people through the pandemic was as little damage as possible. STOP the petty BS.

Also pointing out the response, participant six shared:

> The pandemic should've been controlled more professionally rather than impulsively. The decision-making people should've found ways not to negatively impact the economy. The social media was under no control hence, their strengths wasn't harnessed, but were freely allowed to spread panic and havoc.

Participant seven also pointed out the United States government and attitude, including the public's perception to the response. Pointing a comparison of the September 11, participant seven demonstrated that

> No one could have accurately predicted nor properly prepared for this unknown. The USA holds onto the belief that "These things don't happen here." How quickly so many have forgotten September 11, 2001 and how it caused us to actually become "United." We became a more than a divided nation with people pointing the accusatory finger after the fact. A is less than productive effort. We can only learn from the past and hope to allow it to improve the future.

> Unprecedented times call for unprecedented and often unpopular actions...and it all starts with asking the man in the mirror "What can I do to help?"

Participant 18 also demonstrated that "Good education and communication are key to control to the pandemic effectively." While participant 21 pointing out government failure demonstrated that "The government have not shown enough leadership during this pandemic." Furthermore, participant 29 pointed out that "Better communication and sharing best practices from countries/ communities where the pandemic is better controlled." More detailed response was demonstrated by participant 11 showing that:

> The pandemic spread so rapidly that the people reacted in a panic. Unfortunately, the Ministries of Health in different countries and officials reacted in a knee-jerk/ impulsive manner as they didn't understand or fully grasp the situation. The measures enforced in tiny Belgium seemed not to work, but now it appears the pandemic is under control, but our neighbors are not doing that well. Post BREXIT we hope travel from UK may decrease, but unlikely as there are still business relations and the new UK strain may infiltrate. The Belgian Authorities and the Headquarters of EU in Brussels must come up with a joint programmed with all the affiliations of EU, Rest of Europe, USA etc., and these nations must influence World Health Organization (WHO) to bring out joint policies to control this pandemic, but without destroying the economy. Indeed, it is not easy/ impossible, but specialist/ experts must figure it out by working together and not separately as it is being done now.

Furthermore, and in responding to the government effort participant 19 pointed out:

> The federal government failed massively to mount any kind of national effort to fight this pandemic. The Trump Administration is directly responsible for several tens of thousands of deaths that did not have to happen. And now that the vaccine is here, the federal government is massively failing at distributing it. The national guards should be getting the vaccine where it is needed. It is likely some vaccine batches will expire before they can be used. It's a disgrace.

Summary

In this study, I asked how individuals balance socioeconomics, demographics, and religious views, with their actual behavior in response to public health guidelines during an epidemic/pandemic. I explored participants' perceptions and experiences of a practical problem, how the public was asked to respond, and how the public ultimately responded to public health guidelines.

Thirty participants with similar socioeconomic and demographic background provided their answers to this survey of open-ended questions. Most participants have higher education, work, live in their own houses, and have health insurance, reflecting their higher living standards and economic status. Still, they have struggled to manage their financial, physical, mental, and social well-being during the COVID-19 pandemic. Many encountered the virus within their families and communities, many faced unemployment and economic hardship within their families and community.

The majority seek information from experts and the government and support vaccination. Acknowledge the extensive diversity among people but stress that diversity among people should not affect people's individual rights during a pandemic. Individual human rights are essential for this group of participants; however, amid pandemic communal obligation supersede individual human rights. Most participants would like to participate in the decision-making process and/or offer their perspectives. In Chapter 5, I concluded and discussed this research.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to understand the impact and the contribution of public participation in the decision-making process when planning for, and responding to, an epidemic/pandemic to create a whole-of-society approach to the implementations and adherence to public health guidelines to curb and reduce the severity of the pandemic. The central phenomenon is how individuals balance socioeconomics, demographics, and religious views with their actual behavior in response to public health guidelines during an epidemic/pandemic.

Based on the retrospective analysis of participants' demographics, the answers of a homogenous group of people have been already collected. Thirty participants with a similar socioeconomic and demographic background completed the study. Despite different religious backgrounds, they share similar views on the challenges experienced during the recent pandemic. Most participants are working in the healthcare or healthcare-related industry. It seems that self-selection led to biased data, as the participants who chose to participate shared similar views and beliefs and did not represent the entire targeted population, the public. This appears to be accurate, although out of the 30 participants, 24 reside in the United States, two in Europe, three in India, and one in Latin America.

Discussion and Interpretation of Findings

The discussion and interpretation of findings follow the Chapter 4 analysis based on five topics:

- Impact of the Pandemic on the Participants Group
- The Decision-Making Process During a Pandemic
- Rights, Responsibilities, and Obligations during a Pandemic
- Participants Reflection on the Polarity of Democracy of Model
- Participants Reflection on the Response to Pandemic

Impact of the Pandemic on the Participants Group

The data within this study suggest that people's perception behavior is influenced by the desire to stay healthy physically and mentally through the pandemic. Despite challenging situations such as financial hardship, health issues, social distancing from family and friends, and inability to travel, most participants aimed to reinforce a positive outlook on the situation by taking care of themselves, their family, and supporting the community. The participants in this study focused on preserving good physical and mental health, staying in good spirit, and seeking education about the pandemic. Participants showed determination to do all possible to prevent infection and stay informed.

Javed et al. (2020) discussed the different factors that affect a person's life, considering that perception is also based on a person's exposures and life experiences. These factors include financial capability, association with family and friends, mental

health and capacity, and COVID-19 (Javed et al., 2020; Pedrosa et al., 2020). Participants understood that the social network could amplify the spread of the virus and they agreed the public health guidelines. People may be instrumental in slowing the disease because they can spread positive interventions by following and promoting the public health guidelines (CDC, 2020; WHO, 2020).

Büssing et al. (2020) explained that during the COVID-19 pandemic, people assumed similar perceptions, driven by reactions taken by their countries' department of health and other regulatory bodies. People's desire to stay healthy matched measures that governments took to maintain public health. In almost all countries, the pandemic brought about a complete social and economic lockdown, either in the most afflicted regions or throughout the entire country (Büssing et al., 2020). With such measures by countries' internal securities, public health systems' primary focus is to diagnose, quarantine, and support treatment options for already infected patients. However, it has always been challenging for public health offices to manage people at risk of contracting the virus since no single cure or a specific treatment method was established (Saladino et al., 2020). For this reason, this study validates the assertion that people's desire to stay healthy as a personal precaution was paramount. The lack of established cures for the virus resulted in fears among people, and such fears only exacerbate people's needs and changed perceptions toward personal hygiene as well as social distancing (Saladino et al., 2020).

The COVID-19 pandemic generated fears of a threatening economic crisis. Mandatory closing of business and schools, social distancing, self-isolation, and travel

restrictions have led to a reduced workforce across all economic sectors and/or loss of jobs. The food sector faced increased demand due to panic buying and stockpiling of certain products (Nicola et al., 2020). Despite a few reports of financial hardship, the socioeconomic implications among participants were not significant. Everyone was able to keep working, at least partially, and kept their home and health insurance.

The Decision-Making Process During a Pandemic

Due to the COVID-19 pandemic, leaders have been forced to formulate decisions under considerable pressure (Hale et al., 2020). As government responses to COVID-19 demonstrated that it is essential to implement public health guidelines that protect the community and slow the pandemic, the public struggled to manage their financial, physical, mental, and social well-being (Hale et al., 2020; Isautier et al., 2020; Liu & Mesch, 2020; Pedersen & Favero, 2020).

The professional community and the government play a crucial role in responding, interpreting, evaluating, and communicating with the public during the pandemic. The government transmits information through its public health venues, whereas the professional community offers support services (CDC, 2020; Hale et al., 2020)

This study suggests that people's participation is paramount since personal responsibility is the main requirement for people staying safe from the virus. As a result, their involvement in how people feel that they can be safer only highlights the need for having a dialogue between the public and the people in governance. Lastly, this study

stresses the need for leaders to be fair representatives. In representation, leaders only act on behalf of the people they serve, which means that leaders have a personal responsibility to align their priorities with people's needs by supporting and protecting them when they are in need (Hale et al., 2020; Turner & El-Jardali, 2020).

Most participants are working in the healthcare or healthcare-related industry. Participants in this study have a good education; they were able to maintain basic needs during the pandemic, they shared very similar views about vaccination and public health care guidance. However, a whole society approach to a pandemic should include diverse groups of stakeholders. Participants with similar backgrounds, ideas, and beliefs might not see all the challenges and possibilities of a pandemic. Following guidelines might not allow innovative ideas. Thus, various points of view should be considered to ensure a whole-society approach to a pandemic.

Rights, Responsibilities, and Obligations During a Pandemic

A person's protective behavior is often associated with their perception of the risk posed by health threats and their capacity to evaluate the likely benefits and challenges in pursuing a particular course of preventive action (Marroquín et al., 2020). People's perceptions of risks usually influence their responses to different threats, like this pandemic. Based on answers regarding obtaining information about a pandemic, the results suggest that participants have a good understanding of what a pandemic is. They are overwhelmingly seeking answers and guidance from official sources such as the CDC, WHO, NIH, and the government (Glass & Glass, 2008).

The method used to access information concerning a particular health threat and the level of trust for that method determines risk perception. This perception then results in either adoption or failure to adopt protective behaviors. It was, therefore, evident that an effective response plan for a pandemic cannot be realized without an effective communication method, a method that airs accurate and relevant information, and with the latest details (Baharom et al., 2020; Turner & El-Jardali, 2020; Zacher & Rudolph, 2021).

Using COVID-19 as an example of the most recent pandemic, enough evidence shows that minority populations experienced an increased incidence and severity of the disease than White Americans. Key risk factors, such as age, sex, race, socioeconomic status, dense living conditions, and comorbidities, are linked to worse outcomes during COVID-19 infection (CDC, 2020).

Individual human rights are essential, it is also emphasized by Bezerra et al. (2020) who pointed out that despite situations like the lockdowns, people's rights should be maintained, which only results in a better community; for instance, people who need to seek treatment should not be restricted from the movement if they comply with public health guidelines. In close connection to human rights, the government has an obligation to support a community, protect it, and offer all essential and required services in such unprecedented times. Consideration must be given to changes in subjective wellbeing during a pandemic (Zacher & Rudolph, 2021).

According to the international human rights law, every person has the right to access the highest standard of health. It is the obligation of all governments to avoid all

public health threats and ensure that people who need medical care can get it (WHO, 2017). However, due to the nature of the infectious disease, this is impossible to achieve without considering individual responsibilities to follow health guidelines and communal obligations.

Participants Reflection on the Polarity of Democracy of Model

In the study, I used the three pairs of PDM to validate that first, the pandemic affects people differently. Different people have different situations, all of which result in variable risks of contracting the virus. This study advances the need for equality, which implies equal rights and opportunities for all people. Regardless of people's diversity, there should be no form of discrimination in patients' treatment, source of information, and ability to care for themselves, their family, and the community.

Infectious diseases in today's globalized world require robust public-private partnerships and communication for optimal health and economic security (Smith et al., 2019). While the PDM (Benet, 2013) represents two sets of opposite concepts of democracy, they can be used as collaborative tool that strive for the best possible outcome in each situation. Using the polarity map for representation (Figure 13) as an example we can examine the challenge of closing business during a pandemic.

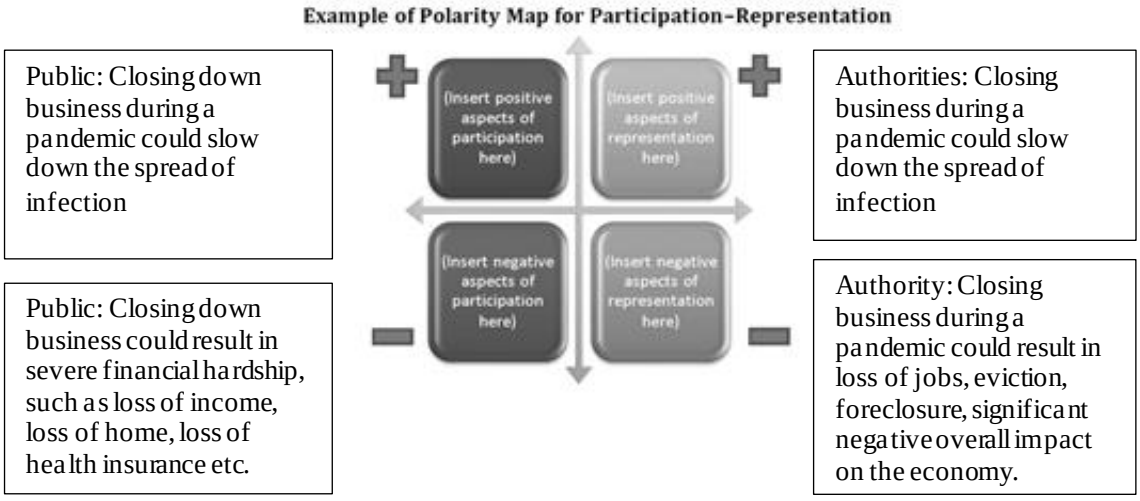
A person’s protective behavior is often associated with their perception of the risk posed by health threats and their capacity to evaluate the likely benefits and challenges in pursuing a particular course of preventive action (Marroquín et al., 2020; Bavel et al.,

2020). People's perceptions of risks usually influence their responses to different threats, like this pandemic.

The method used to access information concerning a particular health threat and the level of trust for that method determines risk perception. This perception then results in either adoption or failure to adopt protective behaviors. It was, therefore, evident that an effective response plan for a pandemic cannot be realized without an effective communication method, a method that airs accurate and relevant information, and with the latest details (Baharom et al., 2020; Bavel et al., 2020).

Figure 13

Example of a Polarity Map for Representation



Note. Retrieved from (Benet, 2013, p. 34).

The PDM can guide and enhance the decision-making process during a pandemic to ensure more effective processes, procedures, and outcomes. For example, giving businesses the option to propose protective measures while keeping at least part of the business running. PDM can help the investigator to improve the decision-making process by:

- understanding and exploring the different points of view
- maximizing the positive aspects of conflicting opinions
- making sure that no decision is based on a single idea
- seeking a compromise or a new innovative approach to a given situation.

For example, giving businesses the option to propose protective measures while keeping at least part of the business running.

Participants Reflection on the Response to Pandemic

Participants in this study identified the following opportunities for improvement:

- Lack of formal communication and education
- Lack of transparency, consistent guidelines, and metrics
- Negative and incompliant examples set by officials
- Politicization of the pandemic
- Media miscommunication and false information
- Lack of unity among people, communities, government, and professional world
- Lack of collaboration, strategic planning, and alignment
- Lack of participation in the decision-making process

Participants echoed that a response to a pandemic is less about human rights and more about communal obligation and to act in the best interest of all, indicate the desire for education and information from official sources, support of vaccination, public health guidelines, and determination to place a community's needs above individual human rights.

Limitation of the Study

Methodological limitations relate to issues with sample and selection. The very decision to engage the general public in this discussion via an anonymous survey limit my study since it was impossible to predict who were to participate. I defined participants retrospectively based on answers to the demographic questions in the last section of the survey. I included one open-ended semistructured online survey to address the posed research question. The open-ended questions were limited to the initial response because there was no interviewer to direct and follow up on the answers. Only participants with computer access were able to participate. Furthermore, only participants comfortable with Survey Monkey volunteered to participate in the study. It seems that self-selection led to biased data, as the participants who choose to participate shared similar views and beliefs and did not represent the entire targeted population.

The Survey Monkey platform had many limitations such as simple, standardized templates requiring questions to fit the template, inability to upload complex structure and place a time limit on questionnaires, and none of them impact the research study. Furthermore, since this was a novel exploratory study, I used a newly developed questionnaire. More research is needed to determine if this questionnaire is enough to

address the posted research question and establish valid data collection sufficiency to answer the research question. I evaluated the full validity of the survey based on data collected and the view of the respondents.

Recommendation for Further Study

I included answers from 30 participants with a similar socioeconomic and demographic background and no significant differences based on religious background. Long-term assessments including more participants with diverse background and point of views are needed to determine if observation drawn from collected data holds against the brother population. The anonymous survey proved to be a good start, but more in-depth research is needed focusing on specific communities. Even though this approach to data collection via self-selection seemed to introduce a new biased, as the participants who choose to participate shared similar views and believes and did not represent the entire target population, the "public".

In the context of the decision-making process in response to a pandemic, further studies of local communities and narrowly defined communities are needed to reveal new insights into the people's perception of opposite factors crucial to a successful response pandemic. This would be essential, especially if any laws and mandatory guidelines are to be provided. Due to the study limitations, I failed to collect any data from people that do not have access or do not feel comfortable using a computer, or do not speak English. I also failed to collect input from people with low socioeconomic status or anti-vaccine views

Implications

It was fundamental to determine the role that the public played during the decision-making process in preparation for a pandemic and respond to the occurrence of a pandemic. When using a survey to determine this role, it was evident that a problem existed regarding how the public was engaged during a pandemic, mainly since the public was not involved when decisions were being made. Not involving the public was quite unfortunate, considering that problems of the magnitude of a pandemic require a multidisciplinary approach to come up with better and long-lasting solutions.

In most cases, however, the people in governance tasked with representing people ignored the need for such a multidisciplinary approach that incorporated the whole society to find a solution. For this reason, I made use of PDM method, which aided in establishing how decisions should be made during a pandemic. It was also essential to conduct this research to offer a different lens into harmonize decision-making as a preparation for or in response to a pandemic. This research also made it possible to explore how the public was advised to respond to a pandemic and the actual way the public responded.

Conclusion

The purpose of this study was to understand public participation in the decision-making process arising from, planning for, and responding to an epidemic/pandemic to create a whole-of-society approach. My central focus on the phenomenon was to research Original RQ:

How does an individual balance socioeconomics, demographics, and religious views with their actual behavior in response to public health guidelines during an epidemic/pandemic?

The participants who chose to participate had a similar socioeconomic background, shared similar views and beliefs, and experience similar hardships during the COVID-19 pandemic. They had higher education, jobs possible to carry during the pandemic, live in their own houses, have health insurance, and live in the USA. During the pandemic, they focused on maintaining their physical and mental health and good spirit. They sought information from official sources and focused on helping their families and community. The majority were interested to learn more and get engaged in the decision-making process.

Revised RQ:

How does an individual in my cohort behave in response to the COVID-19 pandemic and public health guidelines during the pandemic?

I was unable to collect information from participants from diverse socioeconomic background or with diverse points of view. Thus, "the public" was not represented in this study. A whole society approach to a pandemic should include various groups of stakeholders. Participants with similar backgrounds, ideas, and beliefs might not see all the challenges and possibilities of a pandemic. Following guidelines might not allow innovative ideas. Thus, various points of view should be considered to ensure a whole-society approach to a pandemic.

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Appendix A: Invitation to the Survey

Welcome to My Survey

You are invited to take part in a research study about:

The Role of the Public during the Decision-Making Process in Preparation for and in Response to a Pandemic.

The researcher is inviting the public (adults, 21 years of age or older) to be in the study. Please follow the URL Link to gain a better understanding about this study before deciding whether to take part.

This study is being conducted by a researcher Ludmila M. Flores, who is a doctoral student at Walden University.

Appendix B: Survey

1. If you feel you understand the study requirements and wish to volunteer, please indicate your consent by clicking YES.
2. Describe in your own words what a pandemic is.
3. What are the ways the pandemic impacted you?
4. What are the ways the pandemic impacted your family?
5. What are the ways the pandemic impacted your community?
6. Based on your understanding, who are the people that are participating in the public health decision-making process during a pandemic?
7. Who creates public health guidelines and laws in your community?
8. Where do you get information about the COVID-19 pandemic?
9. If you could, would you like to be part of the decision-making process that develops public health guidelines and laws during a pandemic?
10. Describe ways you could be a part of the public health decision-making process during a pandemic. How do you see yourself doing that?
11. Do you practice civic engagement and actively help your community?11. Share your thoughts about your responsibilities, rights, and obligations during the COVID-19 pandemic. Which factors influence the way you see your rights, responsibilities, and obligations during COVID-19 pandemic (education, religion, peers, political affiliation, finances, etc.)
12. Describe

a. Describe the responsibilities to yourself during a pandemic
b. Describe the responsibilities to your family during a pandemic
c. Describe the responsibilities to your community during a pandemic
d. Describe the rights to yourself during a pandemic
e. Describe the rights to your family during a pandemic
f. Describe the rights to your community during a pandemic
g. Describe the obligations to yourself during a pandemic
h. Describe the obligations to your family during a pandemic
i. Describe the obligations to your community during a pandemic

13. If you could, would you change anything in the current response to the COVID-19 pandemic?
14. Describe in your own words what these word pairs represent to you during a pandemic

    Diversity – Equality

    Individual Rights -Communal obligations

    Individual participations – Representations
15. What is your age?
16. What is your gender?
17. What is your race or ethnicity?
18. Do you identify yourself with any religion?
19. What is the highest level of education you have completed?
20. What is your occupation?

21. In what country do you currently reside?
22. Do you currently have health insurance, or not?
23. Do you rent or own the place where you live?
24. Which of the following best describes your current relationship status?
25. Please feel free to share any additional thoughts about the decision-making process and your role in the decision-making process during an epidemic/pandemic. Would you like to share any other views, ideas, or scenarios arising from, planning for, and responding to an epidemic/pandemic that was not fully addressed or missed by the questionnaire? Considering the challenges experienced during the COVID-19 pandemic, would you like to share any other ideas on how the pandemic's response could have been handled differently by individuals, communities, health care intuitions, and the government?