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# 1A) The Health Belief Model

The [Health Belief Model](http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories2.html) is a theoretical model that can be used to guide health promotion and disease prevention programs. It is used to explain and predict individual changes in health behaviours. It is one of the most widely used models for understanding health behaviours.

Key elements of the Health Belief Model focus on individual beliefs about health conditions, which predict individual health-related behaviours. The model defines the key factors that influence health behaviours as an individual's perceived threat to sickness or disease (perceived susceptibility), belief of consequence (perceived severity), potential positive benefits of action (perceived benefits), perceived barriers to action, exposure to factors that prompt action (cues to action), and confidence in ability to succeed (self-efficacy).

## Health Belief Model Examples

* The [Michigan Model for Health™](https://mishca.org/how/michigan-model-for-health/) *is a curriculum designed for implementation in schools. It targets social and emotional health challenges including nutrition, physical activity, alcohol and drug use, safety, and personal health, among other topics. This model adapts components of the*[*Health Belief Model*](http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories2.html)*related to knowledge, skills, self-efficacy, and environmental support*

Health beliefs are a component of an individual’s predisposing characteristics in the behavioural model and shape the individual’s preferences in the economic model. Health beliefs, particularly feelings of self-efficacy, relate to an individual's perceived ability to perform a certain behaviour. These perceptions of self-efficacy may influence whether individuals will attempt certain behaviours and how the behaviours will be carried out. Health beliefs are myths that people believe that are actually not true. This affects people’s mind set towards a particular health treatment. People believed that Ebola be cured by drinking salt and bath with it, so people used salts to drink, bath and brush but the accepted treatment is in the hospital.

Accepted treatment refers to the legal treatment of patients. That is what the doctor has prescribed for a patient in the hospital. Accepted treatment is mostly done and occurs in the hospital by doctors. With accepted treatment people are aware o their health status because of the different test ran on. Some undergo X-ray.

Health beliefs influence accepted treatment in the sense that the beliefs of individuals towards a particular health affects his or her acceptance towards treatment. For example; I heard of one rumour that it takes 7years for paracetamol to metabolize in your body. Though that is not true. It still affects me in some way and because of that I do not like to take paracetamol. For this we believe that and its affect and influence my accepted treatment towards any paracetamol drugs. Patients treated with dialysis who have lower self-efficacy beliefs have been found to be less adherent to treatment than HD patients with higher self-efficacy beliefs. Two studies found patients with lower dietary self-efficacy had higher potassium levels and IDWG. There is also evidence that increasing self-efficacy can lead to improved adherence. An RCT showed that patients who received self-efficacy enhancement training had a greater reduction in IDWG compared with those who did not receive the intervention at all follow-up periods.

B) Biological processes are those processes that are vital for an [organism](https://en.m.wikipedia.org/wiki/Organism) to live, and that shape its capacities for interacting with its environment. Biological processes are made of many [chemical reactions](https://en.m.wikipedia.org/wiki/Chemical_reaction) or other events that are involved in the persistence and transformation of life forms. [Metabolism](https://en.m.wikipedia.org/wiki/Metabolism) and [homeostasis](https://en.m.wikipedia.org/wiki/Homeostasis) are examples. Regulation of biological processes occurs when any process is modulated in its frequency, rate or extent. Biological processes are regulated by many means; examples include the control of [gene expression](https://en.m.wikipedia.org/wiki/Gene_expression), protein modification or interaction with a protein or substrate [molecule](https://en.m.wikipedia.org/wiki/Molecule).

Culture influence biological processes in the form of genetic makeup and human evaluation. The way our ancestors ate, cooked, explored, and interacted with others has had a profound influence on our genetic inheritance. So how will modern culture shape the genetic legacies we leave to our descendants? Drinking milk is just one of example of the way that traditions and cultural practices can influence the path of our evolution. Culture and genetics are traditionally thought of as two separate processes, but researchers are increasingly realising that they are intimately connected, each influencing the natural progression of the other. Scientists call it "gene-culture co-evolution." Why does it matter? If we can pin down how culture influences our genetic makeup and how the same processes apply to other creatures too then we can be better understand how the way, we act as a society today could influence our future.

Another example of how culture influences our genes is the relationship between yam farming and malaria resistance. Throughout much of Africa, people are in constant battle with malaria. [According to the CDC](http://www.cdc.gov/malaria/), in 2010 there were some 219 million cases of malaria reported worldwide, and 660,000 were fatal. More than 90% of those who died lived in Africa. There are some people who seem to have a natural defence force. Their red blood cells, normally shaped like flattened disks, are shaped instead like a crescent or sickle. Because of the odd shaped blood cells, [sickle-cell disease can lead to blockages in blood vessels](http://www.nhlbi.nih.gov/health/health-topics/topics/sca/), which in turn cause pain and organ damage. Under normal circumstances, evolution keeps sickle-cell disease to a minimum because it can be so harmful and can reduce life expectancy. But because of a biological quirk, the sickle-cell gene can actually protect against malaria. So in parts of the world where malaria infection rates are extremely high, like Africa, natural selection may actually favour the sickle-shaped cells. In the gamble of life, protection against malaria may be preferable, even at the potential cost of suffering from sickle-cell disease. those communities that farm yams have much higher rates of the sickle-cell gene than nearby communities with different agricultural practices. In order to cultivate yams, trees had to be chopped down. "The removal of trees had the effect of inadvertently increasing the amount of standing water when it rained, which provided better breeding grounds for malaria-carrying mosquitoes," writes biologist Kevin Laland of the University of St Andrews in [Nature Reviews Genetics](http://www.nature.com/nrg/journal/v11/n2/abs/nrg2734.html). More mosquitos mean more malaria, creating the conditions for sickle-shaped cells to become adaptive.

So while it's sickle cell disease that's protective against malaria, it was a uniquely human behaviour yam farming that allowed evolution to act. It would be easy to assume that cultural influences are unique to humans. Yet some animal species have at least rudimentary cultures, and it would be silly to think that this couldn't influence their genetics just as ours does.

C) Traditional medicine (also known as [indigenous](https://en.m.wikipedia.org/wiki/Indigenous_peoples) or folk medicine) comprises medical aspects of [traditional knowledge](https://en.m.wikipedia.org/wiki/Traditional_knowledge) that developed over generations within various societies before the era of modern [medicine](https://en.m.wikipedia.org/wiki/Medicine). The [World Health Organization (WHO)](https://en.m.wikipedia.org/wiki/World_Health_Organization) defines traditional medicine as "the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. Traditional medicine is contrasted with [scientific medicine](https://en.m.wikipedia.org/wiki/Evidence-based_medicine).

In some [Asian](https://en.m.wikipedia.org/wiki/Asia) and [African](https://en.m.wikipedia.org/wiki/Africa) countries, up to 80% of the population relies on traditional medicine for their [primary health care](https://en.m.wikipedia.org/wiki/Primary_health_care) needs. When adopted outside its traditional culture, traditional medicine is often considered a form of [alternative medicine](https://en.m.wikipedia.org/wiki/Alternative_medicine).

Western medicine refers to a system in which medical doctors and other healthcare professionals (such as nurses, pharmacists, and therapists) treat symptoms and diseases using drugs, radiation, or surgery. Also called allopathic medicine, biomedicine, conventional medicine, mainstream medicine, and orthodox medicine

The WHO notes, however, that "inappropriate use of traditional medicines or practices can have negative or dangerous effects" and that "[further research is needed](https://en.m.wikipedia.org/wiki/Further_research_is_needed) to ascertain the efficacy and safety" of several of the practices and [medicinal plants](https://en.m.wikipedia.org/wiki/Medicinal_plants) used by traditional medicine systems. Ultimately, the WHO has implemented a nine-year strategy to "support Member States in developing proactive policies and implementing action plans that will strengthen the role traditional medicine plays in keeping populations healthy. Herbal medicine is a part and parcel of and sometimes synonymous with African traditional medicine. It is the oldest and still the most widely used system of medicine in the world today. It is used in all societies and is common to all cultures. Herbal medicines, also called botanical medicines, vegetable medicines, or phytomedicines, as defined by World Health Organization (WHO) refers to herbs, herbal materials, herbal preparations, and finished herbal products that contain whole plants, parts of plants, or other plant materials, including leaves, bark, berries, flowers, and roots, and/or their extracts as active ingredients intended for human therapeutic use or for other benefits in humans and sometimes animals.

Herbal medicine is a special and prominent form of traditional medicine, in which the traditional healer, in this case known as the herbalist, specializes in the use of herbs to treat various ailments. Their role is so remarkable since it arises from a thorough knowledge of the medicinal properties of indigenous plants and the pharmaceutical steps necessary in turning such plants into drugs such as the selection, compounding, dosage, efficacy, and toxicity. The use of herbal medicines appears to be universal in different cultures. However, the plants used for the same ailments and the modes of treatment may vary from place to place. The plants used for medicinal purposes are generally referred to as medicinal plants, i.e., any plant in which one or more of its organs/parts contain substances that can be used for therapeutic purposes, or in a more modern concept, the constituents can be used as precursors for the synthesis of drugs. For example, a number of plants have been used in traditional medicine for many years without scientific data to back up their efficacy. In this case, these plants, whole or parts, which have medicinal properties, are referred to as crude drugs of natural or biological origin. They may further be classified as “organized drugs,” if such drugs are from plant parts with cellular structures such as leaf, bark, roots, etc., and “unorganized drugs,” if they are obtained from a cellular portions of plants such as gums, balsams, gels, oils, and exudates. Compared with modern allopathic medicine, herbal medicine is freely available and can easily be accessed by all. As a result, there is limited consultation with traditional healers because there is a fairly good knowledge of common curative herbs especially in the rural areas except in the case of treatment of chronic diseases. Even where consultation is done, there is lack of coherence among traditional healers on the preparation procedures and correct dosage of herbal medicines. However, according to WHO, at least 80% of people in Africa still rely on medicinal plants for their health care. In Nigeria, and indeed the entire West Africa, herbal medicine has continued to gain momentum, some of the advantages being low cost, affordability, availability, acceptability, and apparently low toxicity.

Examples of plant parts used in herbal medicines are as follows:

1. Roots—i.e., the fleshy or woody roots of many African plant species are medicinal. Most of the active ingredients are usually sequestered in the root bark rather than the woody inner part.
2. Bulbs—A bulb is an underground structure made up of numerous leaves of fleshy scales, e.g., Allium sativa (garlic) and Allium cepa (onions).
3. Rhizomes—Woody or fleshy underground stem that grows horizontally and brings out their leaves above the ground, e.g., Zingiber officinale (ginger), which is used for respiratory problems; Imperata cylindrica (spear grass) for potency in men and Curcuma longa (turmeric), an antioxidant, anti-inflammatory, and anticancer drug.
4. Tubers—Swollen fleshy underground structures which form from stems/roots, e.g., potatoes and yams such as Dioscorea dumetorum (ona-(igbo)) for diabetes and Gloriosa superba for cancer.
5. Bark—The outer protective layer of the tree stem or trunk. It contains highly concentrated phytochemicals with profound medicinal properties. A host of plants have barks of high medicinal value.
6. Leaves, stems, and flowers of many plants are also medicinal.
7. Fruits and seeds also contain highly active phytochemicals and essential oils.
8. Gums, exudates, and nectars, which are secreted by plants to deter insects and grazing animals and to seal off wounds, are very useful in the pharmaceutical industries.

### Sale of herbs in form of dried or fresh plant parts is as lucrative as the prepared medicines. They are usually displayed in markets and sold with instructions on how to prepare them for maximum efficacy. In many areas of Africa, the knowledge of plant species used and the methods of preparing and administering the medication, especially for serious ailments, still reside with traditional healers. Secrecy and competition still surround the use of these medications, with the healers often being reluctant to hand down their knowledge to anyone but trusted relatives and initiates.

### *History of Modern Medical Services*

### Western medicine was not formally introduced into Nigeria until the 1860s, when the Sacred Heart Hospital was established by Roman Catholic missionaries in Abeokuta. Throughout the ensuing colonial period, the religious missions played a major role in the supply of modern health care facilities in Nigeria. The Roman Catholic missions predominated, accounting for about 40 percent of the total number of mission-based hospital beds by 1960. By that time, mission hospitals somewhat exceeded government hospitals in number: 118 mission hospitals, compared with 101 government hospitals.

### Mission-based facilities were concentrated in certain areas, depending on the religious and other activities of the missions. Roman Catholic hospitals in particular were concentrated in the south eastern and mid-western areas. By 1954 almost all the hospitals in the mid-western part of the country were operated by Roman Catholic missions. The next largest sponsors of mission hospitals were, respectively, the Sudan United Mission, which concentrated on middle belt areas, and the Sudan Interior Mission, which worked in the Islamic north. Together they operated twenty-five hospitals or other facilities in the northern half of the country. Many of the mission hospitals remained important components of the health care network in the north in 1990. The missions also played an important role in medical training and education, providing training for nurses and paramedical personnel and sponsoring basic education as well as advanced medical training, often in Europe, for many of the first generation of Western-educated Nigerian doctors. In addition, the general education provided by the missions for many Nigerians helped to lay the groundwork for a wider distribution and acceptance of modern medical care.

The British colonial government began providing formal medical services with the construction of several clinics and hospitals in Lagos, Calabar, and other coastal trading centres in the 1870s. Unlike the missionary facilities, these were, at least initially, solely for the use of Europeans. Services were later extended to African employees of European concerns. Government hospitals and clinics expanded to other areas of the country as European activity increased there. The hospital in Jos, for example, was founded in 1912 after the initiation there of tin mining. World War I had a strong detrimental effect on medical services in Nigeria because of the large number of medical personnel, both European and African, who were pulled out to serve in Europe. After the war, medical facilities were expanded substantially, and a number of government-sponsored schools for the training of Nigerian medical assistants were established. Nigerian physicians, even if trained in Europe, were, however, generally prohibited from practicing in government hospitals unless they were serving African patients. This practice led to protests and to frequent involvement by doctors and other medical personnel in the nationalist movements of the period.

After World War II, partly in response to nationalist agitation, the colonial government tried to extend modern health and education facilities to much of the Nigerian population. A ten-year health development plan was announced in 1946. The University of Ibadan was founded in 1948; it included the country's first full faculty of medicine and university hospital, still known as University College Hospital. A number of nursing schools were established, as were two schools of pharmacy; by 1960 there were sixty-five government nursing or midwifery training schools. The 1946 health plan established the Ministry of Health to coordinate health services throughout the country, including those provided by the government, by private companies, and by the missions. The plan also budgeted funds for hospitals and clinics, most of which were concentrated in the main cities; little funding was allocated for rural health centres. There was also a strong imbalance between the appropriation of facilities to southern areas, compared with those in the north.

By 1979 there were 562 general hospitals, supplemented by 16 maternity and/or paediatric hospitals, 11 armed forces hospitals, 6 teaching hospitals, and 3 prison hospitals. Altogether they accounted for about 44,600 hospital beds. In addition, general health centres were estimated to total slightly less than 600; general clinics 2,740; maternity homes 930; and maternal health centres 1,240. Ownership of health establishments was divided among federal, state, and local governments, and there were privately owned facilities. Whereas the great majority of health establishments were government owned, there was a growing number of private institutions through the 1980s. By 1985 there were 84 health establishments owned by the federal government (accounting for 13 percent of hospital beds); 3,023 owned by state governments (47 percent of hospital beds); 6,331 owned by local governments (11 percent of hospital beds); and 1,436 privately owned establishments (providing 14 percent of hospital beds).

The problems of geographic maldistribution of medical facilities among the regions and of the inadequacy of rural facilities persisted. By 1980 the ratios were an estimated 3,800 people per hospital bed in the north (Borno, Kaduna, Kano, Niger, and Sokoto states); 2,200 per bed in the middle belt (Bauchi, Benue, Gongola, Kwara, and Plateau states); 1,300 per bed in the southeast (Anambra, Cross River, Imo, and Rivers states); and 800 per bed in the southwest (Bendel, Lagos, Ogun, Ondo, and Oyo states). There were also significant disparities within each of the regions. For example, in 1980 there were an estimated 2,600 people per physician in Lagos State, compared with 38,000 per physician in the much more rural Ondo State.

In a comparison of the distribution of hospitals between urban and rural areas in 1980, Dennis Ityavyar found that whereas approximately 80 percent of the population of those states lived in rural regions, only 42 percent of hospitals were located in those areas. The maldistribution of physicians was even more marked because few trained doctors who had a choice wanted to live in rural areas. Many of the doctors who did work in rural areas were there as part of their required service in the National Youth Service Corps, established in 1973. Few, however, remained in remote areas beyond their required term.

Hospitals were divided into general wards, which provided both outpatient and inpatient care for a small fee, and amenity wards, which charged higher fees but provided better conditions. The general wards were usually very crowded, and there were long waits for registration as well as for treatment. Patients frequently did not see a doctor, but only a nurse or other practitioner. Many types of drugs were not available at the hospital pharmacy; those that were available were usually dispensed without containers, meaning the patients had to provide their own. The inpatient wards were extremely crowded; beds were in corridors and even consisted of mattresses on floors. Food was free for very poor patients who had no one to provide for them. Most, however, had relatives or friends present, who prepared or brought food and often stayed in the hospital with the patient. By contrast, in the amenity wards available to wealthier or elite patients, food and better care were provided, and drug availability was greater. The highest level of the Nigerian elite frequently travelled abroad for medical care, particularly when a serious medical problem existed.

In the early 1980s, because of shortages of fuel and spare parts, much expensive medical equipment could not be operated. Currency devaluation and structural adjustment beginning in 1986 exacerbated these conditions. Imported goods of all types doubled or tripled in price, and government and public health care facilities were severely affected by rising costs, government budget cuts, and materials shortages of the late 1980s. Partly as a result of these problems, privately owned health care facilities became increasingly important in the late 1980s. The demand for modern medical care far outstripped its availability. Medical personnel, drugs, and equipment were increasingly diverted to the private sector as government hospitals deteriorated.

Government health policies increasingly had become an issue of policy debate and public contention in the late 1980s. The issue emerged during the Constituent Assembly held in 1989 to draft a proposed constitution. The original draft reported by the assembly included a clause specifying that free and adequate health care was to be available as a matter of right to all Nigerians within certain categories. The categories included all children younger than eighteen; all people sixty-five and older; and all those physically disabled or handicapped. This provision was, however, deleted by the president and the governing council when they reviewed the draft constitution.

Colonialism changed the entire face of societies that it touched. A domain in which these effects can be readily observed is in that of medicine. Western medicine (biomedicine) and indigenous medicine (culturally and socially specific medicinal practices) have been in contest for centuries. Western biomedical knowledge has long challenged the ideas and medical understandings of non-Western societies. Each society has its own distinct reaction to these struggles, with many African societies taking an all or nothing approach. Some societies embraced the ideas and conceptions of the West, effectively side lining indigenous values and ideals in the exchange. Other communities, in order to shield themselves from outside influences, refused all permeation of biomedical knowledge and continue to operate according to their native medical traditions though this is progressively rarer. Very few cultures have been able to adapt some of the beliefs, habits and measures of foreigners as well as maintain the systems of their own culture in a collaborative fashion.

Igbo people have progressively blended the indigenous and Western medical perspectives to achieve a complex and detailed understanding of disease. This paper is concerned with the relationship between biomedical beliefs and cultural medical knowledge, examining the effect of the former on the latter. Scholar Azuka Dike says “where new structure is a combination of the traditional values and Western values…we have a case of adaptation of borrowed objects to traditional functions or a blending of the two.” Igbo people are able to adapt borrowed Western knowledge of biomedicine and weave these ideas with indigenous medical understandings to create a blend of two mind sets. This adaptation is well noticed in the ethology, or causation, of disease. Disease causation can be approached from multiple perspectives. In modern biomedicine, origins and cause of illness are typically physical and explicable through Western scientific principles, a major feature of medical diagnosis in modern health systems. In Igbo indigenous medicine, illnesses have a broader set of components and explanations that include physical as well as spiritual causations.

2) Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. COVID-19. COVID-19 is the disease caused by the new coronavirus that emerged in China in December 2019. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment.  Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness. The best way to prevent and slow down transmission is being well informed about the COVID-19 virus, the disease it causes and how it spreads. Protect yourself and others from infection by washing your hands or using an alcohol based rub frequently and not touching your face. The COVID-19 virus spreads primarily through droplets of saliva or discharge from the nose when an infected person coughs or sneezes, so it’s important that you also practice respiratory etiquette (for example, by coughing into a flexed elbow).

At this time, there are no specific vaccines or treatments for COVID-19. However, there are many ongoing clinical trials evaluating potential treatments. WHO will continue to provide updated information as soon as clinical findings become available.

The COVID-19 virus affects different people in different ways.  COVID-19 is a respiratory disease and most infected people will develop mild to moderate symptoms and recover without requiring special treatment.  People who have underlying medical conditions and those over 60 years old have a higher risk of developing severe disease and death. Symptoms of COVID-19 are non-specific and the disease presentation can range from no symptoms (asymptomatic) to severe pneumonia and death. As of 20 February 2020 and based on 55924 laboratory confirmed cases, typical signs and symptoms include: fever (87.9%), dry cough (67.7%), fatigue (38.1%), sputum production (33.4%), shortness of breath (18.6%), sore throat (13.9%), headache (13.6%), myalgia or arthralgia (14.8%), chills (11.4%), nausea or vomiting (5.0%), nasal congestion (4.8%), diarrhoea (3.7%), and haemoptysis (0.9%), and conjunctival congestion (0.8%).

People with COVID-19 generally develop signs and symptoms, including mild respiratory symptoms and fever, on an average of 5-6 days after infection (mean incubation period 5-6 days, range 1-14 days). Most people infected with COVID-19 virus have mild disease and recover. Approximately 80% of laboratory confirmed patients have had mild to moderate disease, which includes non-pneumonia and pneumonia cases, 13.8% have severe disease (dyspnoea, respiratory frequency ≥30/minute, blood oxygen saturation ≤93%, PaO2/FiO2 ratio <300, and/or lung infiltrates >50% of the lung field within 24-48 hours) and 6.1% are critical (respiratory failure, septic shock, and/or multiple organ dysfunction/failure). Asymptomatic infection has been reported, but the majority of the relatively rare cases who are asymptomatic on the date of identification/report went on to develop disease. The proportion of truly asymptomatic infections is unclear but appears to be relatively rare and does not appear to be a major driver of transmission. Individuals at highest risk for severe disease and death include people aged over 60 years and those with underlying conditions such as hypertension, diabetes, cardiovascular disease, chronic respiratory disease and cancer. Disease in children appears to be relatively rare and mild with approximately 2.4% of the total reported cases reported amongst individuals aged under 19 years. A very small proportion of those aged under 19 years have developed severe (2.5%) or critical disease (0.2%). As of 20 February, 2114 of the 55,924 laboratory confirmed cases have died (crude fatality ratio [CFR2] 3.8%) (note: at least some of whom were identified using a case definition that included pulmonary disease). The overall CFR varies by location and intensity of transmission (i.e. 5.8% in Wuhan vs. 0.7% in other areas in China).

In China, the overall CFR was higher in the early stages of the outbreak (17.3% for cases with symptom onset from 1-10 January) and has reduced over time to 0.7% for patients with symptom onset after 1 February. The Joint Mission noted that the standard of care has evolved over the course of the outbreak. Mortality increases with age, with the highest mortality among people over 80 years of age (CFR 21.9%). The CFR is higher among males compared to females (4.7% vs. 2.8%). By occupation, patients who reported being retirees had the highest CFR at 8.9%. While patients who reported no comorbid conditions had a CFR of 1.4%, patients with comorbid conditions had much higher rates: 13.2% for those with cardiovascular disease, 9.2% for diabetes, 8.4% for hypertension, 8.0% for chronic respiratory disease, and 7.6% for cancer.

The COVID-19 virus is a new pathogen that is highly contagious, can spread quickly, and must be considered capable of causing enormous health, economic and societal impacts in any setting. It is not SARS and it is not influenza. Building scenarios and strategies only on the basis of well-known pathogens risks failing to exploit all possible measures to slow transmission of the COVID-19 virus, reduce disease and save lives. COVID-19 is not SARS and it is not influenza. It is a new virus with its own characteristics. For example, COVID-19 transmission in children appears to be limited compared with influenza, while the clinical picture differs from SARS. Such differences, while based on limited data, may be playing a role in the apparent efficacy of rigorously applied non-pharmaceutical, public health measures to interrupt chains of human-to-human transmission in a range of settings in China. The COVID-19 virus is unique among human coronaviruses in its combination of high transmissibility, substantial fatal outcomes in some high-risk groups, and ability to cause huge societal and economic disruption. For planning purposes, it must be assumed that the global population is susceptible to this virus. As the animal origin of the COVID-19 virus is unknown at present, the risk of reintroduction into previously infected areas must be constantly considered.

Concerning, global and national preparedness planning is often ambivalent about such interventions. However, to reduce COVID-19 illness and death, near-term readiness planning must embrace the large-scale implementation of high-quality, non-pharmaceutical public health measures. These measures must fully incorporate immediate case detection and isolation, rigorous close contact tracing and monitoring/quarantine, and direct population/community engagement.

A huge array of COVID-19 studies, scientific research projects and product R&D efforts are ongoing in China and globally. This is essential and to be encouraged and supported. However, such a large number of projects and products needs to be prioritized. Without prioritizing, this risks compromising the concentration of attention and resources and collaboration required to cut timelines by precious weeks and months. While progress has been made, the urgency of the COVID-19 situation supports an even more ruthless prioritization of research in the areas of diagnostics, therapeutics and vaccines.

SYMTOMS

Common symptoms include:

* fever
* tiredness
* dry cough.

Other symptoms include:

* shortness of breath
* aches and pains
* sore throat
* and very few people will report diarrhoea, nausea or a runny nose.

People with mild symptoms who are otherwise healthy should self-isolate and contact their medical provider or a COVID-19 information line for advice on testing and referral.

PREVENTIONS

To prevent infection and to slow transmission of COVID-19, do the following:

* Wash your hands regularly with soap and water, or clean them with alcohol-based hand rub.
* Maintain at least 1 metre distance between you and people coughing or sneezing.
* Avoid touching your face.
* Cover your mouth and nose when coughing or sneezing.
* Stay home if you feel unwell.
* Refrain from smoking and other activities that weaken the lungs.

Practice physical distancing by avoiding unnecessary travel and staying away from large groups of people.

## TREATMENT

Currently, no antiviral medication is recommended to treat COVID-19. Treatment is directed at relieving symptoms and may include:

* Pain relievers (ibuprofen or acetaminophen)
* Cough syrup or medication
* Rest
* Fluid intake

If you have mild symptoms, your doctor may recommend that you recover at home. He or she may give you special instructions to monitor your symptoms and to avoid spreading the illness to others. You may be asked to isolate yourself as much as possible from family and pets while you're sick and to use a separate bedroom and bathroom. Your doctor will likely recommend follow up with you regularly.

If you're very ill, you may need to be treated in the hospital.

that you stay home for a period of time except to get medical care. Your doctor will likely recommend you stay at home for a period of time except you get medical care. Your doctor will likely follow up with you regularly. If you are very ill you have to be treated in the hospital.

Relating coronavirus to culture using Africa and Nigeria

In the African context, social distancing cannot be implemented and taken into serious consideration by the people so it cannot be effective in rural communities where we have Afrocentric culture. In these rural communities, the cultural, social, financial and traditional determinants are there. For instance, you have a house where five people are sleeping on the same bed, nine people sleeping in the same room and all of that. How do you do social distancing in such an environment? We need to be careful about that. We should be careful when it comes to intrinsic differences when it comes to the African context. We don’t just pay lip service by saying social distancing. Social distancing can be enforced in cities than rural areas in Africa. But how do you enforce it in the villages? You know that 70 percent of Africa’s population live in rural areas. People live in one house and do everything together. That is the fact about it. The aero source is there. Africans need to be able to design an Afrocentric approach to the control of COVID-19. To this end, our research team in the STK Biotech have a proposal which we call Evolutionary Learning Conceptual Laboratory (ELCL) for the prevention and management of infectious diseases. This is an article that we have written some time ago and we have published it in the American Journal of Experimental Medicine. What we mean by ELCL is that we need to come up not with a linear approach to tackling infectious diseases but a holistic integrated approach.

What this integrated approach means is that you bring in different forms of therapies. You also bring indigenous knowledge as well as the preventive measures. Let all these come as a package for tackling infectious diseases. It should not only be focusing on vaccine approach and producing synthetic drugs but mixing it with indigenous drugs, vaccines preventing Medicine. So, we call that in our package as the Evolutionary Learning Conceptual Laboratory for the prevention and control of infectious diseases globally. Africa must combine both traditional and modern medicine to Combat COVID 19.