

## Community Perception of Coronavirus Disease (COVID-19), Stigma and Preventive Practices in Lafia, Nasarawa State, Nigeria

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### Abstract

Coronavirus Disease (COVID-19) is a pandemic that has affected the whole world and Nigeria is not an exception. Perceptions about every disease determine attitude and behaviours towards it with significant consequences. This study examined community perception of COVID-19, stigma-generated fear and investigated adherence to COVID-19 preventive measures in Lafia Local Government Area (LGA). The study anchored on Social Cognitive Theory and the design was a cross-sectional survey. The study population was 463,989 people, resident in Lafia. Respondents were selected using a multi-stage sampling method. Instruments of data collection were questionnaire and Focus Group Discussion. 397 respondents completed the questionnaire while 2 FGDs were held in each selected ward for the study. Quantitative data were analysed using descriptive statistics. Qualitative data were content-analysed. Mean age of the respondents was  $37.6 \pm 4.6$ . Findings revealed that the community perception towards COVID-19 is negative (Rich/elites disease, White man's virus, exist only in big cities, cannot be transmitted under the sun, political disease). Fear generated stigma is high (62.2%) and adherence to Covid-19 preventive measures is generally poor. The majority (70.3%) do not observe all the preventive measures when they are in public places. The study recommends that the government and non-governmental organizations should sponsor educational campaigns through health extension workers to educate and enlighten people at the community level on COVID-19 to help in reshaping community member's perceptions and attitude towards the disease.

**Keywords:** Adherence, COVID-19, Perception, Preventive measures, Stigma.

### Introduction

The global community is facing unprecedented challenges due to Coronavirus Disease. Coronaviruses are emerging respiratory viruses that are known to cause illnesses ranging from the common cold to severe acute respiratory syndrome (SARS) (Yin & Wunderink, 2018). The coronavirus disease (COVID-19) is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Zhou, Yu, Du, Fan, Liu, Liu, Xiang, Wang, Song, Gu, Guan, Wei, Li, Wu, Xu, Tu, Zhang, Chen & Cao, 2020) and it is transmitted from humans to humans through droplets,

feco-oral, and direct contact and has an incubation period of 2-14 days (Backer, Klinkenberg, & Wallinga, 2020). Illnesses resulting from the virus could be fatal in severe cases.

The COVID-19 is reported to have originated from Wuhan, Hubei, China, in December 2019 (CDC, 2020) and has rapidly spread across the globe (WHO, 2020). COVID-19 is a public health emergency of international concern (WHO, 2020) and it is declared a pandemic by the World Health Organization (WHO, 2020). The disease has affected a lot of communities worldwide. The World Health Organization observed that COVID-19 pandemic has led to severe socio-economic disruption (WHO, 2020). The disease has also led to discrimination of people (Zhou, et al, 2020) as well as a high rate of morbidity and mortality across the globe. Nigeria confirmed its first case of COVID-19 in Lagos State in February 2020 (NCDC, 2020) and has continued to have her fair share of its effects. The disease is ravaging Nigeria as in many parts of the world (Olapegba, Ayandele, Kolawole, Oguntayo, Gandi, Dangiwa, Ottu, & Iorfa, 2020). According to the NCDC, all the 36 states and the FCT have been affected (NCDC, 2020).

Although, many countries across the globe, including Nigeria, are facing challenges as a result of the COVID-19 pandemic; there are yet no specific vaccines or treatments for the disease. Various non-pharmaceutical strategies have however been adopted to help in preventing and lowering spread and transmission of the disease. Social distancing is one of such non-pharmaceutical measures adopted. Social distancing aims to minimize physical contact between individuals and thereby reduce the possibility for new infections (ECDC, 2020). Regular hand washing for at least 20 seconds after visiting public spaces using soap and water or rubbing the hands with sanitizer that contains at least 60% of ethanol is also recommended (IPC, 2020.) The use of a face mask in public places is also recommended. It is believed that being well informed about COVID-19 and adhering to the adopted preventive strategies could help in preventing and slowing the transmission of the disease.

The benefit of the strategies adopted to mitigate the impact of COVID-19 in the world and Nigeria in particular can, however, be realised depending on the people's perception and attitudes towards the disease. Studies have proved that people's perception about a disease does influence their attitude and health-seeking actions/behaviours for the diseases concerned (Infanti, Sixsmith, Barry, Núñez-Córdoba, Oroviogicoechea-Ortega, & Guillén-Grima, 2013). People's

beliefs and perceptions also shape their behaviour's and the ability to adopt or cope with existing health interventions (Tanner & Vlassof, 1998; Glanz, 2013). Perceptions about COVID-19 in Nigeria can, therefore, influence people's attitude towards the disease and their ability to cope with the preventive strategies adopted and this is capable of determining the rate of transmission and spread as well as health outcomes. Thus, assessing community perceptions of coronavirus disease (COVID-19), stigma and preventive practices becomes necessary. The study generally explored community perception of COVID-19, stigma and preventive practices in Lafia LGA.

### **Theoretical framework: Social Cognitive Theory (SCT)**

This study was guided by the social cognitive theory developed by Albert Bandura. Social Cognitive Theory (SCT) started as the Social Learning Theory (SLT) in the 1960s by Albert Bandura. It developed into the SCT in 1986 and posits that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behaviour. Bandura argued that human behaviour is caused by personal, behavioural, and environmental influences (Bandura, 1986). According to this theorist, the environment does not only affect behaviours but it also leads to the development of thoughts and emotions that shape behaviour. This implies that individuals determine their behaviour while being influenced by environmental factors and their behaviour. Bandura (1986) also contends that behaviour is largely regulated by cognitive factors such as the perception of an issue and the pattern within the environment.

In the context of this study, it can be argued that perceptions, stigma-generated fear and preventive behaviour towards COVID-19 cannot occur in isolation; it could emanate from the interaction of individuals in their environment and reflect in their attitude towards the disease. In the process of interacting with others in the environment, people are more likely to adopt behaviours by observing attitudes of other individuals with whom they can identify. By identifying with others, the observer feels similar to such individuals and the observer could imitate their actions (Bandura, 1988).

### **Materials and Methods**

The study was carried out in Lafia LGA, Nasarawa State. Lafia LGA is located in North Central Nigeria. Lafia is the capital city of Nasarawa State; it has a land area of about 2756.44 sq. km

and shares boundaries with Nasarawa Eggon LGA to the North, Obi LGA to the South, Doma LGA to the West and Plateau State to the East. The LGA is made up of 13 council wards namely; Adogi, Agyaragu Tofa, Akurba/Bakin Rijiyi, Arikya, Ashigye, Assakio, Chiroma, Gayam, Keffi Wambai, Makama, Shabu/Kwandere, Wakwa and Zanwa. The population of Lafia based on the 2006 census results stands at 330,712 (National Population Commission, 2006). Based on projection the 2019 population of Lafia Local Government stands at 463,989 using 3.1% increment for 13 years.

The study was a community-based cross-sectional study and the populations of the study were total population in Lafia estimated at 463,989. Individuals from 20 years and above resident in Lafia LGA participated in the study. A sample size of 400 respondents was drawn using Taro Yamane sample size determination formula for a finite population.

Multistage sampling was used to select respondents. First, Lafia was demarcated into 13 clusters according to the number of existing wards that make up Lafia and six (6) wards were randomly selected and considered for the study. In each selected ward, a systematic sampling technique was employed in selecting households in the ward headquarters. In each selected household a respondent from 20 years and above was purposively selected after consent to participate in the study.

The instruments for data collection were the questionnaire and Focus Group Discussion (FGD) guides. A total of 400 copies of questionnaire were distributed and 2 FGDs were held in each of the 6 council wards selected for the study. Three (3) field assistants who were thoroughly trained on the instruments used for the data collection helped in the data collection process. During the Focus Group Discussions, social distancing and wearing of face mask were ensured and each group of discussants consisted of 8 members.

Face validity of the instruments used for data collection was ascertained by a team of researchers from Benue State University, Makurdi and the Federal University of Lafia after the instruments were thoroughly scrutinized for appropriate content.

## **Results**

At the time of collation of the quantitative data, only 397 (99.3%) of the retrieved copies of the distributed questionnaire were completed correctly and found ready to be used. The 397 copies of the questionnaire formed the basis of the quantitative analysis. The qualitative data were transcribed, content-analysed and presented in narrative form. Result of the quantitative and qualitative data was triangulated and presented jointly.

**Table 1:** Socio-demographic variables

<b>Variables</b>	<b>Frequency(N=397)</b>	<b>Per cent (%=100)</b>
<b>Age</b>		
20-29	57	14.4
30-39	106	26.7
40-49	131	33.0
50 and above	103	26.0
<b>Sex</b>		
Male	240	60.5
Female	157	39.5
<b>Marital status</b>		
Single	100	25.2
Married	279	70.3
Divorced/separated	7	1.8
Widowed	11	2.8
<b>Educational background</b>		
Non-formal	4	1.0
Primary	106	26.7
Secondary	190	47.9
Tertiary	97	24.4
<b>Occupation</b>		
Self-employed	161	40.6
Public-employed	107	27.0
Private- employed	129	32.5

**Source:** Field survey 2020

Table 1 presents the demographic characteristics of respondents. The gender distribution shows that more males (60.5%) participated in the study. The low percentage of the female composition may be connected to gender bias occasioned by possible cultural issues found in most patriarchal communities which Lafia LGA may be no exception. It could be that males are more favourably disposed and more willing to air their views on the issue of COVID-19 in the study area. The age distribution shows that the respondents are adults who are capable of stating their opinions on issues of COVID-19 in their communities. Educationally, the distribution shows that only

4(1.0%) have a non-formal education. Majority of the respondents were literate enough to read and respond to questions.

**Table 2:** Community perceptions of COVID-19

Statements.	Response Frequency/Percentages (%)				
	S/A	A	U	D	S/D
COVID-19 has political undertone in Nigeria and is projected by politicians to their advantage.	149(37.5)	134(33.8)	1(0.3)	96(24.2)	17(4.3)
COVID-19 is a White man's virus and cannot survive in this region of the world.	77(19.4)	139(35.0)	17(4.3)	128(32.2)	36(9.1)
COVID-19 is a disease for only old people	19(4.8)	87(21.9)	5(1.3)	222(55.9)	64(16.1)
COVID-19 is a disease of the rich/elites in Nigeria.	10(2.5)	216(54.4)	2(0.5)	148(37.3)	21(5.3)
COVID-19 is just like any other flu out there and not as deadly as magnified in Nigeria.	11(2.8)	209(52.6)	21(5.3)	101(25.4)	55(13.9)
COVID-19 is not heat-friendly and cannot be transmitted when the sun is high.	56(14.1)	132(33.2)	37(9.3)	151(38.0)	21(5.3)
COVID-19 is transmitted and spread only in big cities and cannot be in rural communities.	99(24.9)	161(40.6)	2(0.5)	125(31.5)	10(2.5)
COVID-19 adversely affects only people with underlying health conditions such as diabetes, cancer, high blood pressure, kidney disease, stroke, HIV among other chronic diseases.	81(20.4)	183(46.1)	9(2.3)	120(30.2)	4(1.0)

**Source:** Field survey 2020

From the pattern of responses shown in table 2, it can be deduced that there is a negative perception of COVID-19 among members of the community. Participants at the Focus Group Discussions held also demonstrated negative perceptions. A 42-year-old male participant during a discussion stated thus:

I don't think there is any serious COVID-19 in Nigeria as projected by our leaders; it is just a political disease. If there were COVID-19 in Nigeria the way they are carrying it half of Nigerian's would have been no more by now. This sickness is not our thing and not with us, those that went to the white man's country to bring it have passed away and so have the disease. The disease is now politically motivated. Our leaders pray for COVID-19 and scare us with it so that they can make money out of it but the Almighty God has shamed them, they will soon be tired and declare Nigeria COVID-19 free.

A 37 years old female participant, on the other hand, said:

COVID-19 is just like any other flu out there that is cold friendly even if it is more chronic than the normal cough and catarrh we know. It is the rich people that can be most affected by it because they are always in cold environments in the name of big man, at homes they are in air-conditioners (AC), in the cars AC, in their offices AC even the water and drinks they take are usually chilled from the refrigerator. Do you see why it is their thing? She concluded.

**Table 3:** Fear generated stigma of COVID-19

<b>Response</b>	<b>Frequency(N=397)</b>	<b>Frequency Percent(%=100)</b>
High	247	62.2
Moderate	111	28.0
Low	39	9.8
Total	397	100

**Source:** Field survey 2020

Table 3 presents findings on fear-generated stigma of COVID-19. To assess the extent of fear-generated stigma, respondents were asked to rate their level of fear of stigma on the scale of 1-5 and points were given. The responses were then grouped into three categories which were high, moderate and low. All responses were then coded and manually entered into the computer and analysed with the aid of SPSS software version 23.0. Results were presented in simple percentages as shown in table 3. The result shows that there is a high level of fear-generated stigma (62.2%) in the communities. Majority of participants during the Focus Group Discussions also expressed that their level of fear of stigma is high. A 45-year-old female participant during a discussion in one of the communities observed:

There is a high level of the fear generated stigma of COVID-19 in our communities because of the things we hear people say concerning victims, even if we do not know the victims it is normal for one to be anxious and afraid that you can be discriminated and stigmatized if you are in any way associated with the disease the same way they talk about the few people we heard suffered the disease and other imaginary victims.

A 35-year-old male participant also noted thus during a discussion:

Everyone is afraid to be associated with COVID-19 because the government herself have created stigma factor by the way they handle and isolate people even without carrying out the test. We have heard of cases where a whole family is moved to isolation centre's after telling us that there is no cure so what exactly do, they take people away for? This creates fear of stigma and discrimination, the whole thing is just scary.

**Table 4:** Adherence to COVID-19 preventive measures

<b>Variables</b>	<b>Response/Frequencies(N=397)</b>	<b>Frequency Percent (%=100)</b>
Do you always wash your hands with soap and water whenever you visit public spaces?	Yes (168)	42.3
	No (229)	57.7
Do you always use alcohol-based hand sanitizers to rub your hands when you are in public space?	Yes (189)	47.6
	No (208)	52.4
Do you always wear a face mask when going out or in public places?	Yes (91)	22.9
	No (306)	77.1
Do you always maintain social distancing whenever you are in gatherings?	Yes (57)	14.4
	No (340)	85.6
Do you always observe all the COVID-19 preventive measures whenever you are in public places?	Yes (118)	29.7
	No (279)	70.3

**Source:** Field survey 2020

From the findings presented in table 4, it can be implied that, adherence to COVID-19 preventive measures is generally poor in the study area. 70.3% of the respondents do not observe all COVID-19 preventive measures. Majority of participants at the Focus Group Discussions held also demonstrated poor adherence to COVID-19 preventive measures. A 52-year-old male stated:

I don't wash my hands regularly when I am in public space except if I am compelled to do so before gaining entrance in some places. To me, the so-called idea of washings hands with soap and water in Nigeria is just a public drama considering the nature of our society where we don't even have running water in public places even where we have we use our bare hands and open the tap or the container the water is stored in to wash our hands and close it again. Assuming the virus is on the surface of the tap handle as we touch it to open for water to rush, we pick the virus to wash it off then we use the same hands again to touch the handle to close the tap and pick up the virus again then walk away with it. Another person comes and repeats the process in the same way and manner so what is the logic here? If the virus is on the tap handle everyone coming to open and

wash hands and then close the tap with bare hands is at risk. It is only God that is helping us from this COVID-19 if it is in Nigeria; it is not by regular hand washing.

Another participant, a 28-year-old male noted:

Adherence to COVID-19 preventive measures is generally poor; hardly do you see people adhering to it and I don't regularly adhere to the preventive measures too. Some of the measures cannot even be observed even if someone is willing to try. Take the issue of social distancing for example, how do you think social distancing can be achieved in the market places? Putting on a face mask is not easy too, though I put on the face mask occasionally I am usually not comfortable with it on my face, it feels choky. Sometimes people even make jest when they see someone making conscious efforts to even adhere to the preventive measures. I once visited a friend with a face mask on and he told me to pull that thing off that there is no COVID-19 in this community except if I want to invite it.

### **Discussion**

This study assessed community members' perception of COVID-19, examined stigma-generated fear of COVID-19 and investigated adherence to COVID-19 preventive measures in Lafia LGA. The study observed that community members have a negative perception of COVID-19 in Lafia LGA. This finding is in line with similar studies such as those carried out by Ahmad, Ahmed, Hussaini, Nuru and Shehu, (2020) in Gyadi-Gyadi, Kano State where they noted that perception towards COVID-19 in the communities was poor and the communities also had negative perception towards COVID-19 transmission and prevention. It could be that since the coronavirus disease is new with many yet to be known facts about it, a lot of people are, therefore, ignorant about the disease and hold negative beliefs towards it.

This study further revealed that the level of stigma-generated fear of COVID-19 among the community members is high (62.2%). The high level of stigma-generated fear could be due to misguided information about the disease. Studies carried out by Lai, Shih, Ko, Tang, and Hsueh (2020) noted that widespread misinformation about COVID-19 is a serious concern causing fear of people worldwide. Other studies by Banarjee, (2020) noted that misinformation about COVID-19 gives rise to mass hysteria and mistrust. Fear, hysteria and mistrust could heighten tension and anxiety in people which can lead to perceived stigma.

The study also revealed that majority (70.3%) of the community members do not adhere to all the adopted COVID-19 preventive measures when in public places. Adherence to preventive measures in the study area is generally poor. This finding is in contrast to studies carried out by

Roy, Tripathy, Kar, Sharma, Verma, and Kaushal, (2020) in Indian where respondents' attitude towards COVID-19 showed a willingness to adhere to preventive measures. This contrast could be due to regional differences and the perceptions people may have about COVID-19 in these places may vary and while this study was based on a physical self-report from respondents, the study by Roy, Tripathy, Kar, Sharma, Verma, and Kaushal, (2020) depended on an online survey.

### **Conclusion**

This study has shown and concluded that perception towards COVID-19 in the study area is negative, fear-generated stigma is high, and adherence to preventive measures is poor in the study area. There is, therefore, need for the government and non-governmental organizations to intensify awareness and raise community consciousness on accurate information on the coronavirus disease, the modes of transmission and spread of the virus. The need for using the face mask, maintaining social distancing especially in gatherings, regular hand washing after visiting public places using soap and water or rubbing the hands with alcohol-based sanitizers should be emphasized in communities.

### **Recommendations**

To ensure that COVID-19 does not remain a burden that will keep on spreading and affecting families, communities and the nation at large, this study recommends that:

- i. The government and non-governmental organizations should sponsor educational campaigns through health extension workers to educate and enlighten people at the community level. This could help in reshaping community members' perceptions towards the disease since perceptions can determine an individual's attitude towards the coronavirus disease positively or negatively.
- ii. Authorities in public health should intensify awareness on COVID-19 and also ensure accurate and necessary health information on COVID-19 is made available and accessible to people in all communities to prevent the problem of misguided information that is capable of creating a high level of tension, fear, stigma and discrimination.
- iii. To curtail further transmission and spread of the virus, government should ensure that the adopted preventive measures are strictly enforced: it should ensure that people adequately adhere to such measures and that failure to comply attracts punishment.

**Conflict of interest:** The authors declare no conflict of interest.

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