Journal of Exclusion Studies
Vol. 11, No. 2, August 2021, 165-186
DOI: 10.5958/2231-4555.2021.00012.7

Research Article

Self-Reliance in Fighting Policy Loopholes during COVID-19 in Hong Kong

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Date of Submission: 04/04/2021; Date of Acceptance: 03/08/2021

ABSTRACT

Waves of COVID-19 introduced through imported cases have impeded Hong Kong in the areas of public health, the economy, and individual physical and emotional wellness, livelihood and social life. Increased public health awareness has encouraged the Hong Kong people to prevent transmission through basic methods such as wearing face masks, personal hygiene, social distancing and environmental hygiene. Although reactive, piece-meal measures were implemented (for example, limited border control, screening, surveillance and quarantines), policy loopholes fuelled these outbreaks, showing not only the government to be dysfunctional but also penalising self-disciplined Hong Kong people, actually victims in this plight, due to the loose administration, in the sense of daily life, livelihood and civic rights. The antipathy between the public and the government increased the tension between the powerless and the powerful, driving the Hong Kong people towards greater self-reliance, showing their effectiveness, efficiency, flexibility and adaptability in combating this pandemic crisis. Although intertwining of self-protection and mutuality is cogent in this public health predicament due to distrust of the present failed leadership, anti-pandemic burnout has become a critical challenge and also threatens this self-reliant approach.

Keywords: COVID-19, Novel coronavirus, Pandemic, Public awareness, Public health policy

Policy Loophole-Incurred Outbreaks

COVID-19 has been threatening Hong Kong since January 2020 and eventually became a pandemic in March. Hong Kong has endured three waves brought about through imported carriers (To *et al.*, 2020) and owing to policy loopholes. Nevertheless, public health awareness has enabled the community to alleviate the spread of this disease effectively and therefore the infection numbers are comparatively low. This outcome benefits from lessons learnt from the sorrowful experiences of severe acute respiratory syndrome (SARS) in 2003: the Hong Kong people have self-consciously adopted preventive means for pneumonia and respiratory tract infection, including wearing face masks in public, reducing social activities, washing their hands frequently, and practising environmental hygiene.

The first confirmed case of novel coronavirus in Hong Kong was reported on January 23, in which the patient returned from Wuhan, China. Public alertness resulted in the panic buying of face masks (Miller, 2020): on contrary, the Chief Executive, the head of the Hong Kong government in this special administrative region of China, did not allow officials to wear masks unless they showed symptoms (Chung, 2020a). More urgently, medical professionals asked the government to temporarily close the border for a few weeks, implementing stricter control measures to curb transmission (Parry, 2020b). The government refused, which brought a 5-day strike (February 3-7) initiated by frontline workers in public hospitals (including nurses, doctors, therapists, and clerical staff) to pressure the government into action (Parry, 2020a), causing the suspension of more checkpoints: albeit three checkpoints were still retained. Daily one-digit growth resulted in 158 cases before March 16 (Hong Kong Government, 2020c).

Induced by arrivals from foreign countries starting mid-March (Barrett, 2020), particularly overseas students returning from Europe and the USA and returnees from outbound tours, two-digit case increases began on March 17 (Hong Kong Government, 2020d) and accelerated fast into the second wave, resulting in 1085 cases by May 31 (Centre for Health Protection, Department of Health, 2020). Thus, stricter measures began, including working from home for civil servants, school suspensions, four-person gathering limits, half capacity limits in restaurants, and provisional closures of fitness centres, bars and public recreation facilities. This was in addition to tighter controls in immigration checkpoints. However, loose follow-up yielded a rapid increase in COVID-19 infections; such as the failure to use digital waistbands for home-stay quarantines (Kwan, 2020) and the lax monitoring of quarantine camps (Davidson, 2020).

After having no local cases for a few weeks, a sudden sharp rise in infections on July 5 (Riordan and Liu, 2020) initiated the third outburst caused by delays in delivering

testing results, cross-transmission in hotels and leaky quarantine arrangements (Cheng, 2020): the quarantined took public transportation to hotels, quarantined and non-quarantined lived in the same hotels, and friends and families of the quarantined were allowed visits (Radio Television Hong Kong, 2020).

This wave attacked older adults and the first case to occur in a nursing home for the elderly, on July 7 (Wong *et al.*, 2020), directly endangered this vulnerable group. Indeed, the Social Welfare Department issued special guidelines and provided financial assistance to long-term care centres in January, together with implementing immediate responses such as the suspension of visits and volunteer activities, and the requiring of face masks, and compulsory leave for staff who had travelled abroad within 14 days. These practices protected elderly residents from being easily infected during their daily lives; for example, feeding, changing diapers, showering, and any activities carried out by close contacts. Although these measures continued, safety deteriorated: the first death of a nursing home resident on July 13 was that of a 95 year old female. The overall fatality list had grown to 108 deceased out of 5390 confirmed cases (2%) as of November 10 (ASEAN Briefing, 2020), among which 99 deaths were over 65 years old (91.67%), including 30 care home residents (27.78%).

More policy defects instigated the third wave. Home quarantine for 14 days was imposed on returnees who were not restricted from going out, which worsened the domestic spread. Shockingly, an unannounced policy allowed 33 categories of incoming people to be exempt from quarantine, including drivers for goods vehicles, seafarers, aircrew, and executives of companies listed on the stock exchange (Hong Kong Government, 2020g); more than 250000 arrivals occurred between February and June through this slack policy (Mahtani, 2020). Although the government emphasised that those arrivals were subject to testing and required medical surveillance for 14 days, many of this group did not comply with the requirements; for instance, going out while waiting for testing results.

Initially, the government denied the relationship of the third wave to this exemption. News unveiled the fact that those who were in logistics, port and/or shipping business in the Mainland were permitted free entry starting in late May (Grinter, 2020) and cabin crew and sailors were then included in early July (Cheung and Ting, 2020). Unfortunately, nine sea crew members who stayed in Hong Kong for one to three days tested positive for COVID-19 in early July (Xu, 2020), and laboratory evidence testified to the link between Philippine sailors and flight crews from Kazakhstan and this wave (Pao, 2020a). In addition, data from a computerised model ascertained that the exemptions given to individual infected people was behind the latest outbreak (Yuan and Blakemo, 2020). Exemption for crews then stopped in late July (Gao, 2020), but infections had spread

within the community. Virologists kept on finding pathogen strains which probably came from Nepal in September and October due to there being no designated hotels for quarantine (Ting, 2020). They suggested prohibiting this loophole immediately.

A recent case regarded a patient who fell into the quarantine exempted groups and came from China in early October (Ting and Choy, 2020), because of whom 11 close contacts were sent to government-run quarantine camps. Additionally, a suspected sex worker showed positive signs of COVID-19 in late October when awaiting deportation due to illegal entry from the Mainland (Wong, 2020e), which left difficulties in tracking her clients during her incubation period. These exemptions ruined the containment efforts related to this pandemic crisis (Ho, 2020a) and led to an expansion from 1206 (Hong Kong Government, 2020f) to 5088 (Hong Kong Government, 2020h) cases in three months (July-September). Notwithstanding, the government announced the release from compulsory 14-day quarantine for residents coming back from Guangdong Province/ Macau who could show negative testing certifications from mid-November (Wong, 2020f), coupled with a travel bubble from Singapore (Lee *et al.*, 2020). These new arrangements reflected pressure from the retail and tourist industries, which had dropped 30% (Leung, 2020b) and 92.4% respectively (Lofton, 2020).

Fatalities stayed low until the third wave. Only four deaths happened in the first six months (Tufekci, 2020) during which time the first death was 39 year old on February 4, there were no healthcare workers, zero cases in elderly residential care homes, which were serving more than 33.5 thousand residents (Mitchell, 2020), and only one possible duty-related case among healthcare personnel. The mortality rate remained at 0.36% until June 20, and rocketed during the third wave from early July, reaching 2% as of November 10, mainly in the senior group as detailed earlier. This tragedy, which was able to be avoided, was caused by policy loopholes.

Powerful-Powerless Tension

Loopholes not only expanded outbreaks but also deteriorated the trust between the public and the government. On one hand, the government called for "Together, we fight the virus!" (Hong Kong Government, 2020a), while on another hand, the Hong Kong people perceived that they were being suppressed by various sectors of authority, resulting in a strong tension between the powerful and the powerless. Three examples serve to illuminate this tension and show how the public has resisted: mass testing, the healthcare strike, and limits on people gathering.

Large-Scale Testing

In order to break unknown chains of transmission, the Universal Community Testing Programme on a voluntary basis was offered to residents free of charge to detect

asymptomatic transmitters from September 1-7. It was extended from September 8-11, and again from 12-14. Participation frequency involved 1.78 million (some people repeated testing), pertaining to 24% of the whole local population, from which a mere 38 new cases were discovered (Sham and Yee, 2020). In addition to the diagnostic reagents sponsored by the Chinese government, US$64.5 were spent for testing centres, facilities and wages (Li, 2020). Such a low participation rate reflected high reluctance, even though the government made great efforts to promote this Mainland-backed project in the name of civil responsibility.

In fact, the peak of the third wave was apparently slipping. Less than 30 cases were reported daily from August 19 and less than 20 daily since August 28. People feel that the programme has been to no avail. Furthermore, medical experts wonder how effective mass testing would be to combat this pandemic because this "scattergun approach" (Mahtani and Kilpatrick, 2020) has little warranty of detecting hidden carriers: rather, strict quarantine implementation plus various measures (for instance, face masks, personal hygiene, and social distancing) should be the first line of control, as with the Taiwanese mode (Taiwan Centres for Disease Control, 2020). Research data support this idea (Leffler and Zhan, 2020).

A 60-member clinical team arrived from the Mainland in early August to prepare for this city-wide scheme (Li, 2020), and subsequently over 400 laboratory technicians came to help this project. However, they did not have licences to work in Hong Kong and their qualifications were ambiguous. Moreover, three China-associated firms were chosen, which did not comply with the tendering system for public work, among which one had been accused of patent infringement (Si and Cheng, 2020) and one had no experience in medical testing and no domestic healthcare offices. Critics complained not only of the reliability of their test kits and professional performance but also about the location of screening centres and testing sites close to residential areas without consulting relevant parties (Cheng, 2020). Alarmingly, the security of the collected biometric data was in major doubt (Wong, 2020c). Although the government guaranteed that no data would be shared with the Mainland authorities, the Hong Kong people worried about leaking privacy and data would assist in establishing a mandatory health code system to tighten state control (Chan, 2020), as with the social credit system in China.

From a healthcare perspective, the programme should target on the most vulnerable populations, particularly the older adult group. Like with other respiratory illnesses, the elderly suffer from higher fatality risks with COVID-19 and/or comorbid diseases (Martínez-Sellés *et al.*, 2020; Özkeskin *et al.*, 2020; Perrotta *et al.*, 2020). The evidence testifies that residents in nursing care centres were infected, resulting in deaths falling

mainly in the elderly cluster in the third wave. Nevertheless, the Secretary for Labour and Welfare affirmed no plans for mass testing for senior residents in these homes (Apple Daily, 2020a), while the Secretary was unable to satisfactorily explicate the reasons for their exclusion from the purpose of "early identification, early isolation and early treatment" (Hong Kong Government, 2020b). The programme was seemingly anchored to a hidden agenda, rather than to community wellness or to the older adults in long-term care centres.

Humiliating Frontline Healthcare Workers

The government rejected a strong demand for a full border shutdown to prohibit non-residents coming from the Mainland for the sake of fending off an outbreak, which provoked a strike by healthcare personnel in public hospitals in early February, as previously depicted. Indeed, more than 77% of Hong Kong people supported a complete border closure (Hong Kong Public Opinion Research Institute, 2020a), and over 61% of the public bolstered this industrial action (Hong Kong Public Opinion Research Institute, 2020b), whilst having limited medical resources and worrying about the collapse of the healthcare system. In stark contrast, the Hospital Authority chairman warned of a disallowance of political ideas in the workplace, but the Chief Executive deemed the strike to be an employer-employee conflict and refused to meet strike representatives to discuss the border issue. Such indifferent responses triggered public resentment. Meanwhile, the strike participants received a warning email in early February from the Human Resources Department of the Hospital Authority stating that the management reserved its right against this action (Wong, 2020a). The Authority sent a letter to participants in October to request them to explain their absence from work, even though the union representatives insisted in a legal industrial action but not absenteeism. A message disclosed that every team member in the Department of Radiology received the letter, disregarding whether or not they actually took part in the strike, even a new member who had joined the team in July, whilst the department head refused to submit a name list of strike participants (Ho, 2020d).

In fighting the pandemic, apart from an institutional shortage of medical professionals (Schoeb, 2016), healthcare personnel had been extremely busy taking care of patients with COVID-19 and/or other illnesses. Job satisfaction among healthcare workers is positively correlated to service quality (Janicijevic *et al.*, 2013). The management and relevant authorities should support them substantially; instead, they attempt to intimidate professionals, greatly increase their psychological burden, attack workplace morale and erode professional performance; which raises the question as to whether the authorities consider community well-being to be their first priority.

Limited in-Person Gathering Regulations

There is no city lockdown in Hong Kong. However, control measures directed at residents began in the second wave which affected daily life and livelihoods, including a ban on four-person gatherings in public places and restaurants from March 29 (Hong Kong Government, 2020e). This limitation varied from time to time: eight persons from May 8 (Creery and Wong, 2020), 50 persons from June 19 (Leigh *et al.*, 2020), two persons from July 29 (Wong and Grundy, 2020), and back to four persons from September 11 (Creery and Wong, 2020). The Chief Executive admitted that the third wave had stabilised, and therefore would adjust social distancing rules (Wang, 2020). Interestingly, dine-in service extended from a four to six-person limitation from late October (Kwan, 2020b), while 30-person groups were permitted for local tours and 50 people for wedding ceremonies, but four-person gathering limits in public areas remained (Wong, 2020d). The government was unable to provide scientific data to support its gathering restrictions and give convincing rationale for why more people could be tolerated in close areas than open areas. An infuriating order forbade daytime dine-in service in late July, forcing workers to eat out of lunchboxes on the roadsides (Ho, 2020c). Strong complaints compelled them to revise this reckless rule immediately. Stern criticism recurred against these contradictory, stringent and apathetic arrays.

The public expressed their suspicions that these social distancing rules aimed to impede anti-government activities brought forward from the social movement against the Extradition Bill in 2019 (Huang, 2020; Hui, 2020). The rules were easily used by police as legal means (for instance, fines) to quell protests or demonstrations (HKFP LENS, 2020). The government and the police forbade a march applied for by reporters to support an award-winning journalist who was arrested and prosecuted in early November (Apple Daily, 2020b). However, this ban fuelled the anger of the Hong Kong people, which would produce political instability and obstruct economic recovery (Huang, 2020).

More arguably, with the excuse of public health and the help of the Emergency Regulations Ordinance, the Chief Executive decided to postpone the election of legislative councillors for not less than one year, which originally was to be held in early September this year (Chan and Yan, 2020). This decision did not consult medical experts in advance (Barron, 2020). Many countries – developed, developing and under-developed – including Britain, Burundi, Croatia, Dominica Republic, Ethiopia, France, Iceland, Ireland, Israel, Italy, Mongolia, Poland, Serbia, Singapore, South Korea, the Solomon Islands, and the USA had successfully carried out elections during the pandemic (Ho, 2020b; Wong, 2020b). In fact, over 610000 voters (13.8% of registered voters) took part in an unofficial election for pan-democratic primaries in July (Chung, 2020b), even though the participants were warned that they could possibly violate social distancing regulations

and the new National Security Law (Lung and Iain, 2020), even though no evidence had reported a relationship between this para-election and infections on July 11 and 12. Freezing civil rights, such as marches and elections, using the pandemic as an excuse, is not a legitimate means of dealing with political disputes.

Self-Reliance Strategy

Among 7.5 million people (Census and Statistics Department, 2020), there have been only 5390 cases as of November 10, which can be attributed to a high level of public health awareness and self-disciplined residents. Predictably, medical adepts alerted the public to a potential fourth wave in the coming winter, which could be an exponential growth of local transmission (Pao, 2020b). Minimising future harm becomes a priority, which requires reliable leadership. Noticeably, a trust problem has challenged local leadership (Barrett and Mcgregor, 2020; Soo, 2020). The latest surveys in October unveiled results showing that 61.3% of Hong Kong people distrust the government (Hong Kong Public Opinion Research Institute, 2020d) and 68.6% have declared their dissatisfaction with the government (Hong Kong Public Opinion Research Institute, 2020c). Meanwhile, the public support rate for the Chief Executive only reached 30.8% in early November (Hong Kong Public Opinion Research Institute, 2020e) and 38.3% agreed that the Secretary for Food and Health should be dismissed (Hong Kong Public Opinion Research Institute, 2020f). Thus, "passive resistance" (Taylor, 2020), for example, against a large-scale testing programme, reflects such dissatisfaction.

Prior to a vaccine becoming available, veterans in the medical field advocate blocking policy loopholes, including testing for high risk groups, intense surveillance, and more importantly, tight border controls (Leung, 2020a). However, the government has always been blamed for placing political considerations over health policies. A competent government should attempt to achieve a balance of social, economic and public health (physical and psychological) concerns (Paes-Sousa *et al.*, 2020).

Although the Hong Kong people are dealing with COVID-19 through their own efforts, with the combined economic loss and a rising unemployment rate put continual pressure on their mental health and evoke emotional problems (Hsu *et al.*, 2020), including sleep disorders (Tony *et al.*, 2020), higher levels of stress and anxiety, particularly for the older and underprivileged population (Zhao *et al.*, 2020), and on hospitalised patients suffering because of the no-visitor policy (Nelson, 2020), which is consistent with other countries/regions (Dong and Bouey, 2020; Ornell *et al.*, 2020; Pfefferbaum and North, 2020; Serafini *et al.*, 2020; Suhail *et al.*, 2020). One study revealed that 43% of respondents suffered from negative impacts on mental health, and 49% felt lonely (Mindhk, 2020). Adverse emotions are devastating to sleep quality (Marelli *et al.*, 2020;

Pinto *et al.*, 2020) and produce sleep difficulties directly or indirectly (Tony *et al.*, 2020). These mental problems together with a long periods of social distancing form "pandemic fatigue" (Sun, 2020); therefore, some people tend to relax their anti-pandemic practices and cannot stop gathering socially; for example, pubs and staycation clusters cause soaring infections (Pao, 2020c). Meanwhile, burnout in the healthcare arena possibly affects service deliverables (Cheung *et al.*, 2020), akin to various disciplines of medical professions in other countries/regions (Burki, 2020; Kannampallil *et al.*, 2020; Sasangohar *et al.*, 2020; Zhang *et al.*, 2020).

This is unlike in Macau, an adjacent special administrative region which also has a direct border with Mainland China, and which has coped with COVID-19 effectively (46 infections without death) (Zuev and Hannam, 2020), with the aid of adopting a top-down approach to closing borders, accepting expert advice and ensuring a sufficient supply of face masks (Ieng and Cheong, 2020; McCartney, 2020). It is also unlike Taiwan, which is currently famous for hitting this pandemic aggressively, and where travellers from the Mainland have been prohibited since February 7 (Lai, 2020), and has benefited from a positive state-civil society synergy (Summers *et al.*, 2020; Yen, 2020). Aside from applying epidemiologically based public health methods such as active case finding, contact tracing, and surveillance and testing to attain "sustainably lower and safer levels" (Bedford *et al.*, 2020, p. 1314) of COVID-19 infection, the Hong Kong people have depended upon self-reliance and have learned the usefulness of foundational methods such as face masks, social distancing, personal sanitation and environmental hygiene (Galvin *et al.*, 2020) to minimise transmission effectively. This bottom-up approach has led to government responses, launching proactive initiatives for public interests gained from their social sensitivity to coronavirus outbreaks (Hartley and Jarvis, 2020). Indeed, the Hong Kong people are combating a complex environment of pandemic, incompetent leadership, policy loopholes, economic decline, and mental health, through which they continuously illustrate a self-reliance model.

Self-protection is the core of such a self-reliance model, which encompasses diverse tactics. First, physical activity improves the body's defence system and immunity, alters the metabolic state, and prevents illnesses (Nieman and Wentz, 2019; Pedersen and Hoffman-Goetz, 2000; Terra *et al.*, 2012). It also ameliorates anti-infective and antioxidant agents, increases energy levels, reduces negative emotions, decreases infection risk, maintains fitness and an active lifestyle (Calder, 2020; Letieri and Furtado, 2020; Rodrýguez *et al.*, 2020) for preventive, curative, and rehabilitative purposes (Kennedy and Sharma, 2020), achieved through regular indoor or outdoor physical exercise. Physical trainers recommend daily practice, preferably 150-300 minutes per week (Fernandez del Valle *et al.*, 2020). Furthermore, green exercise, such as hiking and cycling in parks and green spaces, attain these results as well (Slater *et al.*, 2020).

Although dancing, a physical exercise, also benefits health (Hanna, 1995; Rahim *et al.*, 2016), dancing groups or classes are not recommended due to their higher risks of infection (Jang *et al.*, 2020), as with the celebrity ballroom cluster which burst in November (Apple Daily, 2020c; Cheung and Choy, 2020).

Second, sleep can regulate immunological processes (Besedovsky *et al.*, 2012), lessen infection risk and enhance vaccination responses (Besedovsky *et al.*, 2019). Insufficient sleep affects the immune response against viral, bacterial, and parasitic infections (Ibarra-Coronado *et al.*, 2015). Thus, sleep is essential for coping with COVID-19, while positively affecting physical and mental health due to sharing a neurological basis (Tahmasian *et al.*, 2020). Proper nutrition, vitamin groups and minerals are important for health (Woods *et al.*, 2020), especially for patients with COVID-19 (Brugliera *et al.*, 2020). A healthy and balanced diet is prudent (Aman and Masood, 2020) to prevent obesity during social isolation during the pandemic (Ribeiro *et al.*, 2020). The interaction between sleep, exercise and nutrition formulates a good bodily state (Ghrouz *et al.*, 2019; Pujitha *et al.*, 2019; Rössler, 2016).

Third, sunlight exposure (Füzéki *et al.*, 2020) can activate Vitamin D to enhance the body's immune system (Türsen *et al.*, 2020), because of which experiments vindicate the direct correlation between sunlight exposure and COVID-19 recovery (Asyary and Veruswati, 2020) and the expected use of ultraviolet light in sterilisation (Ratnesar-Shumate *et al.*, 2020). This natural resource is accessible to the underserved population.

Fourth, soothing emotional pressure is necessary for combating the pandemic, for which alternative therapies show encouraging signs for regulating mood, diminishing levels of stress, anxiety and depressive symptoms through art (Martin *et al.*, 2018), gardening (Thompson, 2018), music (Gebhardt and vonGeorgi, 2007), meditation (Cheng, 2016; Yunesian *et al.*, 2008), aromatherapy (Lizarraga-Valderrama, 2020), massage (daSilva Domingos and Braga, 2014) or positive religious coping (Kowalczyk *et al.*, 2020; Pirutinsky *et al.*, 2020). These interventions are suitable during home stays.

Lastly, self-protection does not imply selfishness; rather, it also safeguards family members and friends, radiating throughout the community through mutual help. The supply of face masks illustrates the dynamic of self-reliance and self-protection, which eventually was conducive to the community. Most scientists agree that wearing face masks is effective for preventing and controlling COVID-19 transmission (Peeples, 2020; Wong *et al.*, 2020), but the price of protective items and disinfectants rose too high for poor families to afford (Creery, 2020). When the government was unable to source a sufficient quantity of masks, the duty shifted to society, where social activists and district councillors did the job successfully through their international networks (Dapiran, 2020), distributing or selling them at an affordable price to the public, in

addition to mask donations from individuals (Wong, 2020) from all financial levels (Tsang, 2020). The mask shortage aroused "citizen innovation" (Chandra, 2020), by which a film-maker and entrepreneurs (Block, 2020; Sobti, 2020) started local mask manufacturing factories, and a chemistry teacher produced reusable fabric masks. Likewise, a beautician made homemade hand sanitisers to give to low-income populations freely, and charitable organisations raised food donations (Kwan, 2020a). The mutual assistance exhibited a strong and spontaneous community and social mobilisation within a robust civil society (Wan *et al.*, 2020).

CONCLUSION

The challenges presented by COVID-19 have exposed the incapabilities of the Hong Kong government, whose reactive policies are unceasingly blamed for being too little too late, eventually at the expense of self-disciplined Hong Kong people's wellness, daily lives, livelihoods and civic rights. Absurdly, even though the citizens are the victims, they are being penalised, because of policy negligence (such as limited border closure, and slack monitoring and quarantine management), in a series of piece-meal measures such as limits on gathering, closing bars and leisure spots, and school suspensions. The Hong Kong people have manifested self-discipline, autonomy, altruism and resilience by using basic means (for instance, wearing face masks, personal and environmental hygiene, and a decrease in social activities) in fighting policy loopholes brought about by such distrustful leadership during the pandemic, showing their effectiveness, efficiency, flexibility and adaptability. Nevertheless, nearly one-year of social distancing has yielded anti-pandemic burnout that will imperil this public health and weaken this self-reliance approach which is coupled with self-protection and mutual assistance.

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How to cite this article: Cheng, F.K. (2021) 'Self-Reliance in Fighting Policy Loopholes during COVID-19 in Hong Kong', *Journal of Exclusion Studies,* Vol. 11, No. 2, pp. 165-186.