

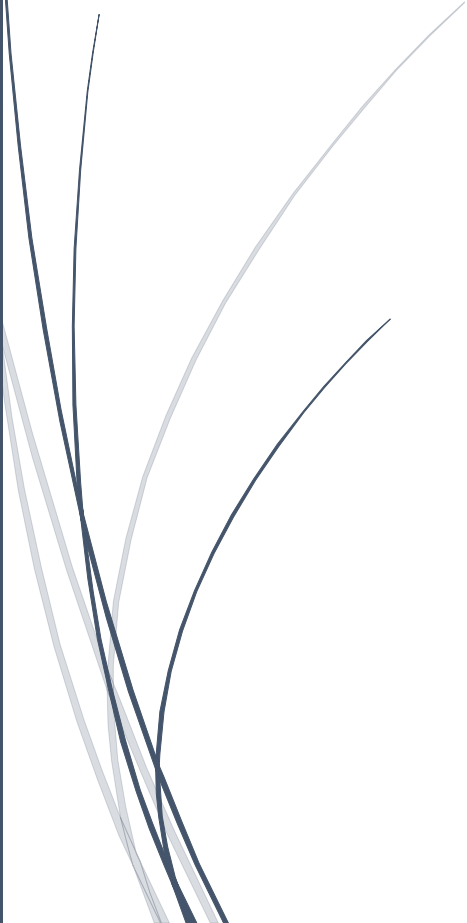
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5/10/2021

PUBLIC HEALTH POLICY

BMHP 5013

TASK 2 ACADEMIC REPORT

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INTRODUCTION

This comparative report will compare the approaches and strategies designed to measure, monitor, and control the spread of the incidence of covid-19 in the UK and Sweden. The different approaches used to contain and control the virus will be evaluated and analysed.

BACKGROUND OF CORONAVIRUS AND COVID-19

The coronavirus disease or covid -19 is a disease that is caused by SARS-CoV-2, this coronavirus **type** is new, and it was first noticed in Wuhan, China, in December of 2019. (World Health Organisation, 2020). This was formerly known as 2019-Ncov. (Cennimo, 2020). Coronaviruses are **not new**, SARS appeared in Southern China in November 2002, it spreads in similar fashion to Covid-19, it killed 774 people worldwide and was declared over by July 2003 when no new cases were found (Centers For Disease Control And Prevention, 2019). It was contained through syndromic surveillance, rapidly isolating patients, quarantine of every contact, and quarantine of the community. **Through interrupting every person-to-person transmission, SARS was conclusively eliminated** (Wilder-Smith et al., 2020). The principal symptoms of Covid - 19 comprises of an elevated temperature, new and continuous cough and a loss of taste or smell, but 1/3 of people are asymptomatic (NHS, 2020). Majority of infected people with Covid-19 undergo moderate to mild respiratory sickness and get well without the need for medical care. The elderly together with people that have underlying medical conditions like diabetic individuals, those with cardiovascular diseases, severe respiratory diseases, and cancer are most likely to suffer from a serious illness. The virus spreads primarily through discharges from the nose and saliva of an infected person that coughs and sneezes (World Health Organization, 2020) Those who are infected can remain contagious for about two weeks and can spread the virus irrespective of the fact that they are asymptomatic. The WHO declared it a public health emergency of international concern on the 30/01/2020 and subsequently declared it a pandemic on 11/03/2020, currently it is one of the deadliest pandemics in history since the influenza pandemic of 1918 (Casella et al., 2020)

STRATEGIC MEASURES EMPLOYED TO MONITOR, MEASURE AND TAKE CONTROL OF THE INCIDENCE OF CORONAVIRUS

The strategies employed in the **UK and Sweden** to contain the outbreak include **screening, containment, and then mitigation**. Then **screening** part is carried out with a device like a thermometer to be able to detect how elevated the body temperature is in relation to fevers that has its origins in the coronavirus. **Containment** is usually undertaken at the beginning

of the disease with the aim of tracing and isolating persons that have been infected and to bring about new ways to halt the spread of the disease. If the disease can no longer be contained the next step would be to go into the **mitigation stage**. This stage involves measures being undertaken to slow down the way the disease spreads and the mitigation of the effects on the system of public health care and on the general public. The spread of the disease has shown some similarity in the **UK in comparison with Sweden** (Locatelli et al., 2021) Depending on the severity, both containment and mitigation measures may be carried out at the same time. **Suppression** of the disease can involve taking very extreme measures to achieve a reversal of the spread of the disease by a reduction in the basic reproduction number of the disease to less than one.

The Timeline of **lockdowns** in the UK from March of 2020 to March 2021 are:

- 23RD OF March 2020: First lockdown ordering people to stay home.
- 25th March 2020: Coronavirus Act receives royal assent.
- 26th March: Lockdown measures come into being legally.
- 16th April 2020: Extension of Lockdown for at least three weeks.
- 30th April 2020: PM claims UK past the peak
- 10th May 2020: Conditional plan for lifting of the lockdown announced.
- 1st June 2020: The re-opening of schools in phases announced.
- 15th June 2020: Shops that are non-essential are re-opened.
- 23 June 2020: Relaxing of some restrictions and the 2-meter rule announced.
- 29th June 2020: First local lockdown in Leicester and some areas of Leicestershire
- 4th July 2020: Local lockdown come into force and easing of restrictions in England.
- 18th July 2020: England local authorities get more backing to enforce social distancing.
- 3rd August 2020: Eat Out to Help Out scheme and discounts starts in UK.
- 14th August 2020: Easing of Lockdown restrictions
- 14th September 2020: 'Rule of six' and over six against the law in England
- 22ND September 2020: Introduction of restrictions in England.
- 30TH September 2020: PM says more sanctions might become necessary.
- 14th October: Three-tier system of restrictions begins in England.
- 31st October: Second lockdown.
- 5th November 2020: Second lockdown enforced.
- 24th November 2020: Three households can meet between 23-27 of December.
- 2nd December 2020: End of second lockdown

15th December 2020: Christmas rules may be relaxed announces the PM.

19th December 2020: Tougher restrictions for London and the Southeast of England.

21st December 2020: Tier 4 restrictions enforced in London and Southeast of England

26th December 2020: Expanded tier four restrictions in England.

4th January 2021: Children can go back to school after Christmas.

6th January 2021: National lockdown

15th February 2021: Hotel quarantine enforced.

22 February 2021: Road map for lifting of lockdown expected.

8th March 2021: Planning of return to school aimed at primary and secondary students in England. (Institute for Government analysis, 2021)

In **comparison** to Sweden there was no lockdown in Sweden. The **UK and Sweden** utilises a monitoring and evaluation framework along with the European union to monitor the implementation and the effects of the covid-19 response measures. (ECDC, 2020).

CURRENT PUBLIC HEALTH POLICY APPROACHES TO REDUCE OR CONTROL INCIDENCE.

PHE guidance on reducing the spread of the coronavirus includes **keeping a safe distance** to avoid infection through aerosols and droplets that are set free from the mouth and nose of a person that is infected when they speak, breathe, sneeze or cough. People are advised to be at least 2 metres away from people that are not in their family circle or support bubble, also reduction of the time spent in crowded areas, avoiding close contact with, and having facial contact with people that are not living in their home. **Following good rudimentary hygiene principles** like washing hands, house cleaning and when sneezing people should cover their noses and mouth. Washing of hands utilising water and soap should be carried out after sneezing, coughing, and blowing the nose before handling food or eating. Also washing hands after touching surfaces that have been touched by multiple people. The public is advised to avoid touching their eyes, nose, and mouth. The public is advised to carry out surface cleaning and give extra care to surfaces that are frequently handled, Like light switches, handles and electronic devices, this is important since surfaces can become contaminated with the coronavirus when infected people cough, touch, talk and breathe over them. The public should use the crook of their elbow when coughing or sneezing. **Wearing a face covering** is also in the guidelines. there are places where wearing a face covering is

legally compulsory like in public transport, taxis, transport hubs, shops and supermarkets, post offices and banks etc.

Good ventilation is also part of the guidelines, doors and windows should be opened for short periods of time to let in fresh air. This is important because when an infected person sneezes or coughs they set free droplets or aerosols that someone else can breathe in, the droplets that are large fall to the ground while smaller droplets and aerosols can hang in the air for some time indoors especially when there is poor ventilation. The ventilation process involves the replacement of the shared air with fresh air and the fresher air that is available to breathe the less the chances of a person inhaling infectious particles. The public is advised to **get tested if they notice symptoms** like a new and continuous cough, elevated temperature and a loss of smell or change in taste known as anosmia. the test is important to ascertain if someone is infected so they can Stay put at home, quarantine, and not cause the infection of other people. Getting vaccinated is another guideline, the vaccines have demonstrated the capacity to reduce the possibility of a severe illness, but it is presently unknown if it stops the disease from spreading (Public Health England, 2021).

In comparison the Swedish public health agency updated regulations and general guidelines to the public is similar in nature to the United Kingdom, but emphasis is on **personal responsibility** and trusting the Swedish people to **act responsibly** based on the **constitutional provision of freedom of movement** for Swedish citizens (Jonung, 2020). The public is advised to **take personal responsibility** and to take preventive measures to protect themselves and others especially vulnerable people, from getting infected with the disease. The public is advised to take **basic precautionary measures** like staying at home if they have symptoms of covid-19, washing hands regularly and using hand sanitizers and being up to the minute with whatever recommendations that is issued by the public health agency of Sweden together with the regional medical officer's recommendations.. The guideline advises on **limiting any new contacts** by mixing only with people that they usually meet. The public should also **maintain their distance from other people** and avoid settings that are crowded especially when spending a long period with other people and when indoors. People should also **work from home** as often as is possible and adjust working hours to avoid crowded areas in public transport and at the workplace. People should also **travel in a manner that reduces the risk of infection**, this means utilising alternative forms of transportation other than public transportation when seats are unavailable and this can include cycling, walking, and using a car to travel.

Face masks should be worn by people born in 2004 or earlier is also advised. **face masks should be worn** on working weekdays between the hours of **7 a.m. - 9 a.m.** and **16**

p.m. – 18 p.m. and they should wear a face mask on public transport where a seat reservation is not offered. Other guidelines include engaging in sporting or leisure activities in a manner that reduces the risk of infecting others and themselves, the collective **responsibility of all organisations** in Sweden to take measures to avoid the spread of the coronavirus disease, **workplaces** should also adopt the given measures to allow their employees to adhere to this guidelines and regulations, **adult education** should be offered in the form of distance learning, sufficient services should be rendered by **public transport organisations** to reduce the risk of crowding and infection, clubs etc should postpone meetings if possible or hold them digitally and **sporting, leisure and cultural clubs** should hold training sessions outdoors if possible, minimise the number of people present and refrain from participating in camps, matches etc that is aimed at children born in 2005 or later (Public Health Agency Of Sweden, 2021). **The difference with the United Kingdom** is also with the language, the word **recommendation** is used in Sweden while the UK uses strict mandatory language.

MODELS AND THEORIES RELATED TO HEALTH BEHAVIOUR CHANGE

There are a few theories and models of health behaviour change, some of which are: The **health belief model**, **Theory of reasoned action** and **Transtheoretical Model Stages of change**. **The theory of reasoned action** is the theory that the attitudes directed at a behaviour and the expectations that are perceived will be a determining factor I whether the person intends to carry out that behaviour. The intent is therefore assumed to be the cause of the actual behaviour, and this is also called the reasoned action model (American Psychological Association, 2020) this theory is generally more successful when applied to behaviours that are within the **voluntary control** of the individual. (Boskey, 2019)

Another theory is the **Transtheoretical Model Stages of change**, this model places its focus on the decision-making capabilities of the person, and it is a model associated with **intentional change**. (Lamorte, 2019).

The health belief model is a model used by scientists to try to predict health behaviours. The theoretical basis is that a person's willingness to change their health-related behaviours is first and foremost due to their health perceptions. It further states that a person's beliefs about health and health conditions play an active part in the determination of health-related behaviour. Some **barriers** that affect the persons approach includes Barriers they think stands in their way, the exposure they have to information that causes them to act, how susceptible they think they are to fall ill, the amount of benefit they think they might derive from carrying out healthy behaviours, the likely consequences of falling ill and the confidence that they have of their ability to succeed.

Perceived severity is when the likelihood that an individual would change their health behaviours to avoid a consequence largely depends on **how severe** they think the **consequences** would be. **For example**, people in love are unlikely to stop kissing their

partner just because they might catch a cold, but they are more likely to stop kissing when they believe they would contract a more serious illness, **also, a similar attitude** is demonstrated when people do not wear condoms because they believe that sexually transmitted diseases are a mere inconvenience. **An example** is the perceived severity of contracting **covid-19**, people who believe that they are at risk might decide to change their behaviour and follow the guidelines like wearing masks, sanitising hands etc because they are aware they have underlying health concerns and the contraction of the virus could make them lose their lives or end up in a coma gasping for oxygen, this belief can push them into action. They believe they are **highly susceptible** because they use public transport, mingle with people etc and those with underlying respiratory conditions believe the severity level or consequences will be high if they are infected, they are more likely to change their behaviour and act according to legislation i.e., staying at home, using contact tracing etc.

Perceived susceptibility is related to a person's subjective perception of the risk of contracting an illness (LaMorte, 2019). in this model relates to people not wanting to change their behaviours unless they believe that they are at risk. **For example**, people who believe they will not get the flu are unlikely to get the shot for flu, people who think they will not contract the HIV virus are not likely to use a condom during sexual intercourse and younger people who do not believe that they are at risk of getting lung cancer are not likely to stop their smoking habit. **For example** people in the community who do not believe that covid 19 exists are unlikely to go and get vaccinated, they are likely to behave negatively when told to wear a mask because they believe there is a conspiracy of lies about the coronavirus pandemic, they do not believe that they are susceptible to catching the disease, but they are **more at risk** because it is difficult to change their behaviour.

Perceived benefits relate to when people find it difficult to give up something that they enjoy if they do not get something in return for giving it up, it is not easy to convince people to alter a behaviour if they will not get something in return. The recommended health action would be accepted if it were perceived as beneficial by the person. **For example:** people are unlikely to stop smoking if doing so will not cause any improvement in their lives, people will not get vaccinated if they do not see the personal benefit to them. The perceived benefits can also be connected to other factors, **for example** if eating a healthy diet and daily exercise can prevent the onset of heart diseases then that belief shoots up the perceived benefits of that behaviour. An example is due to **covid-19** students spend less money, being online saves them the cost of transportation and those with underlying conditions believe their susceptibility is high, so they prefer to stay at home.

Perceived barriers means that people think it will be hard to change their behaviour. Changing health behaviour can be expensive, it can cost effort, time, and money. Some perceived barriers include: **the discomfort, danger, effort needed, expense, social consequence, and inconvenience**. To promote health related behaviours like vaccinations, paths must be found to help people overcome their barriers, programmes to prevent diseases do this by cost reduction, increase in accessibility and the promotion of self-efficacy beliefs. Example this barrier can be visualised through the effects of the **Covid 19** pandemic. Barriers exist if someone is told they must go to work or be furloughed. Examining the work environment, housing, employment etc the **inequality that is apparent** creates a potential barrier in the health decisions that people take, the right to choose to have been taken from them and they must go to work to earn a living. People also live-in **overcrowded dwellings** due to family and economic constraints, family members go to risky jobs that exposes them to infection and other family members live with them. Adhering to the rules becomes an impossible task because of the inherent inequalities in income and health. Care workers, nurses and doctors had to go to work physically to support ill people during the Covid 19 pandemic because it was their jobs, and it was impossible to carry it out online. Irrespective of the knowledge of someone about the dangers, the health inequalities that exist can thrust them into a position of being vulnerable, for example nurses went to work and died. This barrier affects the decisions that people take as regards what action to take about their health. Like Sweden in **comparison** some workers had longer sleep periods because they were working from home, and it benefitted their health (Hallman et al., 2021).

Cues to action and self-efficacy are two important elements that can assist the person in taking the step towards changing their behaviour.

HOW POLICIES AND LEGISLATION HAVE IMPACTED THE HEALTH AND WELLBEING OF PEOPLE IN HEALTH AND SOCIAL CARE SETTINGS

The social impact (Chu et al., 2020) of legislation on the health and wellbeing of people in health and social care settings because of the coronavirus pandemic has been far reaching. Visiting restrictions, policies and legislation has had an impact on the physical health of people in care homes. Some of the legislations include the coronavirus action plan of 3rd of March 2020 (Department of Health And Social Care, 2020a), the Covid 19 action plan for adult social care on the 15 April 2020 (Department Of Health And Social Care, 2020b). Residents that were suspected of having been infected were refused visitors etc. Health care workers were more at risk of infection (Kim et al., 2020) **in comparison** to the general

population in **Sweden and the UK**. Health care workers have been more distressed from the death of Covid 19 patients (Mehta et al., 2021) than the slow dying of cancer patients.

Health and social care settings **are mandatory settings** and are better controlled than the public in the **UK**. The visiting restrictions affected the mental health of many residents and staff. Changes like wearing of masks when visiting care homes, using sanitizers, gloves, aprons etc this has affected some people more than others. Patients with learning difficulties, dementia and several illnesses that make it difficult to wear masks have suffered. The lifestyle, overall behaviour, socialising etc has been impacted by legislation. High risk people have been furloughed and it has affected their mental health. In **comparison** on 16/03/2020 PHA **Sweden recommended** that the older community should not interact with family and friends, other older people indoors, exercise every day and maintain a healthy diet for disease prevention. Elderly people over 70years accounted for 70% of Covid deaths as of 28 April 2020. They felt lonelier and many longed to die (Rambaree and Nässén, 2020). **Compared** to UK, there **are no mandatory** recommendations directed at employers in Sweden (Bostrom, 2021) Similar to Sweden in **comparison** some workers had longer sleep periods because they were working from home, and it benefitted their health (Hallman et al., 2021). Psychological distress, inequalities in communication and gender-based violence were noted as undesired social consequences of quarantine measures when **comparing the UK to Sweden**. Negative information (Bagus et al., 2021) that was spread in both countries may have affected the health and wellbeing of its citizens. Health workers in Sweden have never been overwhelmed over Covid-19, **compared to UK** some have asserted that the NHS is overwhelmed already (Sokol, 2021).

ETHICAL CONSIDERATIONS

The discipline of ethics deals with what is morally right, wrong, good, and bad (Singer, 2018). **Moral decisions** have been forced on people because of the pandemic in the **UK and Sweden, for example** the decision to go to work because of financial obligation to their family, a decision that can be wrong and possibly fatal. People **without the status to work** may find it difficult to seek for medical assistance in the hospital because of fear of deportation, irrespective of the moral obligation to take decisions to keep everyone safe, the **ethical dilemma** of fear of being arrested stops them. Medical doctors and nurses making the moral judgement to avoid or treat someone out of fear of contracting the disease and

infecting their families. Ethical considerations must be arrived at, like the government **prioritising** and deciding who will be vaccinated first based on targeting the most **vulnerable first**, also the EU stating that the UK has had an unfair advantage in vaccine distribution, but the UK has existing contracts, and it appears **ethical**, but others see it as being **unfair and morally wrong** to others that are without vaccines. People may have suffered discrimination because of their disability being exposed like the wearing of the disability lanyard. Ethical considerations with the pricing of the vaccines, poorer countries have less access. The Swedish authorities have been accused of overtly planning for **herd immunity** unethically (Lindström, 2021)

RECOMMENDATIONS

Countries should test massively like the UK has done and the test and trace APP should be encouraged, the UK should trust majority of its citizens to do the right thing like in Sweden and respect the right to free movement as enshrined in law.

CONCLUSION

This report has looked at the voluntary and stepwise approach taken by Sweden in comparison to legislation and compulsory measures in the UK as regards the management of the Covid -19, and the effects of the pandemic and legislation on the health and wellbeing of people in health care settings.

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