Community Health Awareness Model: Discussion Revisited on How Hong Kong People are Combating the COVID-19 Pandemic

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SUMMARY

There is a relatively low number of infections and COVID-19-incurred deaths in Hong Kong, with no city lockdown, despite unfavourable factors such as it having a busy transportation centre, directly adjacent borders, a high population density and a poor living environment. Even worse, confused, inconsistent policies and tactics have created more difficulties for citizens to defeat this health crisis. Having experienced SARS in 2003, the Hong Kong people are self-motivated and self-empowered to adopt prevention measures, including face masks, social distancing and personal hygiene. The civic synergy between the people, non-governmental organisations and the community forms a community health awareness model that mitigates risks of infection and protects residents, frontline workers, the community and the healthcare system. This compassionate and altruistic approach sheds light on the significance of humanity in coping with public health threats and attaining health equity amongst cultural diversity and social class variations. However, burnout is a potential peril in the case of long-term anti-pandemic efforts.

1. Challenges and Responses

Despite the fact that Hong Kong has had a comparatively low number of COVID-19 infections (totalling 1085 cases as of May 31, 2020 (Centre for Health Protection 2020, May 31)), including four deaths (but no healthcare workers), zero cases in elderly residential care homes and only one possible duty-induced case among healthcare practitioners because of the containment strategy Hong Kong imposed (Wong, Kwok et al. 2020), the news has unveiled an unopened report submitted by the Chief Executive to the Beijing government revealing that she utilised this crisis to earn political gains (Chung and Ng 2020, March 3). A survey conducted by a domestic university in March indicated that 60.5% of the respondents were dissatisfied with the government’s
performance in monitoring the epidemic and 71.5% felt that insufficient measures had been taken to deal with it (Hong Kong Institute of Asia-Pacific Studies of The Chinese University of Hong Kong 2020, March 31). Similar findings were analysed in a cross-country project showing public complaints against its poor handling (Blackbox Research and Toluna 2020, May 6). These studies hint at how Hong Kong citizens are alert to tackle such hazardous public health scenarios when this “failed” (Marques 2020, February 9) government is seemingly so dysfunctional.

**Border controls**

Rumours about the prevalence of an unknown pneumonia in Wuhan flooded the community towards the end of 2019, in addition to a virologist’s alarm after his visit there that the spread of this mysterious illness would be far more catastrophic than that of SARS (severe acute respiratory syndrome) in 2003 (Liu 2020, January 23, Fifield and Sun 2020, January 24). Eventually the Hong Kong government officially warned the public that a few viral pneumonia cases had been reported there (Zuo, Cheng et al. 2019, December 31). Suspected pneumonia patients who had visited Wuhan in the preceding 14 days were confirmed with rapid increases beginning in early January 2020. With possible person-to-person transmission (Chan, Yuan et al. 2020), strong demands to ban non-residents from Wuhan received zero government reaction until January 25, when they suspended Hong Kong-Wuhan air flights and high speed railway, and disallowed non-residents from Hubei province. Nevertheless, these measures did not suffice to protect the community; there was a dire need for strict border control, particularly against travellers coming from the mainland.

Veterans of the medical field ceaselessly requested an immediate entire border shutdown and more restrictions to thwart a large scale coronavirus outbreak imported from the mainland (Parry 2020, Radio Television Hong Kong 2020, January 25). More than 77% of the public supported this request (Hong Kong Public Opinion Research Institute 2020, January 31). Having received no positive feedback from the government, more than 60 nurses in public hospitals took sick leave in late January to voice their worries (Chan 2020, January 28). Subsequently, over 2400 healthcare workers in public hospitals underwent a 5-day strike from February 3 (Lau 2020, February 3) to urge a complete border closure for the purpose of fending off virus sources. Their urgent demand chiefly aimed at avoiding a collapse of the domestic healthcare system due to an uncontrollably high infection rate transpiring within a short period, particularly with severely insufficient medical facilities such as isolation wards, intensive care units, ventilators, personal protection equipment, and even surgical masks. Although more than 61% of citizens agreed with this industrial action (Hong Kong Public Opinion Research Institute 2020, January 31), strike participants will probably be penalised afterwards (Wong 2020, February 27). Numerous professional associations, political parties and labour unions kept up such calls to safeguard public health. Disappointingly, the government insisted upon continuing to operate three immigration checkpoints, including an international airport, since closing the border would likely send a negative political signal that might embarrass Beijing authority (Yeung 2020, February 16).

**Social distancing**

Medical specialists recommended social distancing to prohibit virus transmission (Hong Kong Government 2020, February 11). School classes were suspended twice after the 2-week Chinese New Year school holiday in late January (Chan 2020, February 25), including in private education centres, tutoring centres and playgroups (Zhang
They resumed conditionally and step-by-step from May 27 (Radio Television Hong Kong 2020, May 5), including for cross-border pupils travelling daily between Hong Kong and the mainland (Cheung and Ho-him 2020, May 21). Moreover, a public examination for university entrance was postponed twice until late April (Chan 2020, April 15).

Civil servants set an example for working from home; only necessary emergency services were offered (Hong Kong Government 2020, March 22, Li January 28, 2020). Public facilities were temporarily closed, especially cultural and recreational facilities such as museums, libraries, sports stadiums and performance theatres (Hong Kong Government 2020, January 28). Numerous private companies followed this arrangement for 1-2 weeks (ejinsight 2020, January 29).

No policies were initially enforced but many people minimised unnecessary social gatherings. However, infected groups, including a hot pot family (AFP 2020, February 9), a monastery (Lum 2020, March 11), bar musicians (Wong 2020, March 23) and a karaoke cluster (Radio Television Hong Kong 2020, March 31), were increasing. Relevant regulations were imposed beginning in late March or earlier April. Restaurants were restricted to half capacity, and 1.5m of separation was kept between tables (Hong Kong Government 2020, March 27). Fitness clubs, cinemas, karaoke centres, mah-jong parlours, nightclubs, bars, places selling liquors, beauty salons and massage parlours were provisional closed (Hong Kong Government 2020, April 2, Low, Zhang et al. 2020, April 8, Chan and Ting 2020, March 28). They reopened with suitable control measures in early May to ensure social distancing implementation (Shackleton 2020, May 2, Cheng, Lau et al. 2020, May 5).

A four-person limit regulation in public areas and restaurants started in late March (Leung and Chung 2020, March 28), and then was eased to eight people in mid-April (Cheng 2020, May 3). However, in spite of intermittent confirmed cases, such a restriction to personal gatherings is inconsistent and makes no sense (Radio Television Hong Kong 2020, May 20). This restriction was not applied to many indoor premises (for instance, to religious worship halls, classrooms or transportation), but strictly to outdoor gatherings or events in order to prohibit social movement following June 2019 (Farry 2020, May 11). This decision has been accused of addressing a political need rather than a health concern (Hui 2020, April 1, Cheng, Ting et al. 2020, May 19, Grundy 2020, May 26).

Social distancing generates negative correlations with the spread of infectious diseases but positive correlations with emotional disorders (De Vos 2020), comprising anxiety, boredom, loneliness and depressive moods (Venkatesh and Edirappuli 2020). Employing innovative methods through online and offline channels, Hong Kong mental health clinicians tackled the problem of regular mental health service interruptions (Tse May 10, 2020). The bureaucracy seemed to take little notice of this issue, whereas mental health would become a challenge during the economic difficulties post-COVID-19.

Quarantine

Beginning from February 8, a mandatory 14-day quarantine was imposed on anyone who came from the mainland: home-quarantine for residents, and hotels or government-run camps for non-residents (Colquhoun and Smail 2020, February 17). This was extended to those from South Korea in late February (Radio Television Hong Kong 2020, February 24), and from overseas in mid-March (Ho 2020, March 16). It also applied to close contacts of confirmed cases. Those who violated the home quarantine order would be sued and sent to government-run quarantine
centres (Cheung and Lum 2020, March 21).

However, many people have complained of the defects in exercising quarantine. There was no monitoring system for those in quarantine. Individuals living with quarantined people still freely left their households (Abate, Tran et al. March 27, 2020). A digital wristband linked to a smart phone application for home-stay quarantine that was implemented beginning in mid-February (Radio Television Hong Kong 2020, February 18) was often faulty in various situations (Kwan 2020, March 24). Without proper protective gear and training, hotel staff worried about occupational safety (Radio Television Hong Kong 2020, April 3) when hotels were used for quarantine. Additionally, government-run quarantine centres caused concerns when placed on locations nearby residential areas (Siu and Chan 2020, February 16), resulting in demonstrations and protests. They were no medical facilities, but individuals were instructed to take body thermometer twice a day and to self report if their body temperature was over 37°C (Davidson 2020, March 26). Such relaxed management fell apart, decreasing the effectiveness of quarantine (Mulholland 2020, April 9).

Surveillance

Starting with the last day of December 2019, thermal imaging systems at all boundary control points were employed to check body temperatures and conduct health surveillance. Self-reported health declarations started in late January 2020 (Centre for Health Protection 2020, January 20) for airport arrivals from Wuhan, excluding passengers on the high speed railway (Radio Television Hong Kong 2020, January 20). Strong criticism was voiced concerning this inconsistent, loose and unreliable self-reported health declaration.

Two measures were added in February. First, electronic systems were linked up between the Hospital Authority and the Immigration Department (Cheng 2020, February 7) and successfully monitored the travel history of suspected patients who denied having come from restricted areas over the preceding 14 days. Second, a major incident investigation and disaster support system (MIIDSS) was utilised to chase sources of infection and people who came into close contacts with confirmed cases (Centre for Health Protection 2020, February 22). Notwithstanding, they would have been more effective against the epidemic if they could have been used in January.

**Screening and testing**

Saliva testing is effective in preventing community transmission (To, Tsang et al. 2020). Patients with fever and respiratory symptoms underwent a deep throat saliva test through a take-home kit beginning in mid-February (Radio Television Hong Kong 2020, February 18). However, invisible patients who show no respiratory symptoms is a feature of COVID-19 (Guan, Ni et al. 2020); therefore it was inappropriate to exclude them in testing. From mid-March, saliva tests were extended to senior air inbound travellers aged 65 or above and those who lived with them (Radio Television Hong Kong 2020, March 19) and then to all arrivals at the airport from early April (Radio Television Hong Kong 2020, April 7). Collection spots for test kits involved public hospitals, public primary care clinics and private clinics, but responses from private sectors were inactive (Ting 2020, March 9).

**Communication with the general public**

Communication is critical during a pandemic, not only for a better understanding of the disease but also to reduce anxiety and fears, resulting in lowering community transmission (Yeoh 2020, February 29). Two multiple lingual websites (particularly targeting languages spoken by Southeast Asians) supply diverse information mainly from the Centre for Health Promotion.

A list of buildings housing quarantined people was circulated on social media in late February, which had the potential to create confusion and panic among the public. In response to this, the Department of Health announced an official list one day later and updated it periodically (Ting 2020, February 28).

Daily press conferences (Cantonese-English bilingual plus sign language) have been arranged to brief the public on new confirmed and probable cases and relevant news. Transparency tends to lessen public anxiety.

**Wearing face masks**

Internal conflicts arose: while the Department of Health has encouraged the public to wear masks to prevent pneumonia since last December through its website, many officials (for example, the Chief Secretary for Administration and the Secretary for Food and Health) did not wear masks, and the Director of Health discouraged wearing them unless symptoms existed (Leung and Lum 2020, January 24). This was possibly related to an ongoing appeal over the anti-mask law that was implemented last October under the emergency laws against social unrest (Radio Television Hong Kong October 4, 2019). Worse, a harsh order from the Chief Executive did not permit government officials to wear masks unless necessary, to reserve supplies for medical staff (Chung 2020, February 4), which provoked resistance from civil servants (The Standard 2020, February 5). The Hospital Authority promptly responded that all medical supplies are purchased through its own administration and budget.

In contrast, owing to the painful experience of the outbreak of SARS in 2003, the Hong Kong people understand the effectiveness of wearing face masks to combat infectious diseases (Cowling, Ali et al. 2010), which has been supported by recent investigations (Cheng, Lam et al. 2020, Cheng, Wong et al. 2020, Esposito, Principi et al. 2020, Howard, Huang et al. 2020). In order to protect themselves, their families, healthcare practitioners, the community and the public health system, most Hong Kong citizens consciously put on masks in public areas. Confusion among government officials increases panic buying due to distrust of the government, and hence the price soared sharply in the first quarter because of a mask shortage (Miller 2020, February 3, Hunter and Choong Wilkins 2020, January 24). People demanded that the government stabilised the mask supply and prices. Again, rejections were imposed (Hong Kong Government 2020, February 10). District councillors, non-governmental organisations, charitable entities, and mutual help groups sourced masks from all over the world to alleviate the panic, especially for the poor and underprivileged who could not afford masks: it would seem the government reluctantly offered necessary administrative and financial assistance (Wong 2020, March 1). Simultaneously, people in the private and public medical fields cried out for masks in order to continue their services safely, and the government failed to do so.

Medical experts predicted that mask use would be needed over a longer period of time until a vaccine becomes available (Radio Television Hong Kong 2020, May 17). A free washable mask, claiming award-winning technology, was given away to residents from mid-May (Zhang 2020, May 6). Interestingly, its practicality is dubious (Parry 2020, Radio Television Hong Kong 2020, May 8), and it has been advised not to use it in certain circumstances.
(GM37 2020, May 8) because of its structural design and material (Dimsum Daily 2020, May 11). Indeed, the private sectors and social enterprises have already been successfully sourcing masks (Cheng 2020, February 24) or manufacturing local products (Wong 2020, February 21, Yiu 2020, February 21) to fulfil community needs in late February.

**Neglecting the homeless**

There are 7.5 million people in Hong Kong (Census and Statistics Department 2020, February 18) living in 1106.66 square kilometres (GovHK 2020). This high density pushes rocketing housing rates; thus, subdivided flats, cubicles, cage units and homelessness continuously increase, even producing a group known as McRefugees (those who stay overnight in 24-hour McDonald’s restaurants) (Hincks 2018, August 23). Homeless people have no access to protective equipment, and have received support from charity bodies rather than the government (Lai 2020, April 14). Unfortunately, McDonald’s suspended dine-in services from 6pm to 4am on March 25 for two weeks (Radio Television Hong Kong March 26, 2020) to minimise coronavirus transmission, causing homeless McRefugees to wander around seeking shelters (Low and Chan 2020, March 25). Non-governmental bodies asked relevant departments (for example, the Home Affairs Department) to open community halls and re-open public showering facilities, but these requests were refused (Sunday Examiner 2020, April 3). They then found temporary shelters for a rising number of homeless when unemployment began to grow during the pandemic (Westbrook 2020, April 5).

**Special arrangement for hospitals and care homes**

The Hospital Authority announced no patient visits from January 26 (Hong Kong Government 2020, January 25) while the Social Welfare Department issued special guidelines and offered financial assistance to care homes (Wong, Lum et al. 2020, April 27). Management of care homes promptly suspended visitations, decreased social and volunteer activities, and enforced mandatory leaves for staff who had travelled abroad within 14 days, along with strengthening defensive tactics such as face masks and frequent cleaning (Chen 2020, May 9). The capability and professionalism of frontline service providers contributed to the prevention of spread within care homes (Fallon, Dukelow et al. 2020), resulting in protecting not only the vulnerable but equally important medical resources (Chor 2020, May 27).

Notably, this pandemic affects mental health both directly and indirectly (Holmes, O’Connor et al. 2020), especially for hospitalised patients and residents of care homes, together with their family members or caregivers because of isolation from each other (Vahia, Blazer et al. 2020). In order to deal with such frustration, technology for social contacts was used (Lum, Shi et al. 2020) which complied with the SARS review report (sections 14.9 and 18.29) (SARS Expert Committee 2003), but this could not replace face-to-face visits and personal touch. For instance, patients with terminal illnesses and their families strongly requested ward visits from a humanity perspective through which they could access the “ultimate companionship” (Cheng 2017) they deserved. The Hospital Authority may consider requests on an individual basis.

2. **Civic Synergy**

Being a busy international transportation hub, Hong Kong has directly adjacent borders to the mainland, coupled with a highly dense population and a crowded living space. These result in high risks for COVID-19 transmission. Unlike neighbouring countries or territories, in which trust has been achieved between patients, healthcare workers
and the community as a whole along with the government (Legido-Quigley, Asgari et al. 2020), this synergy is separate from government in Hong Kong. Approximately 72% of research respondents admitted that community vigilance and effort is necessary to avoid a large scale spread of pandemic (Cheung and Wong 2020, April 1). When political considerations over public health seem to be hiding ulterior agenda, the Hong Kong people are self-motivated, self-empowered and cautious of health concerns. When an arrogant government habitually ignores public opinion and even experts’ advice, Hong Kong people help one another curb pandemic outbreaks (Kammerer 2020, February 25). For instance, free sanitising services for poor residents have been continually provided by volunteers (Tufekci 2020, May 12). In a survey taken in May 19-21, 2020, the approval ratings for the Chief Executive reached only 28.3 out of 100 marks (Hong Kong Public Opinion Research Institute 2020), and the net satisfaction value of the government and net trust value reached -48.8% and -35.7% respectively (Hong Kong Public Opinion Research Institute 2020). Also, the net satisfaction value for the Secretary for Food and Health was -5.1% (a survey taken in May 4-6, 2020) (Hong Kong Public Opinion Research Institute 2020). Such low-rated, incompetent authority lacks self-reflection and a mindset of serving the Hong Kong people, and is consistently blamed for doing too little, too late during this health crisis (Cheung, Sum et al. 2020, January 29). In two relief packages totalling US$36.9 billion (Cheng, Cheung et al. 2020, April 8), spending on medical expenses amounted to only US$2.1 billion (HK$16.4 billion) (Tsang 2020, February 20). In particular, with official foreign currency reserve assets amounting to US$437.5 billion at the end of March (Hong Kong Monetary Authority 2020, April 7) with no debts, the government could have gotten more extensively involved in public health expenditure in such a global health crisis. In spite of these unfavourable conditions, Hong Kong has had no city lockdown during the pandemic, owing to decisive community leadership which should not be

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**Common Health Awareness Model**

- **Individual factors:**
  - Self-motivation and self-empowerment
  - Compassion and altruism

- **Society advantages and resources:**
  - Mutual support
  - Civic synergy between citizens, NGOs and the community
  - Transparent public communication
  - Professional healthcare practitioners

- **Environmental disadvantages:**
  - Directly adjacent borders with China
  - High population density
  - Poor living conditions

- **Institutional threats:**
  - Confused, inconsistent health policies and loopholes
  - Distrust, incompetent leadership

- **Anti-pandemic outcomes**

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**Figure 1.** Community Health Awareness Model
undermined. About 80% and 33% of the population aged 15 and over having attended secondary and post-secondary education correspondingly (Census and Statistics Department 2016). High education levels tend to lead to a mentality of self aid and mutual help among the Hong Kong people, especially when they cannot rely on the government (Barron 2020, March 13), resulting in a mature civic society in which citizens recognise that they have a stake in their own community. Volunteers and non-profit, non-governmental organisations have become key players in overcoming the threats of pandemic. Frontline health practitioners in different levels and with various accountabilities have exerted professional efforts which have not only exhibited their professionalism but have also gained public respect. Having experienced the SARS tragedy, Hong Kong people pay more attention to personal hygiene and recommendations from medical specialists. Furthermore, as a global business centre, Hong Kong fighting this health calamity professionals retain international connections that benefit through the acquisition of assistance from diverse regions in

In a nutshell, the Hong Kong people are proactive and highly sensitive to their own health environment. They have compassionate and altruistic awareness to take care of people and the healthcare system as well. Such engagement creates a civic synergy between people, non-governmental organisations and the community, forming a community health awareness model (Figure 1) that mitigates risks of infection. This approach reveals the significance of humanity itself in coping with public health threats and attaining health equity within a context of cultural diversity and social class variations. Alarmingly, people may feel exhausted exercising such preventive practices to fight this disease for nearly half a year, the effects of which will predictably continue for a longer period of time. Burnout from prolonged anti-pandemic efforts may become a foreseeable challenge for keeping this model in good shape.

Conflicts of Interest

There is no conflict of interests.

Source of funding support

Preparation of this article did not receive any funding.

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