

Building the Culture of Public Health as a Positive Reflection from the COVID-19 Crisis

Hatem H Alsaqqa ^{1,2}

¹Deanship of Scientific Research, Al-Quds University, Jerusalem, Palestine; ²Accreditation and License Unit, Ministry of Health, Gaza Strip, Palestine

Correspondence: Hatem H Alsaqqa, Email hs-mch@hotmail.com

Abstract: The goal of this study was to look at the impact of different components of COVID-19 on the development of a public health culture during the COVID-19 pandemic. Culture is largely acknowledged to have the greatest and most profound influence on many aspects of human and group behavior. Culture is the process of integration that distinguishes members of one group or category of people through others; in other words, culture is the operating system of the communities, cultural nuances among societies cause people to demonstrate different behavioral patterns in the face of events. However, the cultural differences of each community make it impossible to apply these metrics universally. Observing the impact of countries' cultural traits in the fight against outbreaks is one area where social scientists have not put much attention. As a result, this study demonstrates how cultural shifts affect their fight against outbreaks and public health challenges. The human response to COVID-19 is likely to be influenced by country culture and how (and when) overcome will be determined by it. Cultural ideas and assumptions should be assessed as part of public health interventions. These interventions should indeed be addressed at the societal level to stimulate awareness and participation while also guaranteeing culturally relevant events. Healthcare practitioners should emphasize public health exertions on culturally relevant forms of instruction, prevention, behavior and follow-up for successful pandemic management, effective screening, and diagnosis in infected individuals. Public health professionals must recognize the significance of this and learn to use communication messaging and guidelines, which must be culturally acceptable and context-dependent rather than merely grounded on medical methodologies, as was the case in many countries with COVID-19 management.

Keywords: crisis, COVID-19, culture, knowledge, learning, public health

Introduction

The COVID-19 pandemic has formed a chief social and medical crisis, forcing the medical and healthcare communities to face unprecedented challenges and rethink how to provide quality healthcare while enforcing health promotion required for pandemic deterrence and optimal healthcare distribution of resources.

The literature on crisis detection, early cautions and the following activation of crisis administrations has a wealth of information. It also says nothing about the gradual erosion of administrative and healthcare capacity as budget limitations constrict and communal opposition to voluntary compliance grows. COVID-19 provides fertile ground for further investigation.¹ Whether caused by natural catastrophes, conflicts, or disease outbreaks, crises disturb people's lives, hurting their livelihoods, economies and social and personal well-being. The primary idea for developing robust post-crisis healing is to ensure that the situation does not return to "normal" after the recovery process, but rather improves.

Since World War II, COVID-19 has brought the world the longest era of prolonged crisis regimes. Addressing the pandemic will necessitate not only a biomedical approach, but also a larger social sciences approach to health and, most importantly, listening to and learning from existing diverse communities and health management system, flexibility and capacity to work across sectors and recognition of social justice while carrying out public health actions in various contexts. Researchers believe that, just as previous cultural, political and epidemiological transitions led to changes in public health, these turbulent times will result in stronger public health.¹

Traditionally, anthropology, sociology and more lately, cultural studies, rather than medicine and public health, have been interested in culture. In general, the public health literature provides relatively little in the way of relevant interpretations of the culture idea. Instead, the concept of culture is often used blindly, relying on presumptions about culture and the cultural behaviors that are linked to health.² A public health culture can be defined as a new collection of words and effects, signals and facts, that supersedes or modifies the traditional set.³ It is a social construct that provides meaning through which the world is portrayed, in this case as a pandemic requiring massive political participation rather than isolated cases left in the hands of professionals.⁴

Moreover, communities with stronger civic capital are thus more successful at acting collectively and producing essential utilities, necessitating less costly supervision.⁵ Also, in the absence of government initiatives and persuasion campaigns, a strong civic culture can elicit voluntary response action at an early stage in the event of a pandemic. Furthermore, because more civic communities are more law-abiding,⁶ they are more likely to follow required responsive action measures if they are implemented. As a result, the higher the civic capital pool, the greater the adherence to reactive action and the slower the pandemic expansion.⁷

Culture has been a fundamental form of adaptation during the history of humankind. Culture is a socially communicated arrangement of shared ideas, beliefs and/or behaviors that varies across organizations and individuals within those groups.⁸ Because socioeconomic position, gender, religion and moral values all influence how people feel, interpret and react to their surroundings, basic cultural interpretations are insufficient to comprehend a patient's unique experience with well-being and sickness.⁹ Policymakers must understand how communities, as cultures of behavior, adjust to different and composite pressures to develop relevant and responsive health policies and programs.

The Role of Culture in Building the Public Health

Culture may not be considered as an “official” priority by authorities in times of crisis, but it is available as a resource to handle adverse events by individuals and groups. Public culture assets give communities a sense of self, history and social cohesion while also providing resources for economic development and restorative energy. Culture is more than just a pastime; it is essential to human existence.

Hence, culture may increase COVID-19 exposure, early identification and therapy. Handshaking or kissing is common cultural salutations between people, but they can help infections transmit. Although persuading patients to adopt or revise their customary cultural habits as a source of data control can be difficult, it is an important tool for reducing or changing the transmission of infection. The importance of culture in dealing with these situations is sometimes overlooked. The COVID-19 pandemic, on the other hand, demonstrates the necessity of relying on and employing culture to assist individuals in dealing with difficult situations. Many internet-based efforts centered on culture and tradition expressed people's desire to band together and, as a result, strengthen societal resilience in the face of the pandemic.

In 2001, the United Nations Education, Scientific and Cultural Organization (UNESCO) defined culture as “the set of distinctive spiritual, material, intellectual and emotional features of society or a social group ... [which] encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs”.¹⁰ This concept emphasizes that culture is made up of overt beliefs and behaviors and is not confined to national, racial, ethnic, or religious identity as well as the delicate and unquestioned traditions that shape our perceptions of certainty, define what is ordinary and extraordinary, and provide meaning and direction to our lives.

Because culture encompasses more than what we explicitly acknowledge, recognizing that it necessitates the difficult effort of analyzing assumptions, questioning preconceived notions and recognizing how the importance of common group values can sharply diverge, for better or worse: for better when difference allows us to rethink our assumptions in a new way; for worse when difference causes conflicts and misunderstandings. Many public health professionals are aware of the dangers of failing to address the cultural contexts of their work. As a result, public health systems have been weakened in their ability to respond effectively to the health requirements of varied communities, sparking fresh interest in establishing a health and well-being approach that is culturally sensitive.²

Culture has become a normal part of epidemiological research, seemingly unchallenged next to “traditional” health risk behaviors such as food and physical activity. The concept that “culture” can be used to improve one's health has been

expressed in a variety of ways, including incorporating cultural symbols and meanings into health promotion materials^{11,12} asserting that a society or culture may be conducive to better health behaviors and claiming that the process of reviewing and exploring one's cultural ancestors can help one's health.¹³ Hall and Neitz¹⁴ suggest that culture embraces "(1) ideas, knowledge and recipes for doing things, (2) humanly fabricated tools and (3) the products of social action that may be drawn upon in the further conduct of social life".

On the other hand, most scientists and news commentators, appear to approve on one feature of this pandemic: that in the upshot of the COVID-19 pandemic, with its lockdown and movement limitations, this pandemic will be worse. It will be a long and slow process of recalibration to the "new normal" in human contact patterns around the world, as some commentators so eloquently stated it. Different cultures and societies will undoubtedly react differently to the issues they face. The area of community development theorists and practitioners is focused on the post-COVID-19 era's evolution (urban renewal) of our communities. We must take steps to protect ourselves from the pandemic and to participate actively in the repair of our community fabric and quality of life.¹⁵

Adding to the body of knowledge about the cultural settings of health and well-being. Policymakers use broad mortality and morbidity statistics to generate policy suggestions in traditional health impact evaluations, frequently without a good knowledge of the cultural settings that influence individual and societal behaviors. Though based on meticulously acquired statistical facts, the ensuing reports and policies may be out of touch with people's interpreted experiences and expectations as well as what is practicable at the policy level. In response to this common misalignment of evidence, social requirement and health policy, measurements are primarily based on indices that, while they are beneficial in evaluating levels of perceived pleasure and contentment in a particular population, are missing the target when it comes to clarifying the shared meanings and values that support wellbeing.⁴

Collective Action During the COVID-19

The huge number of actors involved; the complexity of the problem; and the time and space separation between the people generating and being affected by the problem are all features of a large-scale collective action problem.¹⁶ The COVID-19 pandemic has many characteristics of a large-scale collective action challenge. As a result of these qualities, stressors arise that operate against the possibility of collective action, such as anonymity (a large number of people and actors are involved, spread across the globe; lack of accountability and heterogeneity (the actors might be from different countries)).¹⁶

A variety of variables explain why different nations and governments have employed different COVID19-fighting measures. Policy advice will always be based on reservations and normative conceptions and scientific models may not be able to effectively forecast future political ramifications in this type of decision setting, even with accessible data.¹⁷ Well-functioning political institutions can build trust and social norms, which can enhance collaboration, and nations with high "collective action capital" have more policy options than only limits and militarism in their arsenal. This is critical when some behaviors are extremely difficult to control or monitor (e.g., washing hands). As a result, governments must respond to the needs of various segments of society in order to deal with the issue. Other potential explanatory variables, such as institutional capacity and cultural aspects must be considered in addition to demographic explanations.¹⁸ We give a convincing explanation for why certain governments are enforcing punitive policies based on the findings of collective action research. Such wealth enables a broader range of actions to combat pandemics.¹⁹

Cultural values,²⁰ thinking patterns,²¹ regulatory focus,²² and other factors have all been utilized to operationalize common cultural meanings. There are considerable differences in coping mechanisms and indications of adaptive outcomes across cultures.²³ Because cultural values imply desirable outcomes, they are worth pursuing.²⁰

People's focus in a collectivist culture may extend beyond personal career growth concerns to issues affecting their workgroups, administrations, and social networks.^{23,24} National culture has also been demonstrated to influence coping strategy choices (eg, De Vaus et al).²⁵ Because of the complexities of social identities and the various levels of cultural identification, there is a possibility of intergroup prejudice or even national conflict.²³

Socioeconomic and other social factors influence the majority of health outcomes. Several studies have been conducted to investigate the impact of social factors on health. The substantial and extensively reported relationships between a variety of health variables and socioeconomic assets or social standing metrics, such as income, academic

achievement, or occupational hierarchy rank, also support the health effects of social variables. This relationship regularly tracks a stepwise gradient pattern in both US and European data, with health increasing incrementally as social status rises.²⁶ In times of crisis, make decisions as a group, management teams are required to make challenging decisions,²⁷ and team decisions are particularly vulnerable to the effects of crises. This is because normal group functioning becomes maladaptive during crises, rendering standard therapies useless. Teams must successfully communicate and coordinate their efforts.²⁸ Crises throw these routines off because they fundamentally alter how we collaborate and create new problems.

According to cultural variation research, tight cultures, such as Japan, and China, have severe social norms and deviant sanctions, whereas loose cultures, such as the United States, and Italy have weaker cultural standards and are more permissive.²⁹ Tight nations are more likely to face substantial historical and ecological risks, such as natural disasters, population size and infection epidemics.²⁹ When groups face collective risks, tight rules may help them coordinate to survive according to evolutionary theory.³⁰

As a result of the spread of COVID-19, communities may become more strongly bonded. It may be more difficult to collaborate in the occasion of a pandemic in cultures that prioritize liberty over security. Communities may also negotiate social norms in order to strike a stability between freedom and restraint, or “tight-loose ambidexterity”.³¹ The research suggests that in the fight against COVID-19, quite diverse measures may be required in different cultural situations.³²

Culture and Communications for Risky Decisions

Culture and communications were predicted to be powerful forces in the twenty-first century, with the goal of improving population health and well-being. Furthermore, these forces would propel a quickly shifting and interconnected globe, with people and nations all over the world sharing common gains and hazards (eg, pandemics, climate change). In order to realize the potential of culture and technology, effective administration and information were to be a chief key in improving public health in this environment. Culture is critical for progress and it is crucial what may be learned from it, is understood and respected by the public, recognizing that there is no one-size culture fits all solution. Nonetheless, there may be some doubt and it is vital that the public understands that knowledge is always evolving and that new issues may arise.

In order to make better decisions in concealed profile circumstances, teams must normally take their time to gather and integrate available data. For example, arguing for several decision options (advocacy procedure).³³ Similarly, true dissent (which can be difficult to extract in real teams) enhanced concealed profile decisions by raising the intensity of discussion in terms of spent talking time and information expansion.³⁴ In addition, making hasty decisions in a crisis shows that the situation is changing.

During times of crisis, even management teams that share and integrate all information at the same time may have to alter their judgments in light of new information; effective decisions are not the end goal, but the beginning of a protracted implementation procedure. This is because catastrophes like the Coronavirus pandemic take time to unfold and so necessitate perseverance.

During the design, delivery, and evaluation phases, the cultural sensitivity technique strives to construct health interventions that take into account the target population’s cultural traits, values, beliefs, experiences and conventions.³⁵ The requirement for cultural competence in health communication stems from the belief that, in order to be most effective, health communication should adapt to a culture’s unique characteristics.^{35,36} Being culturally sensitive entails tailoring communication solutions to the cultural characteristics that the health communicator values. The bigger aims of healthcare organizations and research institutions, which highlight that the means we interconnect about health to various people should be impacted by their cultures, reflect this emphasis on culture. People from more individualistic cultures may be more promotion or approach-oriented, making them more sensitive and susceptible to gain-framed communications that highlight positive results. People from more collectivistic cultures, on the other hand, may be more prevention or avoidance oriented, making them more sensitive and attentive to the negative effects highlighted in loss-framed communications.³⁷

Health communication concepts become culturally responsive by isolating and incorporating specific cultural aspects into the primary ideas and claims of health communication. The goal is to identify common characteristics within the culture that may be used to define it and then design health communication apps that are suited to these characteristics. In

models based on this strategy, certain cultural features are routinely identified and utilized to expect a variety of outcome variables. Health locus of control research, for example, seeks to predict the role of health locus of control in a variety of health outcomes.³⁸

Certain cultural sensitivity health communication programs concentrate on hypothesizing and operationalizing the concept of cultural sensitivity, developing scales to test it and connecting it to outcome determinants. The prominence is once again on adjusting existing communication techniques, styles and messages to cultural characteristics. The goal of the culture-centered method is to identify gaps and/or silences in national public health scheme and practice in order to give a new way of thinking about and doing health communication.

Picturing Reality and Collective Sensemaking During Crisis

Sensemaking is a social construction process that occurs when conflicting inputs disrupt people's ongoing activities, and it entails the production of plausible meanings that legitimize what they are doing retrospective.³⁹ The bracketing of environmental signals and the interpretation of those stimuli based on relevant frames is crucial to the creation of credible meanings. Integrating cues and frames to generate an account of what is going on, is thus the goal of sensemaking. It begins by looking at how people are reacting to the pandemic in their communities so that several contradicting responses have been received. What has occurred in the COVID-19 era is that bottom-up decision-making has been unrestricted in terms of macro strategies, as governments, medical specialists and public health authorities design policies and implement them without the participation of the general public. Citizens have generally been willing to hand over control of social contacts to the state, given evidence that harsh policies of social isolation and social distancing have been effective in slowing the spread of the virus.

Community development professionals must demonstrate their usefulness by providing strong scientific inputs based on strong scientific theory, one of the hallmarks of which is that it allows for some prediction of results,⁴⁰ reducing the likelihood of unintended consequences. The Priority Index (P-Index), a basic requirements assessment technique, is one such hypothesis.⁴¹ The role of community development professionals is to (i) detect, (ii) tap into, and (iii) "piggyback" on the various types of flexibility that are apparent in communities, guiding them to a better quality of life as the lockdowns are lifted. The community needs prioritizing technique that has the proven capacity to aid as a nonstop social development effort to the multidisciplinary crews that organize the encouragement of societies out of the COVID-19 lockdown into the post-COVID-19 era as an information and tracking tool.¹⁵

Globality of the COVID-19 Pandemic in Building Public Health Culture

The COVID-19 pandemic is a major global health emergency as the problem needs large-scale behavior change, the social and collective mind can be employed to assist in aligning human behavior with public health specialists' recommendations. Here, we analyze evidence from various disease outbreak research, such as work on steering hazards and social and cultural implications on behavior.

This is especially important in the aftermath of COVID-19, which has forced communities all across the world to learn how to respond to and deal with a new disaster. The pandemic has highlighted a worldwide hazard, highlighting the need for international collaboration and integration to establish a sense of building back better that combines culture, in order to avoid them being swamped by other national concerns.⁴² The role of international organizations in connecting stakeholders is becoming increasingly vital in order to enable the widespread dissemination of shared information and best practices in order to build a collective resilient recovery from the pandemic.¹⁰

It specifically demands new well-being assessments that interpret for the properties of culturally interceded sickness and health experiences, acknowledging the importance of shared values for well-being. Understanding, recognizing, and aggressively supporting the behaviors that diverse and interconnected cultural practices can increase solidarity and resilience are all part of the process of developing these metrics. This will necessitate nothing less than a whole-of-control and whole-of-society strategy, one that builds on individual shared values to encourage new kinds of critical thinking, ordinary cooperation and long-term mutual cohesion both locally and worldwide.⁴

Data for Collective Sharing and Culture Building

Digital contact tracing automates detecting on a scale and at a speed that would be impossible to achieve without the use of digital tools.⁴³ It lessens the reliance on human memory, which is especially important in densely populated areas with mobile people. Digital contact-tracing apps have been developed for use in numerous countries during the COVID-19 pandemic; these apps rely on ideas and technologies that have never been used on this scale before and they are problematic in terms of privacy. It is critical to assess their accuracy and efficacy.

Assessing local differences in agility and contact behaviors could be crucial for forecasting the heterogeneity of transmission capacity between communities and areas when family size and age-stratified contact patterns varied. This background can help researchers understand the effectiveness of treatments to limit transmissions, such as handwashing,⁴⁴ social distancing and school closures.⁴⁵ Monitoring social-distancing techniques could be used to estimate healthcare system demands⁴⁶ and it will be critical in determining when limits should be eased.

Informing the public in order to ensure community trust, operative performance of measures during a pandemic requires communal education and support, as well as an appropriate communications plan that integrates vigorous community engagement. Since the first reports of an atypical influenza-like sickness resistant to traditional treatment procedures surfaced in China,⁴⁷ online data and social media have played a continuous and crucial role in public communication.⁴⁸ Public health organizations and technology firms are speeding up their efforts to combat misinformation and favor reputable news sites.⁴⁹

Furthermore, existing data-sharing efforts appear to be primarily focused on particular country adjustment and interoperability.⁵⁰ While many of these concerns are not unique to global public health, given the self- or group-identifying qualities of data, there may be a particular urgency in this domain. To address these hazards, such as the misuse of public health data, a variety of actions will be needed, each tailored to the specific data typology and taking into account the motives and interests of data owners. It will also demand that countries and data owners agree to data-sharing rules and recognize data as a global public benefit.⁵¹

We believe the World Health Organization (WHO) could play an active role in managing data sharing efforts, forming partnerships and developing guidelines and standards, particularly for patient data, public health data and health systems data, given its capacity as the normative global health organization. There are numerous examples of similar projects already in progress. The World Health Organization (WHO) has adopted a number of data-sharing protocols.⁵² While these rules are not legally enforceable, they do provide guidance to member nations.⁵³

However, knowledge management is complicated during a crisis because different networks use different tactics such as centralization and alternative organizational structures such as independence. A significant goal in dealing with COVID-19 was to develop health protocols, ensure their effectiveness and publicize the practice among healthcare professionals. The nature of the crisis, which in this case is a pandemic concern, fosters learning once again.

Communities have taken responsibility for their own well-being at the micro level while yielding control at the macro level. They accomplish this in variation of behaviors. Communities are engaged in spontaneous efforts to fortify social connectivity in projects that are congruent with community engagement. The use of social media to check-in on separated friends, the practice of leaving provisions at neighbors' doors and joining balcony singing groups have all contributed to the preservation of social relationships and, as a result, communal solidarity.⁵⁴ In order to preserve mainstreaming culture in catastrophe conditions, more efforts must be made to integrate global knowledge and approaches to their adaptation and implementation to local cases.

Awareness and Learning from Unexpected, Rare Crises

The impending COVID-19 pandemic is a unique time period marked by a slew of social, economic and health issues. In order to meet the aforementioned problems and establish reasonable expectations about the disease's future course, affected populations must have an acceptable level of COVID-19 related understanding. At the middle and lower levels of management, policymakers and senior leadership should try to instill a common feeling of duty among medical and non-medical personnel workers. Well-connected systems infused with a learning culture will aid in the development of successful interactions, coordinated activities and assessments that will help to enhance acceptable healthcare practices

while correcting structures, processes and assumptions. Concisely, healthcare executives can foster a culture of continual learning.⁵⁵

Yet, communities must establish pedagogical ways to learn and grasp the new science and technology in public health and education must develop leaders who can stay up. The development of learning expertise and the use of data collecting allows for the synthesizing of available data and the timely transmission of judgments. Data has become a more prominent focus of teaching and training in most schools of public health in recent years yet, the rate of change in such techniques often outpaces regular educational updates. Researchers believe that recent advances in technology and willingness, revolutionize healthcare diagnosis, assessment, and management, particularly during emergencies and pandemics.⁵⁶

Collaboration through communal charity organizations, regional health agencies and health specialists can provide progressive expertise to these organizations as well as assist in the implementation of solutions to address community concerns. Practices can be employed and shared to improve outcomes using acquired knowledge from outsiders yet ingrained in the working systems. Learning public health culture was also favorably associated with empowerment, dialogue and a philosophy of lifelong learning. Employees at all levels participate in collaborative decision-making and accountability as part of the empowerment process. Logical reasoning and dialogues allow for critical thinking and the development of logical and acceptable answers to a variety of problems. Learning organization culture was also found to be highly linked to continuous learning.⁵⁵ Behavioral competencies (such as creativity, exploration, and knowledge integration) ensure that resources are used effectively and that appropriate actions are taken.

However, few academics have looked at fear and uncertainty in the context of unpleasant outcomes, which may not considerate the genuine dread and doubt people felt during the experience. Any crisis provides an opportunity to learn, improve sympathy and expand flexibility while building a more secure and compassionate community. Taking lessons from a looming mega-crisis COVID-19 is the second global mega-crisis to strike modern nations in this century (following the financial crisis). Given the clear prospect of additional transboundary threats, it is critical to consider COVID-19 reactions and what we should learn from them.¹ COVID-19 posed a significant challenge to the modern state's crisis management capabilities. Until now, the pandemic had caused significant excess mortality in many countries, put enormous strain on health systems and had significant (and diverse) economic and societal repercussions. As a result, COVID-19 is classified as a "mega-crisis".⁵⁷ It also helps civilizations establish collective learning, which improves individual and organizational performance.

Contextual elements, such as culture, influence learning in general. Knowledge culture is defined as an organization's commitment to learning as a crucial component of its commercial success.⁵⁸ Through collective knowledge and increased understanding among teams, collective learning among small teams may result in quality standards.⁵⁹ In the context of healthcare settings, team followers may transform their knowledge into arrangements and then assess those activities against evidence-based practice and current recommendations.

Furthermore, the recommendations made are frequently erroneous because they overlook the distinctions between knowing (ie passive learning) and doing (ie active learning). The irony here is that one faulty system is being examined with the misguided aim of perfecting the other. Despite the widespread use of investigations, there is no evidence that they are a successful way of learning operational lessons from previous crises. As a result, we would support a review of the previous year's events and we would also advocate for a review of how these investigations are conducted to ensure that they result in active rather than passive learning.⁶⁰

Priority Interventions and Policy Considerations

COVID-19 and social capital possibilities as countries respond to COVID-19's numerous obstacles, as well as lessons learned from intervention and prevention studies linking enhanced social capital with improved health outcomes, greater community buy-in and the continuation of healthcare services to vulnerable populations suggest that social capital plays a critical role in ensuring a swift modification to today's neoliberal environment.

Preliminary research from the United States supports the role of social capital in the COVID-19 response, the rising rate of new COVID-19 cases has been demonstrated to be negatively connected to social capital at both the national and county levels.⁶¹ However, actively attempting to use or develop existing social networks in order to improve health results, each intervention group's social structure must be carefully examined.

Different components of socializing may respond to a public health intervention in different ways, so it's critical for a social capital-based response to be able to recognize circumstances in which social capital building initiatives can effectively enhance the public health agenda, as well as accurately identify the subcategories of social capital. In this regard, a social capital-centric public health strategy to the COVID-19 response could be viewed as a paradigm for understanding how the social interactions between various groups of actors can be used to best successfully implement pandemic-related health policies.⁶²

Discussion and Conclusion

The aim of the study was to examine the factors influencing building effective public health culture. Having theoretical and practical implications, this study investigates the role of public health culture and some positive hints in the till-now continuing crisis of pandemic COVID-19. Besides, study findings guide policymakers to create rules and processes relying on experience of learning that develops a coherent workplace culture for a variety of communities sections to offer efficient and effective interventions and public health services.

In public health settings, the new knowledge-based learning should be deeply rooted and integrated into the fields' daily operations. Empowerment, conversation and scrutiny, as well as a mindset of lifelong learning, were all found to be favorably associated with public health culture. Employees at all levels participate in collaborative decision-making and responsibility as part of the empowerment process. This approach increases policymakers' incentive to learn new things so they can make effective choices. In healthcare, however, empowering partners to the point where they can participate in collective decision-making is the main hindrance.

Within the partners, a culture should be fostered where mechanisms infused with new knowledge are properly connected so that lessons can be disseminated across classifications to improve public health outcomes. Due to environmental and cultural differences, caution should be exercised when generalizing study findings in particular nations. Well-connected systems with a learning culture will aid in the development of successful interactions, coordinated activities, and insights that will promote acceptable public health behaviors while addressing protocols, methods, and assumptions.⁵⁵

Culturally informed policies and practices begin with post-crisis assessments. Programs that are outlined and defined by post-crisis assessments are the beginning points and key vehicles for international support to post-crisis recovery. The goal is to prevent teams from overlooking culture in their first assessments, which could lead to missed opportunities or worse. A culturally informed analysis might use a variety of procedures, such as socioeconomic analyses, anthropological research, participatory engagement, and methods for identifying subordinate groups' genuine perspectives and preferences.⁶³ COVID-19 message for community engagement relies heavily on culture. Culture is defined as a collective sense of consciousness that shapes and influences perception, behavior and power, as well as how these are shared and conveyed.⁶⁴

In general, public health is portrayed as action-oriented knowledge and competence at the disposal of decision-makers. The inputs to this knowledge and competence are regarded as natural facts that must simply be represented in statistics and the language of determinants and risk factors. The people who are expected to benefit from actions and decisions are thought to be part of a culture that needs to change for their own good. One method of reaching an understanding of what is happening on, and how a pandemic might transform ourselves and society in a post-pandemic era, is to frame a pandemic as deepening rift and hence as a learning process, in the context of fear (in the present case, the COVID-19 pandemic).⁶⁵

Epidemiology is a social phenomenon. Health Determination of Society (HDOS) in COVID-19 eloquently illustrates how a health condition is profoundly affecting societies, a phenomenon that had hitherto gone unnoticed. The reactions of public health to community illness are also fundamental aspects; the kinds of organizations, rules of decision-making and conduct, and sets of values and principles might alter depending on the situation.⁶⁶ The term "reflective learning" refers to instances in which people intentionally consider something and make an attempt to comprehend why things are the way they are. This includes drawing on relevant knowledge to figure out how to handle a problem and coming to conclusions that become part of a new reference frame.⁶⁵

Because national culture can be initially conceived and operationalized in a variety of ways, future research should look for perspectives from other relevant ones, such as cultural differences in social views,^{67,68} or take an indigenous

approach to gain a better understanding of the various aspects of cultural influence.⁶⁹ Other aspects of a nation, such as economic, geopolitical and historical variables, play essential roles in molding individuals' actions, and future studies should take this into account.⁷⁰ As culture can be manifested at different levels, future research should adopt a multi-level approach to examine how culture interplay with each other in inducing entities' coping and management strategies.

The pandemic has transformed how we give care, allowing us to re-evaluate conventional methods and improve the effectiveness of management techniques. Along with the sadness and significant obstacles, we have a unique influential effect on the public health society now and perhaps in the days ahead, as this pandemic continues to develop. If we are successful in learning from this pandemic and dealing with it, we should include some of the crisis' principles and habits into our new inventive, creative, solidarity, empathetic, effective, equitable, healthy and stronger routine.

Disclosure

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References

1. Boin A, Lodge M, Luesink M. Learning from the COVID-19 crisis: an initial analysis of national responses. *Policy Design Pract.* 2020;3(3):189–204. doi:10.1080/25741292.2020.1823670
2. Bond C, Brough M. The meaning of culture within public health practice-implications for the study of Aboriginal and Torres Strait Islander health. In: *Beyond Band-aids: Exploring the Underlying Social Determinants of Aboriginal Health*. Cooperative Research Centre for Aboriginal Health; 2007:229–238.
3. Dozon JP, Fassin D. *Critique of public health, an anthropological approach*. Paris: Balland; 2001.
4. Fassin D. Public health as culture. The social construction of the childhood lead poisoning epidemic in France. *Br Med Bull.* 2004;69(1):167–177. doi:10.1093/bmb/ldh017
5. Aghion P, Algan Y, Cahuc P, Shleifer A. Regulation and distrust. *Q J Econ.* 2010;125(3):1015–1049. doi:10.1162/qjec.2010.125.3.1015
6. Herrmann B, Thöni C, Gächter S. Antisocial punishment across societies. *Science.* 2008;319(5868):1362–1367. doi:10.1126/science.1153808
7. Durante R, Guiso L, Gulino G. Asocial capital: civic culture and social distancing during COVID-19. *J Public Econ.* 2021;194:104342. doi:10.1016/j.jpubeco.2020.104342
8. Hruschka DJ, Hadley C. A glossary of culture in epidemiology. *J Epidemiol Commun Health.* 2008;62:947–951. doi:10.1136/jech.2008.076729
9. Napier AD, Ancarno C, Butler B, et al. Culture and health. *Lancet.* 2014;384:1607–1639. doi:10.1016/S0140-6736(14)61603-2
10. UNESCO universal declaration on cultural diversity. Paris: UNESCO; 2001. Available from: <https://www.ohchr.org/sites/default/files/diversity.pdf>. Accessed February 13, 2022.
11. Brady HE, Verba S, Schlozman KL. Beyond SES. A resource model of political participation. *Am Political Sci Rev.* 1995;89(2):271–294. doi:10.2307/2082425
12. Simmons D, Voyle JA. Reaching hard-to-reach, high-risk populations: piloting a health promotion and diabetes disease prevention programme on an urban marae in New Zealand. *Health Promot Int.* 2003;18(1):41–50. doi:10.1093/heapro/18.1.41
13. Brook JS, Cohen P, Brook DW. Longitudinal study of co-occurring psychiatric disorders and substance use. *J Am Acad Child Adolesc Psychiatry.* 1998;37(3):322–330. doi:10.1097/00004583-199803000-00018
14. Hall JR, Neitz MJ. Culture: sociological perspectives. 1993.
15. Schutte DW. COVID-19: are community development scientists missing in action or missing the action? *Local Dev Soc.* 2020;1(1):53–56. doi:10.1080/26883597.2020.1794756
16. Jagers SC, Harring N, Löfgren Å, et al. On the preconditions for large-scale collective action. *Ambio.* 2020;49(7):1282–1296. doi:10.1007/s13280-019-01284-w
17. Saltelli A, Bammer G, Bruno I, et al. Five ways to ensure that models serve society: a manifesto. *Nature.* 2020;582:482–484. doi:10.1038/d41586-020-01812-9
18. Walker PG, Whittaker C, Watson OJ, et al. The impact of COVID-19 and strategies for mitigation and suppression in low-and middle-income countries. *Science.* 2020;369(6502):413–422. doi:10.1126/science.abc0035
19. Harring N, Jagers SC, Löfgren Å. COVID-19: large-scale collective action, government intervention, and the importance of trust. *World Dev.* 2021;138:105236. doi:10.1016/j.worlddev.2020.105236
20. Hofstede G. Culture and organizations. *Int Stud Manag Organ.* 1980;10(4):15–41. doi:10.1080/00208825.1980.11656300
21. Spencer-Rodgers J, Williams MJ, Peng K. Cultural differences in expectations of change and tolerance for contradiction: a decade of empirical research. *Personal Soc Psychol Rev.* 2010;14(3):296–312. doi:10.1177/1088868310362982
22. Kurman J, Hui C. Promotion, prevention or both: regulatory focus and culture revisited. *Online Readings Psychol Culture.* 2011;5(3):1–6. doi:10.9707/2307-0919.1109
23. Guan Y, Deng H, Zhou X. Understanding the impact of the COVID-19 pandemic on career development: insights from cultural psychology. *J Vocation Behav.* 2020;119:103438. doi:10.1016/j.jvb.2020.103438
24. Wong PT, Wong LC, Scott C. Beyond stress and coping: the positive psychology of transformation. In: *Handbook of Multicultural Perspectives on Stress and Coping*. Boston, MA: Springer; 2006:1–26.
25. De Vaus J, Hornsey MJ, Kuppens P, Bastian B. Exploring the East-West divide in prevalence of affective disorder: a case for cultural differences in coping with negative emotion. *Personal Soc Psychol Rev.* 2018;22(3):285–304. doi:10.1177/1088868317736222
26. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. *Public Health Rep.* 2014;129(1_suppl2):19–31. doi:10.1177/00333549141291S206

27. Winget JR, Tindale RS. Stereotypic morality: the influence of group membership on moral foundations. *Group Proces Intergroup Relations*. 2020;23(5):710–725. doi:10.1177/1368430219866502
28. Marks MA, Mathieu JE, Zaccaro SJ. A temporally based framework and taxonomy of team processes. *Acad Manag Rev*. 2001;26(3):356–376. doi:10.5465/amr.2001.4845785
29. Gelfand MJ, Raver JL, Nishii L, et al. Differences between tight and loose cultures: a 33-nation study. *Science*. 2011;332(6033):1100–1104. doi:10.1126/science.1197754
30. Roos P, Gelfand M, Nau D, Lun J. Societal threat and cultural variation in the strength of social norms: an evolutionary basis. *Organ Behav Hum Decis Process*. 2015;129:14–23. doi:10.1016/j.obhdp.2015.01.003
31. Gelfand M. *Rule Makers, Rule Breakers: Tight and Loose Cultures and the Secret Signals That Direct Our Lives*. Scribner; 2019.
32. Van Bavel JJ, Baicker K, Boggio PS, et al. Using social and behavioural science to support COVID-19 pandemic response. *Nat Human Behav*. 2020;4(5):460–471. doi:10.1038/s41562-020-0884-z
33. Waddell BD, Roberto MA, Yoon S. Uncovering hidden profiles: advocacy in team decision making. *Manag Decis*. 2013;51(2):321–340. doi:10.1108/00251741311301849
34. Schulz-Hardt S, Brodbeck FC, Mojzisch A, Kerschreiter R, Frey D. Group decision making in hidden profile situations: dissent as a facilitator for decision quality. *J Pers Soc Psychol*. 2006;91(6):1080. doi:10.1037/0022-3514.91.6.1080
35. Resnicow K, Braithwaite RL, Dilorio C, Glanz K. Applying theory to culturally diverse and unique populations. In: Glanz K, Rimer BK, Lewis FM, editors. *Health Behavior and Health Education: Theory, Research, and Practice*. 3rd ed. San Francisco: Jossey-Bass; 2002:485–509.
36. Ulrey KL, Amason P. Intercultural communication between patients and health care providers: an exploration of intercultural communication effectiveness, cultural sensitivity, stress, and anxiety. *Health Commun*. 2001;13:449–463. doi:10.1207/S15327027HC1304_06
37. Betsch C, Böhm R, Airhihenbuwa CO, et al. Improving medical decision making and health promotion through culture-sensitive health communication: an agenda for science and practice. *Med Decis Making*. 2016;36(7):811–833. doi:10.1177/0272989X15600434
38. Dutta MJ. Communicating about culture and health: theorizing culture-centered and cultural sensitivity approaches. *Commun Theory*. 2007;17(3):304–328. doi:10.1111/j.1468-2885.2007.00297.x
39. Weick KE, Sutcliffe KM, Obstfeld D. Organizing and the process of sensemaking. *Organ Sci*. 2005;16(4):409–421. doi:10.1287/orsc.1050.0133
40. Mouton J, Marais HC. *Basic Concepts in the Methodology of the Social Sciences*. Hsnc Press; 1996.
41. Schutte DW. *Identifying Community Needs: Laying the Foundation for Successful Community Development Projects*. Scholars' Press; 2015.
42. Garcia BM. Integrating culture in post-crisis urban recovery: reflections on the power of cultural heritage to deal with crisis. *Int J Disaster Risk Reduct*. 2021;60:102277. doi:10.1016/j.ijdr.2021.102277
43. Ferretti L, Wymant C, Kendall M, et al. Quantifying SARS-CoV-2 transmission suggests epidemic control with digital contact tracing. *Science*. 2020;368(6491). doi:10.1126/science.abb6936
44. Klepac P, Kucharski AJ, Conlan AJ, et al. Contacts in context: large-scale setting-specific social mixing matrices from the BBC Pandemic project. *MedRxiv*. 2020. doi:10.1101/2020.02.16.20023754
45. Zhang J, Litvinova M, Liang Y, et al. Changes in contact patterns shape the dynamics of the COVID-19 outbreak in China. *Science*. 2020;368(6498):1481–1486. doi:10.1126/science.abb8001
46. Deasy J, Rocheteau E, Kohler K, et al. Forecasting ultra-early intensive care strain from COVID-19 in England. *MedRxiv*. 2020. doi:10.1101/2020.03.19.20039057
47. Green A, Li wenliang. *Lancet*. 2020;395(10225):682. doi:10.1016/S0140-6736(20)30382-2
48. Merchant RM, Lurie N. Social media and emergency preparedness in response to novel coronavirus. *J Am Med Assoc*. 2020;323:2011–2012. doi:10.1001/jama.2020.4469
49. Jozaghi Y, Zafereo ME, Perrier ND, et al. Digital technologies in the public-health response to COVID-19. *Nat Med*. 2020;26(8):1183–1192.
50. World Health Organization. WHO forum on health data standardization and interoperability. Geneva: World Health Organization; 2012. Available from: https://www.who.int/ehealth/WHO_Forum_on_HDSI_Report.pdf?ua=1. Accessed September 27, 2020.
51. Yamey G, Jamison D, Hanssen O, Soucat A. Financing global common goods for health: when the world is a country. *Health Syst Reform*. 2019;5(4):334–349. doi:10.1080/23288604.2019.1663118
52. World Health Organization. WHO policy on the use and sharing of data collected by WHO in member states outside the context of public health emergencies; 2020. Available from: <https://www.who.int/about/who-weare/publishing-policies/data-policy>. Accessed July 27, 2021.
53. World Health Organization. Policy statement on data sharing by WHO in the context of public health emergencies (as of 13 April 2016). *Wkly Epidemiol Record*. 2016;91(18):237–240.
54. Kenny S. COVID-19 and community development. *Community Dev J*. 2020;55(4):699–703. doi:10.1093/cdj/bsaa020
55. Alonazi WB. Building learning organizational culture during COVID-19 outbreak: a national study. *BMC Health Serv Res*. 2021;21(1):1–8. doi:10.1186/s12913-021-06454-9
56. Ghaffar A, Rashid SF, Wanyenze RK, Hyder AA. Public health education post-COVID-19: a proposal for critical revisions. *BMJ Global Health*. 2021;6:e005669. doi:10.1136/bmjgh-2021-005669
57. Helsloot I, Boin A, Jacobs B, Comfort LK. *Mega-Crises: Understanding the Prospects, Nature, Characteristics, and the Effects of Cataclysmic Events*. Charles C Thomas Publisher; 2012.
58. Omar AH. Malay in its sociocultural context, Dewan Bahasa dan Pustaka, Kuala Lumpur. 1987.
59. Wan M, Noordin ZM. Wawasan Pendidikan (Educational Vision), Chahaya Pantai, Kuala Lumpur. 1994.
60. Sisa I, Noblecilla E, Orozco F. Rationale to continue approving placebo-controlled COVID-19 vaccine trials in LMICs. *Lancet*. 2021;397(10277):878. doi:10.1016/S0140-6736(21)00357-3
61. Varshney LR, Socher R. COVID-19 growth rate decreases with social capital. *medRxiv*. 2020. doi:10.1101/2020.04.23.20077321
62. Wong AS, Kohler JC. Social capital and public health: responding to the COVID-19 pandemic. *Global Health*. 2020;16(1):1–4. doi:10.1186/s12992-020-00615-x
63. Rao V, Walton M. Relationality, equality of agency, and development. *Culture Public Action*. 2004;3:36.
64. Airhihenbuwa CO, Iwelunmor J, Munodawafa D, et al. Peer reviewed: culture matters in communicating the global response to COVID-19. *Prev Chronic Dis*. 2020;17. doi:10.5888/pcd17.200245

65. Bjursell C. The COVID-19 pandemic as disjuncture: lifelong learning in a context of fear. *Int Rev Educ.* 2020;66(5):673–689. doi:10.1007/s11159-020-09863-w
66. Hahn RA, Schoch-Spana M. Anthropological foundations of public health; the case of COVID 19. *Prev Med Rep.* 2021;23:101331. doi:10.1016/j.pmedr.2021.101331
67. Chen SX, Lam BC, Wu WC, et al. Do people's world views matter? The why and how. *J Pers Soc Psychol.* 2016;110(5):743. doi:10.1037/pspp0000061
68. Leung K, Bond MH. Social axioms: a model for social beliefs in multicultural perspective. 2004.
69. Gelfand MJ, Denison EE. Moving beyond the West vs. the rest: understanding variation within Asian groups and its societal consequences. *Proc Natl Acad Sci.* 2020;117(10):5100–5102. doi:10.1073/pnas.2000930117
70. Tsui AS, Nifadkar SS, Ou AY. Cross-national, cross-cultural organizational behavior research: advances, gaps, and recommendations. *J Manage.* 2007;33(3):426–478. doi:10.1177/0149206307300818

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