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QUESTION 1:

1. What is the relationship between health beliefs and accepted treatments?

Health Belief is a theoretical model that can be used to guide health promotion and disease prevention programmes. It is used to explain and predict health-related behaviours.

The treatment of chronic illnesses commonly includes the long-term use of pharmacotherapy. Although medications are effective in addressing chronic illnesses, their full benefits are often not realized due to lack of adherence. Levels of adequate adherence to diabetes (DMT2) and hypertension (HTN) treatment regimens vary widely with estimates from 36–93% for DMT2 and 30–70% for HTN. Up to 50% of patients who are diagnosed with chronic obstructive pulmonary disease (COPD) fail to take medications as directed and many do not use inhalers effectively.Similarly, it is estimated that 30–70% of asthma suffers are not adherent to preventative medications. The consequences of non-adherence include; significant worsening of disease, treatment failure, increased hospitalizations and increased health care costs.

Adherence is defined as the process by which patients take their medication as prescribed Patients’ acceptance of medical advice, including medication use, may be influenced by subjective beliefs about their health condition. Therefore, it is essential to take beliefs into account when giving health advice and/or providing medical treatment. It has been shown that medication adherence is multi-faceted. Factors contributing to medication adherence include illness perceptions, health literacy, self-efficacy, cognitive abilities such as memory, coping and problem-solving skills, as well as psychosocial factors such as personal and cultural beliefs related to medication taking.

Factors of concern to patients, regarding their illness, may be conceptualized as patients’ illness perceptions. Illness perceptions are personal beliefs and expectations about an illness or somatic symptoms. The basic assumption underlying this model is that illness perceptions, along with “common sense,” are used in interpreting the meaning of illness or somatic symptoms, deciding on a response, and evaluating the effectiveness of the response.

Personal beliefs about illness include both cognitive and emotional representations. Cognitive beliefs include five core domains:

1. “Identity” describes peoples’ beliefs about the label of illness and symptoms, and sets out the targets for change (such as to eliminate symptoms);
2. “Timeline” refers to people’s perception of the duration of illness, including symptoms and recovery;
3. “Consequences” refers to beliefs about the seriousness of the disease and the impacts on daily life;
4. “Control” refers to perceptions about the amenability of the illness to being cured, prevented or treated; and
5. “Causes” refers to people’s perceptions of the possible causes of their condition. Emotional representations are the feelings that arise as a result of illness, such as anxiety and/or depression.

In explaining health behaviours, social determinants such as spirituality and religiosity have been increasingly identified as impacting health and treatment.Though often used interchangeably, spirituality and religiosity are separate, but related, concepts. While spirituality denotes an inner freedom to engage in faith and a relationship with a Supreme Being, such as God, religion refers to the outward adherence to highly prescribed beliefs, practices and rituals related to the Supreme Being, such as church attendance and associated activities. Cultural beliefs, defined as “a set of behavioural patterns related to thoughts, manners and actions, which members of society have shared and passed on to succeeding generations” may also influence the decision making of patients with chronic disease to take medication. Acculturation has been defined as culture change that results from continuous contact between two distinct cultural groups; it also refers to changes in an individual whose cultural group is collectively experiencing acculturation.

Health behaviours in the self-management of chronic diseases can also be affected by both health literacy and self-efficacy. High health literacy, i.e., “the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health” and high self-efficacy, i.e., “the belief in one’s capacity to organize and execute the courses of action required to manage a prospective situation” are more likely to have better adherence to self-care tasks and medication adherence.

Control of illness was the most significant predictor of a favourable outcome; patients who believed in their own ability to control illness, and had strong confidence in treatment reported better medication adherence in many studies. Although one study reported a negative association between patients’ beliefs about their control of illnesses and medication adherence, this discrepancy may be attributed to the fact that patients of this study had high numbers of symptoms and negative emotional responses towards their illness. Different characteristics of the samples, such as household incomes, educational levels or locus of control may have contributed as well; however, these were not reported.

Perception of a lower ability to control a health threat may imply an ineffectiveness of one’s behavioural actions, or cognitive and emotional changes in illness representations because of somatic experiences. Higher control is associated with lower anxiety, lower avoidance/denial of coping strategies and positive reappraisal.

Illness perceptions are influenced by somatic and symptomatic information that patients receive from health care professionals and the satisfaction with the information received. Once patients report symptoms after a diagnosis, inconsistency between symptom attributions of patients and health professionals may arise. Eventually, patients may adopt the perspective of professionals, but they will continue to try to understand their symptom experience based on personal perceptions, not the illness entity, and create more barriers to adherence to therapeutic regimens. Therefore, it is important prior to and during treatment to assess patients’ views about their illness, symptoms, treatments and also their satisfaction with information received.

Other beliefs such as spiritual, religious and cultural beliefs were demonstrated in this systematic review to have a significant effect on medication adherence. Spirituality and religiosity are increasingly identified as impacting health and treatment.Cultural influences may have direct impact on patient’s adherence via perceptions of health and disease management. The health beliefs and cultural values of the culturally and linguistically diverse populations may differ from Western medical beliefs.

Factors that contributed to medication adherence can be classified as modifiable and non-modifiable factors. Age, gender and ethnicity are some of the non-modifiable factors that can affect medication adherence. Personal and cultural beliefs discussed above are difficult to modify in patients who have chronic illnesses; however, these patients are amendable to counselling by health care providers; hence, patients’ perceptions of their illness should be a target for intervention to enhance adherence to medications.

Patient trust in physicians is another modifiable factor, and an important facilitator of self-efficacy, and plays an important role in a patient’s ability to maintain medication adherence. Physician communication training focused on positive and empathic communication can improve patient satisfaction, adherence and trust.

Poorer medication adherence in less acculturated patients might relate to their traditional health beliefs as well as ineffective communication with health care providers due to language barriers. We suggest that migrant patients need to learn the language of countries in which they resettle. In addition, migrants may often be best able to integrate themselves into the receiving society when they receive help, encouragement and tangible support resources from members of the local community.

Non-adherence should not be perceived as only the patients’ responsibility. On the contrary, social factors (such as social support, economic factors, etc.), health care-related factors (e.g., barriers to health care and quality of provider–patient communication), condition characteristics, as well as therapy-related factors (such as patient friendliness of the therapy) play an important role in addressing adherence.

The following constructs of the HBM are proposed to vary between individuals and predict engagement in health-related behaviours:

### **Perceived susceptibility**

Perceived susceptibility refers to subjective assessment of risk of developing a health problem.  The Health Belief Model predicts that individuals who perceive that they are susceptible to a particular health problem will engage in behaviours to reduce their risk of developing the health problem. Individuals with low perceived susceptibility may deny that they are at risk for contracting a particular illness.  The combination of perceived severity and perceived susceptibility is referred to as perceived threat. Perceived severity and perceived susceptibility to a given health condition depend on knowledge about the condition.The Health Belief Model predicts that higher perceived threat leads to a higher likelihood of engagement in health-promoting behaviours.

### **Perceived severity**

Perceived severity refers to the subjective assessment of the severity of a health problem and its potential consequences. The Health Belief Model proposes that individuals who perceive a given health problem as serious are more likely to engage in behaviours to prevent the health problem from occurring (or reduce its severity). Perceived seriousness encompasses beliefs about the disease itself (e.g., whether it is life-threatening or may cause disability or pain) as well as broader impacts of the disease on functioning in work and social roles. For instance, an individual may perceive that influenza is not medically serious, but if he or she perceives that there would be serious financial consequences as a result of being absent from work for several days, then he or she may perceive influenza to be a particularly serious condition.

### **Perceived benefits**

Health-related behaviours are also influenced by the perceived benefits of taking action.Perceived benefits refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behaviour to decrease risk of disease.] If an individual believes that a particular action will reduce susceptibility to a health problem or decrease its seriousness, then he or she is likely to engage in that behaviour regardless of objective facts regarding the effectiveness of the action.For example, individuals who believe that wearing sunscreen prevents skin cancer are more likely to wear sunscreen than individuals who believe that wearing sunscreen will not prevent the occurrence of skin cancer.

### **Perceived barriers**

Health-related behaviours are also a function of perceived barriers to taking action.Perceived barriers refer to an individual's assessment of the obstacles to behaviour change. Even if an individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behaviour. In other words, the perceived benefits must outweigh the perceived barriers in order for behaviour change to occur. Perceived barriers to taking action include the perceived inconvenience, expense, danger (e.g., side effects of a medical procedure) and discomfort (e.g., pain, emotional upset) involved in engaging in the behaviour. For instance, lack of access to affordable health care and the perception that a flu vaccine shot will cause significant pain may act as barriers to receiving the flu vaccine.

### **Modifying variables**

Individual characteristics, including demographic, psychosocial, and structural variables, can affect perceptions (i.e., perceived seriousness, susceptibility, benefits, and barriers) of health-related behaviours. Demographic variables include age, sex, race, ethnicity, and education, among others.Psychosocial variables include personality, social class, and peer and reference group pressure, among others.Structural variables include knowledge about a given disease and prior contact with the disease, among other factors. The Health Belief Model suggests that modifying variables affect health-related behaviours indirectly by affecting perceived seriousness, susceptibility, benefits, and barriers.

### **Cues to action**

The Health Belief Model posits that a cue, or trigger, is necessary for prompting engagement in health-promoting behaviours. Cues to action can be internal or external. Physiological cues (e.g., pain, symptoms) are an example of internal cues to action.  External cues include events or information from close others, the media, or health care providers promoting engagement in health-related behaviours. Examples of cues to action include a reminder postcard from a dentist, the illness of a friend or family member, and product health warning labels. The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers.[[3]](https://en.wikipedia.org/wiki/Health_belief_model#cite_note-Origins_of_HBM-3) For example, individuals who believe they are at high risk for a serious illness and who have an established relationship with a primary care doctor may be easily persuaded to get screened for the illness after seeing a public service announcement, whereas individuals who believe they are at low risk for the same illness and also do not have reliable access to health care may require more intense external cues in order to get screened.

**Self-efficacy**

Self-efficacy was added to the four components of the Health Belief Model (i.e., perceived susceptibility, severity, benefits, and barriers) in 1988.Self-efficacy refers to an individual's perception of his or her competence to successfully perform a behaviour. Self-efficacy was added to the Health Belief Model in an attempt to better explain individual differences in health behaviours. The model was originally developed in order to explain engagement in one-time health-related behaviours such as being screened for cancer or receiving an immunization.Eventually, the HBM was applied to more substantial, long-term behaviour change such as diet modification, exercise, and smoking.

     Accepted treatments are treatments that are generally believed or recognized to be valid or correct. They consist of actions and medicines that have been approved. For example, ibuprofen or paracetamol are accepted treatments for headaches and body pains. Antibiotics are accepted treatments for the elimination of the bad bacteria in someone's body. Surgery is the accepted treatment for a broken bone or a gunshot wound. Antidepressants and meditation are acceptable treatments for General Anxiety Disorder or Depression.

       The link between the health belief and accepted treatment is that they both refer to the actions that individuals take in order to eliminate or reduce the seriousness or severity of a disease or health problem or condition. The health belief model was based on an assumption that people fear diseases, and that health actions are motivated in relation to the degree of fear (perceived threat) and expected fear-reduction potential of actions, as long as that potential outweighs practical and psychological obstacles to taking action which would then lead the people to get or practice the accepted treatments for whatever health condition they want to reduce or eliminate.

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b) How are biological processes influenced by culture?

   Biological processes are those processes that are vital for an organism to live and that shape its capacities for interacting with its environment. Biological processes are made of many chemical reactions or events that are responsible for the persistence and transformation of life forms. A biological process is a process of a living organism. Biological processes are made up of any number of chemical reactions or other events that results in a transformation.

 Biological processes are regulated by many means; examples include the control of gene expression, protein modification or interaction with a protein or substrate molecule. Physiological process, those processes specifically pertinent to the functioning of integrated living units: cells, tissues, organs, and organisms. Reproduction, digestion, response to stimulus: a change in state or activity of a cell or an organism as a result of a stimulus, Interaction between organisms. The processes by which an organism has an observable effect on another organism of the same or different species. Also: fermentation, fertilisation, germination, tropism, hybridisation, metamorphosis, photosynthesis, transpiration. . Regulation of biological processes occurs where any process is modulated in its frequency, rate or extent.

    Culture is an umbrella term which encompasses the social behaviours and norms found in human societies, as well as the knowledge, beliefs, arts, laws, customs, capabilities, and habits of the individuals in these groups.

Humans acquire culture through the learning processes of enculturation and socialization, which is shown by the diversity of cultures across societies.

A cultural norm codifies acceptable conduct in society; it serves as a guideline for behaviour, dress, language, and demeanours in a situation, which serves as a template for expectations in a social group. Accepting only a monoculture in a social group can bear risks, just as a single species can wither in the face of environmental change, for lack of functional responses to the change.

**EXAMPLES OF SOME BIOLOGICAL PROCESSES AND HOW CULTURE AFFECTS THEM.**

**REPRODUCTION**

Reproduction can be defined as the ability of a living organism either asexually from a single parent or sexually from two different parents. Culture has affected reproduction in so many ways and the following are some examples.

1. Some cultures are against the birth of twins, they believe that twins are witches so whenever twins are conceived in those societies, they end up getting killed. The women fear that if they give birth and they are twins their children will be taken from them.
2. The act of Female Genital Mutilation (circumcision in women) is a cultural act in some societies that has definitely affected reproduction because when many women are circumcised, they lose interest in sexual acts making them not to even have interest in reproducing their own children thereby making them adopt children instead of giving birth to them.
3. The culture in some areas is not against homosexual behaviours or sexuality (sexual relations between two people of the same sex either male or female). Two people of the same sex cannot reproduce so this affects reproduction.

**ADAPTATION:**Adaptation, in biology is the process by which a species becomes fitted to its environment; it is the result of natural selection’s acting upon heritable variation over several generations. Organisms are adapted to their environment in a great variety of ways: in their structure, physiology, and genetics, in their locomotion or dispersal, in their means of defence and attack, in their reproduction and development, and in other respects.

    In sociology, adaptation is the adjustment of both individual and group behaviour to conform to the prevailing systems of norms in a given society, class or social group.

Culture affects adaptation in the area of “cultural adaptation”.

**Cultural adaptation** is the process and time it takes a person to integrate into a new culture and feel comfortable within it. A person in this position may encounter a wide array of emotions that the theory describes in four different stages which are:

1. **Honeymoon phase**. Excitement and fascination with the new culture. This is where they will overlook minor problems and look forward to learning new things.
2. **Crisis period (culture shock)**. This is where excitement turns to disappointment and there are more and more differences that occur. Problems start to be overwhelming and irritating and may use the "fight-back" technique by saying rude remarks or making jokes.
3. **Adjustment phase**. This is where they learn to accept the culture and to change their negative attitude to a positive one.
4. **Acceptance and Adaptation phase**. This is where they will feel at home and become involved in activities and may enjoy some of that countries customs.
5. **Re-entry shock**. This is experienced upon returning to the home country and the return may follow with initial euphoria, crisis or disenchantment. It may be hard to readjust and may feel like they are not accepted.

    Culture affects adaptation through these stages.

**INTERACTION BETWEEN ORGANISMS:**

Interaction can be defined as the process by which an individual or group has an observable effect on another individual or group. Cultural interaction can be both negative and positive and has influenced interaction in the following ways:

1. Culture has brought about social change in different societies. Many groups have been able to influence other groups with their own cultural values and norms. An example is festivals, different cultures show their own traditions and values through their festivals and this makes people to learn new cultural values.
2. Culture has also influenced interaction negatively in the area of leadership. Most people from a particular culture will only accept to be led from someone with their same tradition and culture alone and if someone from another culture wants to rule them, it can lead to conflict.
3. Culture also influences interaction in the area of marriage. Culture makes people to indulge in inter-cultural interaction. Many people are now allowed to get married to people from other tribes and not just keep the marriages between on particular society.

(c) What happens when Western medicine is introduced into a foreign culture? (Use Nigeria as a case study)

Evolution is "change" and one of the most consistent phenomena of life is "change". Change is to alter, to vary, to substitute, and to mutate. The complexity of life itself is brought about by change.

Our individuality is fashioned by change. In the process of gamete formation, the genes within the germ cell undergo a complex rearrangement referred to as "meiosis". During this event, the chromatids of homologous chromosomes participate in an almost ritualistic exchange of genetic materials called "crossing-over" or "recombination". At the end of this process, paternal and maternal genes are recombined uniquely to produce an arrangement of genes never before encountered. This ultimate change produces a unique individual generation after generation.

Whether you are an "evolutionist" or a "creationist", change constitutes the main element of the process in which you believe. The entire theory of evolution glorifies "change". Evolution derives its substance from the theory of "survival of the fittest". The fittest are fittest because they have undergone change called "mutation", which confers on them reproductive superiority in a constantly changing environment. Therefore, the "fittest" have a "selective advantage" to deal with a changed environment.

The creationist should remember the story of creation very well. It consisted of a series of changes. As the narrative goes, "And the earth was without form, and void; and darkness was upon the face of the deep. And the spirit of God moved upon the face of the waters. And God said, "Let there be light: and there was light" (see Genesis 1: 2- 3). Light was the very first change God brought to bear in the process of His creation. The story of God's creation becomes even more fascinating as you read the rest of the book of Genesis. It shows how God changed the world and the beauty therein painstakingly. It also shows the changes that were introduced into our very existence when the first Humans disobeyed the instructions of God.

**"Change" therefore is life itself.**

The profession of medicine has been quite active in the arena of "change". Health care systems undergo changes and, except for a few exceptions, the changes are for the better. The way in which we train physicians has changed. The management of disease entities changes constantly. Even the disease entities that we treat and available therapeutic modalities undergo continual changes.

What about Drugs? See how many changes have occurred. Until 1944 when Sir Alexander Fleming and his collaborators, Ernst Chain and Sir Howard Florey, discovered Penicillin, no antimicrobials existed for the treatment of infections. In 60 years since that time, there has been an explosion in the classes of antibiotics. As fast as we have created new classes and forms of antibiotics, so too have changes occurred in the organisms these antibiotics are meant to treat. These changes that have occurred have been as a result of our ever-increasing curiosity to chip into the frontiers of the unknown. The boundary between what we know and what we do not know is very thin. The changes in life have come from our insatiable urge to explore this boundary to expose the unknown. This is the greatness of this creation of God, called HUMAN.

**Evolution of healthcare systems in Nigeria**
**Health Development at Various Periods**

Nigeria is made up of at least 250 linguistic groups (which some describe as ethnic groups), of which 3 are major groups comprising over 60% of the total population. Although all of these groups share common major macro-culture and macro-traditions, each evolved its own micro-culture and micro-traditions in response to prevailing environmental circumstances. Traditional medicine and healing constituted part of the micro cultural evolution.

In pre-explorers and pre-western trader's Nigeria, traditional medicine was the system of health care delivery. Traditional healing and medical practices included herbalists, divine healers, soothsayers, midwives, spiritualists, bone-setters, mental health therapists and surgeons.

In spite of more than 150 years of introduction of Western style medicine to Nigeria, traditional healing and medical practices remain a viable part of the complex health care system in Nigeria today. In 1988, a casual survey in Benin City revealed that for every sign-post that indicated a Western-style clinic or office, there were 3 that indicated a traditional doctor. Although this traditional system of health evolved separately in different micro-cultures, there is a great deal of philosophical and conceptual similarities. The origin of diseases in Africa was simplistic. It is either an enemy had cast a spell on you or you are being punished by divine powers for your sins. Although the Arabs have had the distinction of early-organized medical services, there is no recorded evidence of the introduction of such services to Sub-Saharan Nigeria during trade interactions of the fifteenth century. The same thing is true of the early Portuguese and English traders in their interactions with the Delta/Riverine areas of Nigeria during the latter part of the fifteenth century.

The first record of modern medical services in Nigeria was during the various European expeditions in the early-to mid-nineteenth century. The earlier explorations of Mongo Park and Richard Lander were seriously hampered by disease. In the expedition of 1854, Dr Baikie introduced the use of quinine, which greatly decreased mortality and morbidity among the expeditioners. It is still a subject of considerable debate whether the use of quinine by Dr. Baikie was his original discovery or whether he borrowed the idea from traditional herbalists with whom he had interacted in the course of his expeditions.

**Nationwide Health Care Services**

The health care services in Nigeria have been characterized by short-term planning, as is the case with the planning of most aspects of the Nigerian life. The major national development plans are as follows:

1. The First Colonial Development plan from 1945- 1955 (Decade of Development)
2. The Second Colonial Development plan from 1956- 1962
3. The First National Development Plan from 1962- 1968
4. The Second National Development Plan from 1970- 1975
5. The Third National Development Plan from 1975- 1980
6. The Fourth National Development Plan from 1981- 1985
7. Nigeria's five year Strategic Plan from 2004 - 2008 All of these plans formulated goals for nationwide health care services.

The overall national policy for Nationwide Health Care Services was clearly stated in a 1954 Eastern Nigeria government report on "Policy for Medical and Health Services." This report stated that the aim was to provide national health services for ALL. The report emphasized that since urban services were well developed (by our standards then), the government intended to expand rural services. These rural services would be in the form of rural hospitals of 20- 24 beds, supervised by a medical officer, who would also supervise dispensaries, maternal and child welfare clinics and preventive work (such as sanitation workers). The policy made local governments contribute to the cost of developing and maintaining such rural services, with grants-in-aid from the regional government. This report was extensive and detailed in its description of the services envisaged. This was the policy before and during Independence. After independence in 1960, the same basic health care policy was pursued.

By the time the Third National Development Plan was produced in 1975, more than 20 years after the report mentioned above, not much had been done to achieve the goals of the Nationwide Health Care Services policy. This plan, which was described by General Yakubu Gowon, the then Head of the Military Government, as "A Monument to Progress", stated, "Development trends in the health sector have not been marked by any spectacular achievement during the past decade". This development plan appeared to have focused attention on trying to improve the numerical strength of existing facilities rather than evolving a clear health care policy.

**Health Care during the Struggle for Independence**

As already stated, traditional medical practices are very much a part of the health care delivery system in Nigeria today as they were during and before the struggle for independence. Health care during the period of independence was oriented primarily to curative rather than preventive care. For example, as a result of the poor attempt to establish preventive programs, measles remained the greatest killer of children. By this time, the WHO had proven beyond reasonable doubt that proper execution of preventive programs can eradicate deadly diseases, and indeed, small pox was almost non-existent in Nigeria at this time.

In terms of access to health care services, it is estimated that in 1960 only 10-15% of the Nigerian population was covered by any form of modern health care services. Also, services were concentrated in the urban areas to the detriment of the rural areas. Consequently, whereas more than 50% of the urban population had access to health care, less than 5% of the rural population had comparable access. This pattern becomes more striking if one realizes that about 90% of the population was rural in 1960. The situation has not changed very much today, except that urban migration has increased, further tasking the existing urban facilities, making them ineffective and inadequate. Also, today there are more quacks parading as doctors all over the country with impunity, thanks to poorly regulated and underfunded system. We have no wherewithal to monitor and to weed them out of the system.

**The Financing of Health Services**

The Federal Ministry of Health is the planning and coordinating body for health services issues. The state governments through their Ministries of Health implement national programs and run state health institutions while the local governments ensure the delivery of health care to the masses. The federal government "dictates the tune", and provides the bulk of the money for paying the "piper." Over 90% of the money for health care services come directly or indirectly from the federal government, which has allowed the states some independence and freedom to spend the money as they see fit. The states, in the same way, allow the local governments some freedom in the way they spend the money.

Because the federal government provides over 90% of the money for health, a look at the federal allocation to health will give a clear indication of the position that health care occupies in the list of the government's priorities. The opening sentence of the Chapter on Health, in the Third National Development Plan, states, "Development trends in the health sector have not been marked by any spectacular achievement during the past decade." In the same way, the financial allocation to health did not show any remarkable improvement in the decade that followed independence. During the Third National Development Plan of April 1, 1975 to March 31, 1980, N689 million naira was planned to be spent on health care out of an anticipated total expenditure of N43,000 million. This comes to only 1.6% of the total proposed expenditure for health. There are, unfortunately, no statistics to show the actual amount spent. Because of the instability of the Naira, the picture can be made clearer by converting to the dollar. In 1975, the Naira was almost $2.00 and the population of Nigeria was estimated as 75 Million people. Per capita expenditure on health therefore was about $18.40 in 1975. For the same period of time, defence was allocated 5.1% of the total proposed expenditure.

**Contributions from International Organizations**

Several international organizations have played phenomenal roles in the development and maintenance of health services in Nigeria. Unfortunately most of these contributions pass through government (mostly federal government), which has kept very little record of the impact these contributions have made. Also, records of the exact cash amount of these contributions are sketchy, partly because of poor government record-keeping and partly because a lot of the contributions are in services, and in equipment and training, whose cash amount is normally difficult to establish. These organizations include the World Bank, United States Agency for International Development (USAID), WHO, UNICEF, and British Technical Assistance (BTA).

In a collaborative effort between the Nigerian government, USAID, and WHO, a very successful program was launched against smallpox and measles in 1967 and 1968. Whereas USAID financed the cost of technical immunization expense, the Nigerian government and WHO provided medical personnel and local costs. This program was so successful in Lagos that in 1968, a 97% efficiency was estimated for it, with more than 90% of the target population immunized. The success of this program against smallpox was so remarkable that by mid-1968, smallpox incidence had dropped to only 2 cases a month in Western Nigeria, mostly among immigrants. In the 1960's several projects aimed at controlling malaria (that accounted for about 11% of all mortality) were launched by WHO and UNICEF. The Expanded Program on Immunization (EPI), Oral Rehydration Therapy (ORT), and bore-hole projects for drinking water are all areas in which UNICEF's contributions are immense. There are several investigative projects, such as the Guinea worm project in Anambra State, in which WHO and, later the Jimmy Carter foundation, had invested substantial amounts of money.

During the cholera epidemic in Nigeria in 1970-71, WHO established cholera diagnosis and treatment centres throughout the country. But without this timely intervention by the world body, it is generally agreed that the losses to human life would have been catastrophic. Today these agencies, along with the United States government, through the President's Emergency Plan for AIDS Relief (PEPFAR), as well as private philanthropic organizations, such as the Jimmy Carter Foundation, the Bill Gates Foundation, the Bill Clinton Foundation, etc., have contributed to support efforts in various sectors of the Nigerian health scene, particularly HIV/AIDS. Once again the exact monetary contributions are impossible to estimate.

**Present Health Situation**

there are several health indicators used in assessing the health status of a nation. When these indicators are measured in African populations, it becomes clear how poorly Africa is doing. In attempting to measure these indicators, the first problem one encounters is the absence of reliable data/statistics for doing so. Consequently, the figures published are as varied as the authors. My efforts in obtaining figures have come from a combination of several published reports and my own experience.

***Perinatal mortality:*** This is the number of stillbirths plus death within the first week of life out of a total of 1000 births (dead or alive). The perinatal mortality rate in all of Africa south of the Sahara, excluding South Africa, is generally thought to be 100-110 per 1000. In Nigeria, the figure is not different. At the University of Benin Teaching Hospital in Nigeria, Omene and co-workers reported that the perinatal mortality rate was 89 in 1974, but it dropped to 33 in 1980 and by 1986 it was back up to 57. In 1990 no reliable data is available, but it is estimated that the rate is near the 1974 level. The reduction of the rate by two-thirds between 1974 and 1980 coincided with the development of an aggressive and effective neonatology program at the Teaching Hospital which reduced to almost zero the deaths within the first week of life. Today from the same hospital the perinatal mortality rate is as high as 110-120 per 1000.

***Infant mortality rate:*** This is the death of an infant before the first birthday and it is measured as the number of deaths per 1000 infants. In Nigeria, this figure in 1960 was 190; in 1978 it was 157 and the latest figures obtained for 1988 range from 104 to 110. There are lots of concerns with the figures for 1988 because they do not appear to be consistent with the realities of the health situation in Nigeria. However, the situation has improved somewhat over the last 20 years. The United States Central Intelligence Agency now publishes a "Fact book" on State of the Worlds Health and it has estimated Infant Mortality for Nigeria since 2003, as follows: In 2003, Infant Mortality was 71.35, but in 2004, it rose to 98.8, which was a 38.5% jump. It remained unchanged in 2005 and dipped slightly in 2006 to 97.14. In 2007, it dipped further to 95.52, then remained at 95.72 in 2008, 94.25 in 2009 and, this year, it is 94.35. According to UNICEF's report on the "State of the World's Children" in 2010, Infant Mortality in 1990 was 120 while in 2008, it was 96. No reason was given for this decline, but credit must go to Health Care Institutions and health care providers.

***Under-5 mortality:*** This is the total number of infants that die before their fifth birthday and the rate is measured per 1000 children. This value includes the infant mortality rate. For Nigeria, this value was 318 in 1960, 209 in 1978 and 174 by the latest data of 1988. As is the case with the infant mortality data, we have concerns that the 1988 figures may have grossly underestimated the enormity of this problem in Nigeria. UNICEF's "State of the World's Children 2010" reports that in 1990, Under-5 mortality rate in Nigeria was 230, and in 2008, it was 186. There are only 30 nations with under-5 mortality of greater than 170 and Nigeria is one of them. In 2007, the federal Ministry of Health published a report on Integrated Maternal, New born and Child Health Strategy, in which it is stated, "The country loses 2,300 under-five year olds and 145 women of childbearing age every day, making Nigeria the second largest contributor to the under-five (U5MR) and maternal rat e(MMR) in the world" . In a separate report published in Lancet in 2003, Black and co-workers stated that 1 million Nigerian children die before their fifth birthday every year, a figure that amounts to 10% of the world total annual deaths.

***Prematurity:*** This is the birth of a baby, whose gestational age is between 28 and 37 weeks. In Nigeria, the estimated rate as of 1984 is between 5 and 7.5%. Because of obvious worsening health care services, this value is probably higher now. Today, it looks as if nobody cares enough to keep any records.

***Maternal mortality:*** This is the death of a mother arising from complications of childbirth, measured in this report, as number of deaths per 100,000 births. Whereas in the USA this value is about 8, in Nigeria the 1988 value is 800, meaning that 8 out of every 1000 births is likely to result in maternal death, a figure that is 100 times higher than in the USA. The World Bank reports 1500 in 1980 but UNICEF reports 800 in 1988. It is difficult to conceive of a nearly 50% reduction in maternal mortality, when the evidence available seems to suggest a declining state of general well-being since 1980. Today the estimate is about 1100 but the data is at best questionable. If maternal mortality rate is about 1100 in Nigeria, a country with a population of about 150 million, it means that about 53,000 women die from pregnancy-related complications every year in Nigeria. Given that the global pregnancy-related maternal death is estimated at 529,000, it means that Nigeria contributes about 10% of world maternal deaths. There have been many advocates for safe-motherhood in Nigeria. None is so persistent, so knowledgeable and as passionate as Professor Kelsey Harrison, whose many writings on this subject, I hope, can be made available as a publication for posterity. One cannot even imagine how Professor Harrison and his countless protégé’s feel about a subject they have invested so much effort in, yet making no substantial dent on the painful statistics. In one of his most recent public addresses in Nigeria, Professor Harrison states, "One of the greatest failings in Nigeria and one that is partly responsible for much of the confused state of affairs be it in health care or whatever, is not knowing enough about the past and unwillingness to learn from it."

***Population:*** Nigeria's population at Independence in 1960 was estimated at 46 million. In 30 years the population reached 110 million. It is estimated that the population growth rate between 1965 and 1980 was 2.5%; but between 1980 and 1990, the growth rate is about 3.5%. The current growth rate is about 4%, 4 times higher than in the USA and 6 times higher than in Japan. Nigeria is the tenth most populous nation in the world with a population estimated at 150-160 million. One out of every four Black Africans is a Nigerian.

***GNP per Capita:*** Nigeria is ranked the 158th poorest country in the world out of 177 countries surveyed, according to the 2005 Human Development report, also cited by the Federal Ministry of Health report of 2007. In 1994, the World Bank reported a figure of US$260. By 2005, the World Bank reported a value of US$360. In 2009 however, the United States Central Intelligence Agency World Fact book reports a value of US$2400. This amount is still being used today, although everyone knows that it is inaccurate in view of the fall in the value of Nigerian currency without a corresponding rise in the overall Gross National Product. Also, the distortion of this value by the wide gap between the rich and the poor is not reflected. The proportion of the population that is below absolute poverty is not certain in Nigeria, but estimates ranged from 65 to 85 percent 10 years ago, but now it is about 53%.

***Life expectancy:*** This is the number of years new born children would live if subject to the mortality risks prevailing for the cross-section of the population at the time of their birth. For Nigeria, the life expectancy was 40 in 1960 and it is generally believed that it was 51 for all sexes (49 for males and 53 for females) in 1990. Today it is estimated at 42 (thanks to the scourge of HIV/AIDS).

***Access to safe drinking water:*** Only 46% of the Nigerian population is said to have access to safe drinking water. When this is broken down to urban and rural Nigeria, it is estimated that while 100% of the urban dwellers have access to safe drinking water, only 20% of the rural dwellers have access to safe drinking water. The 100% figure for urban Nigeria is quite misleading. In the first place, water is not available 100% of the time. Secondly, when water is available, at least 50% of the homes do not get it. Consequently, there are modern homes in urban Nigeria with water systems, connected to the city water lines that have never had water run through them in 10 years. Viewed against this background, therefore, the figure of 46% is exaggerated. In an article titled, ***" World Water day 2010: Nigerians still lack access to clean water"***, published in ***"Business Day"***, on March 22, 2010, it was stated, inter alia, that "the inadequacy of drinking water has however propelled some wealthy Nigerians to drill boreholes while those who don't have access to such are left with an option of carrying kegs in search for water no matter the distance. Sadly, even children of tender age are not left out of this search".

***Immunization of children and pregnant women:*** For a one-year-old to be fully immunized, he must have received 1 BCG (TB), 2 or 3 DPT (diphtheria, pertussis, and tetanus), 2 or 3 OPV (oral polio vaccine) and 2 MMR (measles, mumps and Rubella). In the absence of MMR, measles only. The data available for 1960 is very scanty, but the estimate is 5- 10%. The data for 1981 is about 23%, while for 1988 it is close to 75%, reaching a high point of about 80% in 1990. This represents 6- 10 fold improvement in this health status indicator since independence. The 1983- 1986 massive EPI (Expanded Program of Immunization) campaign supported by the federal and state governments with huge financial and material aid from UNICEF achieved enormous success in this regard. Today there is a shameful decline in the percentage of eligible children immunized. The available UNICEF data puts the number at 13%.

The issue some prominence here because it highlights our failure not only in leadership but also in effective policy-making. The 13% of fully immunized children in Nigeria is the lowest in the world, even lower than in many countries in perennial conflict, such as the Republic of Congo. In some states in Nigeria, the rate is less than 1%. Nigeria's performance on routine immunization has continued to decline since the high point achieved in 1990, so states the Nigerian Demographic Health Survey (NDHS) in 2003 and supported by the National Immunization Coverage survey (NICS) conducted by National Program on Immunization (NPI). As already stated, under- 5 mortality rate was nearly 200/ 1000 and it is estimated that Vaccine Preventable Diseases (VPD) accounts for about 22% of these. About 5 million babies are born in Nigeria every year, which means that nearly 1 million children die annually out of which > 200, 000 are preventable if adequately immunized.

The immunization of mothers against tetanus was equally successful. Whereas in 1960 this was rare, by 1981 about 11% of pregnant mothers were being immunized against tetanus to protect their unborn babies form neonatal tetanus, which has a near 100% fatality rate. By 1988, this figure has jumped to 20%. This success can also be credited to the EPI campaign. Today the value is less than 5% by all accounts.

**Main Health Problems**

Malnutrition is age-specific, occurring in the under-5 year old. Whereas only 10 to 15% of all sick children were malnourished in 1960, in 1990 and 2000, the value was between 50 and 60 %. Another age-specific disease, Measles, showed a downward trend in 1990, but by 2000, the figure was back up to 1960 rate. This is probably because of relaxation of the immunization initiatives of the 80's and early 90's. Hypertension is also age-specific and seen amongst adults 18 and above. No record was available to me for 1960 but, in 1990, hypertension was seen in 20% of all adults in Nigeria. The data for 2000 puts the rate at 30% to 35%. It is my belief that if the population is screened again, the frequency of hypertension will be much higher than that of 1990 because of new stresses and new uncertainties. Trauma has taken a giant leap among the health care problems of Nigerians. It is believed to be the most common cause of death amongst Nigerians, particularly trauma arising from Road Traffic accidents. Homicide is now a close second. Homicide is strictly speaking not a health care problem because those affected are already dead, needing no health care. However, it has reached an epidemic proportion, adversely affecting the economic and social life of Nigerians. The feeling of insecurity has created a feeling of pervasive fear in every section of Nigeria. Consequently, the very sick cannot be rushed to the hospital or to a health care facility in the middle of the night. It is for this reason alone that Homicide is included among major health problems.
It will be impossible to discuss the full impact of HIV/ AIDS on the health of Nigerians. The prevalence of HIV/AIDS in Nigeria is 5.4% among 15 to 40 year olds. It varies from 7.0% in North Central to 3.2% in North West. It is found in every socio-economic group, from civil servants to students. It is a rapidly fatal disease, associated with frequent infections and the classic "wasting syndrome". Because of HIV/AIDS, the entire African continent is filled with children without parents. It has impacted the economy of Nigeria adversely, such as loss of investment, increases in healthcare costs, reduced life expectancy, fertility rate and decrease revenue because most fatalities occur among those in their most productive years. In agriculture, it has caused decreased crop productivity and loss of international competitiveness.

The HIV/AIDS pandemic has reversed many of Africa's developmental achievements of previous decades, particularly in Sub-Saharan Africa, and it has clearly emerged as the paramount threat to development. In an article published in "TRUST" by Hussain J. Ibrahim and his co-journalists on April 16, 2010, they state, "Nigeria is rated 23rd as the country with the highest number of people living with HIV/AIDS. Worryingly, newer carriers of the scourge are adding to the figures of the infected, creating more demands for Anti-Retroviral Drugs and hospital facilities to manage the patients just at a time when HIV/AIDS funding to fight the spread of the scourge is declining and the hospitals are in poor shape."

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**2.) WAYS THE CORONA VIRUS PANDEMIC HAS IMPACTED THE GLOBAL HEALTH.**

What is Corona virus?

     The **2019–20 coronavirus pandemic** is an ongoing pandemic of the corona virus disease 2019 (COVID-19) caused by severe acute respiratory syndrome corona virus 2 (SARS-CoV-2). The outbreak was identified in Wuhan, China, in December 2019, declared to be a Public Health Emergency of International Concern on 30 January 2020, and recognized as a pandemic by the World Health Organization on 11 March 2020. As of 17 April 2020, more than 2.16 million cases of COVID-19 have been reported in 210 countries and territories, resulting in more than a number of one hundred and forty-five thousand (145,000) deaths. More than five hundred and fifty thousand (550,000) people have recovered, although there may be a possibility of relapse or reinfection. The deaths per diagnosed cases varies significantly between countries.

The virus is primarily spread between people during close contact, often via small droplets produced by coughing,sneezing, or even talking. While these droplets are produced when breathing out, they usually fall to the ground or onto surfaces rather than being infectious over long distances. People may also become infected by touching a contaminated surface and then touching their eyes, nose, or mouth. The virus can survive on surfaces up to 72 hours. It is most contagious during the first three days after the onset of symptoms, although spread may be possible before symptoms appear and in later stages of the disease. Common symptoms include fever, cough and shortness of one’s breath. Complications may include pneumonia and acute respiratory distress syndrome. The time from exposure to the virus to the onset of the symptoms is typically around five days, but may range from two to fourteen days. There is no known vaccine or specific antiviral treatment. Primary treatment is symptomatic and supportive therapy.

Recommended preventive measures include hand washing, covering one's mouth when coughing, maintaining distance from people (about 6 feet), and monitoring and self-isolation for people who suspect they are infected. Authorities worldwide have responded by implementing travel restrictions, quarantines, and curfews and stay at home orders, workplace hazard controls, and facility closures.

The pandemic has led to severe global socio-economic disruption, the postponement or cancellation of sporting, religious, political and cultural events, and widespread shortages of supplies caused by panic buying. The pandemic has caused the largest global recession in history, with more than a third of the global population being in lockdown. Schools, Universities and Colleges have closed either on a nationwide or local basis in 197 countries, affecting approximately 99.9 per cent of the world's student population. Misinformation about the virus has spread online, and there have been incidents of xenophobia and discrimination against Chinese people and against those perceived as being Chinese or as being from areas with high infection rates. Due to reduced travel and closures of heavy industry, there has been a decrease in air pollution and carbon emissions.

     Global health is the understanding of health care in an international and interdisciplinary context. It includes the study, research, and practice of medicine with a focus on improving health and health care equity for populations worldwide. Global health initiatives take into account both medical and non-medical disciplines, such as epidemiology, sociology, economic disparities, public policy, environmental factors, cultural studies, etc.

       The global health issues to be aware of are environmental factors, pandemics, political factors, economic disparities and access to health care, non-communicable diseases and animal health.

It is becoming clearer that the effect on COVID-19 upon health and care systems goes beyond the disease it produces as health systems have to somehow contemporaneously cope with the existing levels of non-communicable diseases. This is an enormous challenge since in all too many cases, the systems cannot cope with the volume of patients needing care as a result of COVID-19, even if there were no other calls associated with cardiovascular, pulmonary and metabolic diseases and cancer.

INFLUENCE OF CULTURE OF CORONA VIRUS

Every major pandemic in human history has been exacerbated by cultural behavior in one way or another. For example, the 1918 influenza pandemic was negatively affected by population movements and censorship of the press due to wartime restrictions during World War I.

A more contemporary example might be the resurgence of measles in the US and Western Europe. Groups of people are rejecting vaccines for vaccine-preventable diseases, such as [measles](https://www.futurity.org/measles-vaccines-viruses-2003552-2/). Interestingly, research has shown that vaccine-hesitant people in the US are not uneducated or under-privileged, rather the decision not to vaccinate is due to the use of this behaviours as a symbol of group membership and like-mindedness.

If we are concerned about the resurgence of vaccine-preventable diseases, health care providers and public health professionals need to think carefully about how to separate this particular behaviour from its status as a symbol of group membership.

The [COVID-19 pandemic](https://en.wikipedia.org/wiki/COVID-19_pandemic) had a sudden and substantial impact on the [arts](https://en.wikipedia.org/wiki/Arts) and [cultural heritage](https://en.wikipedia.org/wiki/Cultural_heritage) sectors. The global health crisis and the uncertainly resulting from it profoundly affected organisations' operations as well as individuals – both employed and independent – across the sector. Arts and culture sector organisations attempted to uphold their (often publicly funded) mission to provide access to cultural heritage to the community; maintain the safety of their employees, collections, and the public; while reacting to the unexpected change in their [business model](https://en.wikipedia.org/wiki/Business_model) with an unknown end.

By March 2020, across the world most cultural institutions had been indefinitely closed (or at least with their services radically curtailed) with exhibitions, events and performances cancelled or postponed. In response there were intensive efforts to provide alternative or additional services through digital platforms, to maintain essential activities with minimal resources, to document the events themselves through new acquisitions, and simultaneously an awareness that there would be many new [creative works](https://en.wikipedia.org/wiki/Creative_works) which had been inspired by the event.

Many individuals across the sector would temporarily or permanently lose contracts or employment with varying degrees of warning and financial assistance available. Equally, [financial stimulus](https://en.wikipedia.org/wiki/Financial_stimulus) from governments and charities for artists, would provide greatly differing levels of support depending on the sector and the country. The public demand for cultural activities was expected to return, but at an unknown time and with the assumption that different kinds of experiences would be popular.

As the world increasingly bunkers in to help slow the virus’ spread, one of the most interesting phenomena taking place is the creative, quirky and inspiring ways that different cities and countries are coping with the pandemic and defining their own distinct “quarantine culture” along the way. In [Italy](http://www.bbc.com/travel/story/20200325-italys-inspiring-response-to-the-coronavirus), self-isolating residents have been filmed belting opera from their balconies. In Belgium, the nation’s iconic friteries are still doling out French fries. And throughout Scandinavia, some people are still pedalling to work on bikes.

In many ways, this global pandemic is laying bare what really matters to different nations, and in the process, revealing a lot about a country’s character. It’s also reminding us of the many people, places and cultures that make this world so wonderfully diverse.

We recently asked a few of our contributors to talk about the emerging quarantine cultures where they live.

**Response to disease treatment:**

There is no specific treatment for the disease caused by novel corona virus. However, many of the symptoms can be treated based on the patient’s clinical condition. Moreover, supportive care for infected persons can be highly effective.

As the [COVID-19 pandemic](https://theconversation.com/coronavirus-where-do-new-viruses-come-from-136105) continues to spread across the world, killing thousands and bringing economies to their knees, doctors, scientists and governments are on the lookout for safe and effective treatments to help those who are sick. And yet a large issue with COVID-19 is that there is, as yet, no cure.

Though there are treatments that can alleviate the symptoms – such as difficulty breathing – they do not address the underlying cause: the virus. The idea is that treating the symptoms will help prolong a patient’s life and buy time for their own [immune systems](https://theconversation.com/regular-exercise-has-long-term-benefits-for-immunity-its-important-to-stay-active-135836) to kick in and remove the infection.

The responses to the corona virus pandemic are traveling restrictions, evacuation of foreign citizens and International Aid in the area of funding the treatment of countries being heavily consumed by the coronavirus.