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Opinion

East Meets West: Overcoming Barriers to Compliance with Mitigation Behaviours during the COVID-19 Pandemic

Julian W. Tang [1,*], Daniel Pan [1] and Tze Ping Loh [2]

[1] Department of Respiratory Sciences, University of Leicester, Leicester LE1 5WW, UK
[2] Laboratory Medicine, National University Hospital, Singapore 119074, Singapore
* Correspondence: julian.tang@uhl-tr.nhs.uk; Tel.: +44-116-258-6516/3574; Fax: +44-116-255-1949

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Abstract: The initial response to the COVID-19 pandemic varied among different countries and cultures with large contrasts in outcomes. Western countries were generally slow in implementing pandemic restrictions while Southeast/ East-Asian countries quickly adopted social distancing, universal masking, mass testing and lockdown measures – resulting in fewer COVID-19 cases and death. Despite the apparent benefits of these restrictions, many countries did not adopt similar actions, allowing the virus to spread further in their populations. Three cultural barriers may explain the poor compliance. "We are not like them" refers to the exceptionalism attitudes by Western (British/ European) countries over their former colonies leading to reluctance in following effective pandemic responses of the latter. "We cannot be like them" posits that Western countries cannot emulate the operational and infrastructure readiness in coping with pandemic that the Asian countries have inculcated following the 2003 SARS-CoV-1 outbreak since their healthcare services are more optimized for non-communicable disease management. "We don't want to be like them" describes the Western individualism attitudes (as opposed to the general collectivism attitudes of Asian countries) that impedes with compliance with social restrictions. Underlying compliance include various factors: social norms, self-interest vs. prosocial actions, individual vs. collectivism action, value reframing. To improve compliance, public health messaging needs to be consistent, nuanced and customized to its target audience, with specific attention paid to vulnerable populations. Going forwards, during inter-pandemic periods, policy-makers need to understand and be more aware of localised practices and cultures that require specific interventions to get sufficient 'buy-in' from such groups, so that their compliance can be more reliable for any future pandemic response when such an event again arises.

Keywords: compliance; barriers to compliance; cultural diversity; pandemic

1. Introduction

The first year of the COVID-19 pandemic saw different responses across different populations, countries and cultures, with large contrasts in outcomes. Broadly speaking, many Western countries delayed in implementing pandemic restrictions, such as social distancing, universal masking, and lockdown measures, leading to high numbers of COVID-19 cases and deaths and ultimately failing to prevent the virus from becoming endemic. Conversely, many Southeast/East-Asian countries reacted very quickly to the threat by universal masking, adopting social distancing measures, mass testing and complying with isolation and quarantine orders, as required, resulting in fewer COVID-19 cases and deaths [1] and in some countries, complete virus eradication, until SARS-CoV-2 was reintroduced from abroad. Furthermore, when Western countries saw the benefits of the actions taken

by Southeast/East Asian countries, many still did not adopt similar actions, allowing the virus to spread further in their populations. So why did people behave so differently, initially, and still resist adopting a different approach later, despite seeing obvious benefits from a different set of actions taken elsewhere?

As well as media interest [2], there have been many academic studies on how to increase compliance with pandemic restrictions [3–6], but most have been rather vague about underlying reasons on why compliance was so poor in the first place. Here, we discuss three main barriers that limited compliance of COVID-19 mitigation behaviours by the general public in the West, compared to the East. Without understanding more about these barriers to compliance, efforts to increase compliance may only have a limited success.

2. Barrier 1: "We Are Not like Them"

This is an uncomfortable expression, which has also been phrased as British exceptionalism in the UK [7,8], but a similar phrasing could be applied to attitude of other Western countries (Figure 1). There may be a reluctance of former colonial powers in Europe to follow the example of their former colonies, in terms of the attitude to masking, for example ("It's not British") [9–11]. In a historical context, this may be understandable (if not acceptable) to some extent. The attitude of colonising countries, such as those in Britain and Europe, during the 16th–18th centuries was one of superiority over those countries and populations that were colonised, including those that were active perpetrators of the slave trade [10,12,13], with some of these discriminatory attitudes persisting into modern times [14–17].

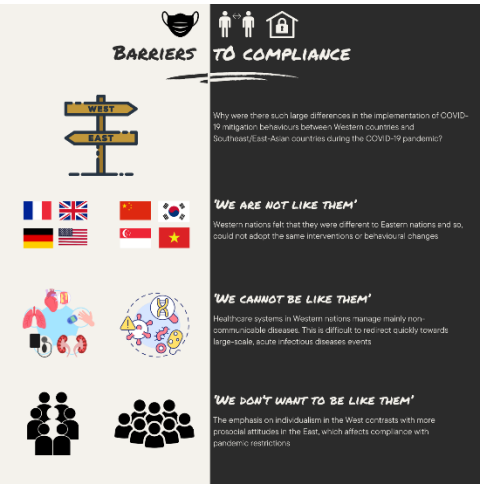

Figure 1. Summary of barriers proposed to compliance.

Other reasons have been offered to explain these differences in pandemic response, such as differences in infrastructure, resources, manpower [18–20], as well as long-standing social inequities that the pandemic exacerbated [21]. Responses to pandemic restrictions can also be affected by how this is communicated. One study from Denmark showed how a nuanced rephrasing of the language used to refer to immigrant populations, to show them more respect, could improve compliance [22].

However, it is likely that senior government figures in some of these former colonial European countries were reluctant to follow examples of effective pandemic responses by their former colonies due to this inherent attitude of superior and 'otherness' (even if unspoken) that "We are not like them" [10,23].

3. Barrier 2: "We Cannot Be like Them"

This statement refers to some of the offered reasons for not following examples of successful responses to the pandemic elsewhere, e.g., the existence of high volume throughput testing, contact tracing, isolation and quarantine facilities that existed in Southeast/East Asian nations following their experience of the 2003 SARS-CoV-1 outbreaks, with all the infrastructure funding that followed to support the expansion of these capabilities [18,24]. For example South Korea, very early on, had quickly set up large laboratories for screening suspected COVID-19 cases, as well as organised large contact tracing teams with high capacity isolation and quarantine facilities [19,25,26]. Elsewhere, China built a large new hospital within 10 days to house only COVID-19 patients [27]. Hong Kong and Singapore had already upgraded their single-room, negative pressure containment, isolation facilities in their major hospitals to house infectious patients, following their experience of the 2003 SARS-CoV-1 outbreaks [28–31].

In addition, the hospitals and healthcare services in most Western countries have been optimised for the diagnosis and management of non-communicable diseases [20,32] such as diabetes, dementia, cardiovascular disease (e.g., ischaemic heart disease and hypertension), respiratory (e.g., asthma, chronic obstructive pulmonary disease), renal (chronic kidney disease and dialysis), neurological (e.g., Parkinson's disease, multiple sclerosis, schizophrenia, depression), cancer and organ transplantation—rather than highly transmissible, often airborne infectious diseases requiring large numbers of isolation rooms, intensive care beds and ventilators [33].

Thus this phrase describes not just differing cultural attitudes across different populations and countries, but also the different healthcare needs and environment within which they live and work, with all the limitations inherent to them (Figure 1).

4. Barrier 3: "We Don't Want to Be like Them"

Although this statement might sound antagonistic, it reflects choices we make all the time either consciously or subconsciously, e.g., when we are walking through town and are accosted by someone asking for money, we may choose to give them money or not, but inside, we may be telling ourselves that we do not want to "be like that". Scaling this up to foreign travel, for example, many Western tourists, may pay a lot of money to travel to other countries to experience new cultures, food, accommodations, such as joining local Indian people eating curry with their hands [34], or Chinese people eating with chopsticks [35], or Mexicans eating insects [36], or experiencing living in a Mongolian yurt for several weeks (with no running water, showers, or flushing toilets [37]. But this is usually a short trip and many will be thankful to return to their Western homes with running water, showers and flushing toilets.

When such populations then encounter a pandemic, where unusual restrictions are imposed, such as universal masking, social distancing (not travelling to see friends or relatives), remaining in your own homes except for necessary shopping or work, without any socialisation, and on a wider scale unjustified border controls and travel bans, naturally there will be feelings of resentment—even if they see other populations elsewhere accepting and complying with such restrictions and having fewer cases and deaths from the infection [23,38,39] (Figure 1).

Having such unique restrictions imposed may therefore make people unhappy and rebellious, as was seen often in Western countries, particularly where there were pre-existing inequalities, such as in ethnic minority immigrant populations [21,23,40,41].

This 'rebellious' attitude was less common in Southeast/East Asian countries which had experience of earlier outbreaks, like SARS-CoV-1 in 2003 [23,40], or the West African countries that had experienced the Ebola outbreaks of 2014–2016, where not only social distancing was imposed but also restrictions on burial rites for the dead [42].

This sense of cultural identity or norm likely comes from our experience as children and experience as young adults, and it is difficult to change our expectations and habits suddenly without sufficient time to adjust—and this adjustment period is variable between different people, even if the change is accepted [23,43,44]

5. Key Factors Contributing to Barriers and How to Overcome Them

A previous review has examined the characteristics of different cultures using the frame work of Hofstede Insights, where certain individual features (e.g., individualism, indulgence, motivation towards success), may affect how individuals respond to pandemic restrictions, for the greater good of the individual versus their wider society [23,40]. So how can we persuade people to give up their previous attitudes and values to enhance compliance with uncomfortable and unpleasant pandemic restrictions that may be inconvenient to the individual, but will be of benefit their wider society?

Previous studies have noted that the natural human need to socialise forms the basis of much of the resistance to non-pharmaceutical interventions (NPIs), which will form the initial response to any next pandemic, where social separation and isolation is needed to reduce close contact pathogen transmission. These principles underlie the familiar NPIs that became widespread tools used during the COVID-19 pandemic, such as social distancing (including hospitality, entertainment venue and school closures), self-isolation (if infected), self-quarantine (if exposed), and stay-at-home orders—collectively known as 'lockdown' measures [45].

In addition, for airborne pathogens, increasing mechanical or natural ventilation (even just by opening windows) is also effective but these interventions may not always be immediately possible, due to cost and building design issues, e.g., not all buildings are designed with openable windows. Thus, barriers to compliance where pandemic restrictions prevent people from socialising or working (where such work cannot be performed remotely) can be high and strategies are required to overcome them to reduce the spread of infection.

Several studies/articles on pandemic messaging have identified a mix of common factors that appear to influence people to adhere more closely to pandemic guidance, particularly where:

(i). they see others they know (such as family and friends) complying such that it becomes an expected social norm [46,47].
(ii). there is a desire to support national government to do this as a sense of duty—including to reduce the burden on healthcare services [48,49].
(iii). there is a perceived threat and compliance helps to protect them and their loved ones—and also others—to reduce overall infection rates, though the benefits need to be visible quickly [2,48].
(iv). they've experienced something similar previously, so they know that compliance has longer-term wider benefits, despite short-term personal inconvenience [23,40,50].

One review has categorised various aspects of compliance as follows [51]:

Social norms: Social norms can be descriptive (doing what most people do already), or injunctive (doing what people believe they ought to do). Examples of this during the early pandemic could be mask-wearing, where initially, this was not the norm in Western countries. However, during the pandemic people were instructed that this is what they should be doing (injunctive) to limit the spread of the infection, to the point where masking became the norm (descriptive), as most people were doing this.

Self-interest vs. *prosocial actions:* The implementation of NPIs such as masking and social distancing can protect both the individual and others. Thus the motivation to follow such guidance can come from the desire to protect oneself and also those around you that may be vulnerable, particularly friends and family. The level of compliance with this guidance is higher if individuals perceive themselves as more vulnerable, which in turn leads to increased protection for others

Individual vs. *collective action:* Messaging to enhance compliance with NPIs can emphasise the incremental benefit to the wider society from individuals complying, or highlight the wider benefit from a collective response where reaching a specific threshold of many individuals working together can then achieve a particular goal. The success of the messaging depends very much on people's individual belief that the goal is achievable. This belief has to be strong enough to motivate enough people to comply and reach this threshold, even when some decide not to comply.

Values reframing: If complying with a pandemic restriction can be viewed as heroic and brave, rather than cowardly and selfish, then people would be more likely to comply. For example, if being considerate and kind to others is seen as a desirable norm in society, then masking and social distancing during a pandemic would be seen as brave and self-sacrificing rather than cowardly and selfish—thus increasing compliance with this public health restriction. Popular leaders in government or on conventional or social media can play a valuable role in framing how society views such actions.

6. Style of Messaging Is Important—And Varies Across Different Cultures

The other facet of increasing adherence to pandemic restrictions revolves around how the message is delivered. This can range from being an informative to a persuasive to a more coercive style of messaging [52–55]. Yet this can also induce a variety of individual responses. Some people just want to be told what to do without caring too much as to why, whereas others want to know exactly why they should do something and what the evidence of any benefit might be, before complying at some inconvenience to themselves. However, unlike other safety regulations, such as wearing helmets and seatbelts which tend to mostly benefit the individual, variable and unpredictable responses to pandemic restrictions affect others—more similar to driving speed limits for vehicles on highways.

To be effective, public health messaging needs to be customised for specific vulnerable populations, such as the elderly, ethnic minority groups and those from lower socioeconomic status, as opposed to a 'one size fits all' approach. This requires greater understanding of individual motivations and how to overcome any cultural, or group-specific barriers, so that a socially cohesive response can be achieved at time of crisis.

Such an approach, although harder work for policy-makers, is possible. This was seen to some extent in Australia where not everyone complied with every restriction, but most were motivated to adhere to most of the guidance (at least most of the time) out of a sense of national duty—the additional legal enforcement and penalties, notwithstanding [48]. In contrast, a US study found that compliance was more likely when people perceived not social distancing as being more reckless rather than being brave, where this action protected others, and where this highlighted the risks from COVID-19 and the benefits of collective action [51].

As discussed elsewhere, one important factor underlying such collective actions and a more socially cohesive response is peoples' trust in their government or other advisory bodies, and where their messaging and advice is inconsistent (such as in Canada and the WHO), trust and compliance is poor [40,48,56,57]. Furthermore, Western

nations often relied on voluntary compliance compared to Eastern nations, where compliance was both compulsory, but strongly supported by the public due to the consistent public health messaging from national media outlets.

Nudges have variable effectiveness in increasing compliance. A global study on how nudging could improve COVID-19 vaccine uptake concluded that it was of variable effectiveness—and could even backfire [58]. Interestingly, in this particular study, appeals to contemporary descriptive norms (where, globally, most, 87%, of people had already taken the vaccine) also failed to increase uptake in response to nudging, consistently across all test populations. This suggested that the impact of nudging was likely significantly affected by differing local cultures, experiences, and beliefs.

However, even within one cultural setting, the specifics of the nudge messaging are still important to improve compliance. For example, one American study, again focused on improving vaccine uptake (for both seasonal influenza and COVID-19), found that nudges framed specifically as reminders of an existing appointment, had the most effect (increasing vaccine uptake by up to 11%) [59].

7. Conclusions

In this article, we highlight three main barriers to why there were behaviour differences in the uptake of COVID-19 mitigation behaviours between Western and Eastern nations during the COVID-19 pandemic. Whilst some of this was attributable to differences in resource availability, there were also clear differences in attitudes to the virus, due to a lack of experience in the West, as well as pre-existing social and cultural prejudices that reduced compliance with behaviours that had already been shown to be effective in controlling the virus in Southeast/East Asian nations.

Our opinion article highlights broad differences in managing the outbreak between Western and Eastern nations. Of course, there are also more nuanced differences in culture, mentality, and political systems among individual countries. Nevertheless, the overall attitudes toward pandemic management differed markedly between Western and Eastern nations. Notably, in many Western nations with significant ethnic diversity, differential clinical outcomes were observed between ethnic minority and majority groups [60]. Often, however it has emerged that these differential risks were more attributable to a higher likelihood of exposure and infection rather than to more severe disease once infected and deeply rooted within decades of structural inequalities and discrimination [21, 61–63]

This article focuses on the initial differences in COVID-19 mitigation behaviors at the start of the pandemic. This focus is important because if all nations had effectively controlled an emerging outbreak, the pandemic might not have become endemic. Estimated mortality in Asian countries was higher toward the end of the pandemic period because SARS-CoV-2 became endemic globally, and all countries were eventually forced to reopen. Moreover, prolonged periods of social isolation, lasting years, impose a societal cost and are not necessarily beneficial in the long term.

Going forwards, during inter-pandemic periods, policy-makers need to understand and be more aware of localised practices and cultures that require specific interventions (e.g., the Leicester textile factories [64], and Singapore immigrant workers [65]) to get sufficient ‘buy-in’ from such groups, so that their compliance can be more reliable for any future pandemic response when such an event again arises.

Author Contributions

J.W.T. and T.P.L. conceived and researched the article. J.W.T. wrote the first draft. D.P. assisted with the referencing, created the figure, and drafted the revised manuscript and responses to the reviewers. All authors have read and agreed to the published version of the manuscript.

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Conflicts of Interest

None to declare for all authors. Note that the views expressed here are solely those of the authors and are not representative of the institutions to which they are affiliated.

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