

Article

Resident's roles in the optimization of the preparedness protocols for Ebola pandemic in urban environment

Analysis of Residents' preparedness protocols during Ebola pandemic in urban environment

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Abstract: **Background:** The study provided empirical analysis of the change in hygiene behavioural practices among community in Ogun and Lagos State with respect to Ebola outbreak in Nigeria. The study assessed men's role in the preparedness against emerging pandemic of Ebola Virus Disease in Ogun State, Nigeria. It examined the changes in men's hygiene practices as response to the news of the outbreak of Ebola Virus Disease (EVD). **Methods:** The data were extracted from a 2015 Cross-Sectional Survey on wellness, knowledge, attitude and practices towards the control and prevention of Ebola Virus Disease. The respondents (933466 male) in the main survey were selected using simple random sampling technique within two enumeration areas that represent the sampling points within the local government areas selected (EAs). **Results:** The results revealed high level of knowledge of EVD but over 70% were not aware of centre for EVD treatment, 60.2% believed they are not susceptible to EVD. There were changes in certain practices that were canvassed and adhered to during the outbreak. The practice of handshaking reduced, eating of hunted animals decreased only marginally by 6.9% and washing with soap increased by 4%. **Conclusion:** The study provides helpful information for public health policy especially in terms of behavioral risk factors that are prone to Ebola virus infections or other communicable diseases. The study emphasised that regular hand washing with soap and the use of sanitising agents including availability of treatment centres would be helpful in preventing the occurrence or re-occurrence of pandemic. The protocols identified in this study could be relevant to both medical personnel and the community for adoption especially as the unlikelihood of pandemic re-emergence have not been established. It emphasises regular hand-washing with soap and sanitizing agents and recommended that availability of treatment centres and vaccines that can enhance effective response in curtailing further health emergencies.

Keywords: Ebola Virus Disease; knowledge; attitude; practices; wellness; men; sexual behaviour; environment

1. Introduction

Since its first incidence in 1976 at the northern part of Democratic Republic of the Congo in Africa, over 38 outbreaks of Ebola virus disease have been recorded across the globe (Kamorudeen & Adedokun, 2020; Centers for Disease Control and Prevention [CDC], 2019). The disease, between 2014 and 2016, hit adversely several countries in West African coast such as Guinea, Sierra Leone, Liberia and Nigeria and was noted as the first worst recorded outbreak of Ebola in sub-Saharan Africa (Baize, Pannetier, Oestereich, Rieger, Koi-vogui, *et al.*, 2014; Centers for Disease Control and Prevention, 2014; Kamorudeen & Adedokun, 2020). Nigeria first record of the incidence of Ebola was announced on July 20, 2014 and by October 20th of 2014, the WHO declared Nigeria Ebola free (World Health Organization, 2014). While Nigeria experience was short lived, the intermittent emergence of the disease in other parts of sub-Saharan Africa, in addition with the incursion of Lassa fever and COVID-19 have made EVD pandemic a serious threat in public health domain. Besides, the repeated occurrence of the Ebola disease around the world (Kamorudeen & Adedokun, 2020; Centers for Disease Control and Prevention [CDC], 2019), in addition with the absence of any declaration that the disease cannot resurface again (wherever it has been once treated or warded off), has created public health apprehension. This has also make any analysis on the necessary protocols to prevent the re-occurrence or stop the spread of the disease a relevant and worthy scientific exercise.

Generally, infectious diseases caused more than 300 million illnesses and over five million deaths each year worldwide and more than 31% of deaths in developing countries are caused by communicable diseases (WHO, 2014a). The burden of communicable diseases (e.g. Ebola infection, follow by Lassa fever and COVID-19) in developing nations was unacceptably high. While the proportional mortality in percentage of total deaths for all ages due to communicable diseases are 51%, 48%, 46% and 66% for Ghana, South Africa, Afghanistan and Nigeria respectively, the rates are as low as 5%, 4% and 6% in Canada, Italy and France, respectively (Young, Critchley, Johnstone & Unwin, 2010; WHO, 2014b). These deaths are largely preventable by adopting simple measures that could reduce risk factors for communicable diseases at community level. A report have indicated that the global Years of Life Lost (YLL) due to communicable diseases is as high as 69% (WHO, 2010) and more than 80% of this occurred in developing countries including Nigeria. The pre-Ebola era shows that Nigeria government expenditure on health ranges between 4.6% and 9.0% of her gross domestic product, while the private expenditure on health was as high as 60% and above (Organisation for Economic Co-operation and Development [OECD], 2010; World Health Organisation, 2014; Dye, 2014; Maiyaki & Garbati, 2014). Total per capita expenditure on health as at 2013 was estimated at \$217 (WHO, 2015b). In addition to the domestic expenditure, the development assistance on health from 2000 and 2010 from donor countries is more than \$27 billion (Maiyaki & Garbati, 2014; Murray, Anderson, Burstein, Leach-Kemon, Schneider, Tardif & Zhang, 2011; Dye, Mertens, Hirnschall, Mpanju-Sumbusho, Newman, Raviglione, Savioli & Nakatani, 2013). These proportions must have heightened with the emergent of EVD as addition diseases without notable decline in the existing prevalent rate of other communicable diseases.

Total confirmed (including probable) cases of EVD were 14124, 10678, 3814 and 20 in Sierra Leone, Liberia, Guinea and Nigeria respectively but with disease severity (fatality rate) as high as 28% (Sierra Leone), 45% (Liberia), 66.7% (Guinea) and 40% in Nigeria (Centers for Disease Control and Prevention [CDC], 2019). Reported cumulative cases of EVD in Guinea, Liberia, Sierra Leone, Nigeria and Mali totaled 28645 out of which 11,324 resulted into death (World Health Organization, 2014, 2015; Centers for Disease Control and Prevention [CDC], 2019). Ebola infection is feared among the citizenry especially due to the fact that it has no regional boundary and gender variation is a subject of controversy

The major control measures undertaken for EVD have been supportive care that range from rehydration and treatment of specific symptoms especially immune-based therapies and drug therapies. It also includes surveillance with urgent alert systems in cases of unexplained fever or deaths due to febrile illness (Seale, *et al.*, 2020; Abena, *et al.*, 2020). The recent approval of vaccines and antibodies in DRC e.g. Inmazeb and Ebanga, Ervebo vaccine for adult ≥ 18 years and Zabdeno-and-Mvabea that are meant for individuals that are one year

and older (World Health Organisation [WHO], 2021). Ebola disease is characterized with high case-fatality rate, potential for repeated occurrence and rapid spread (Oureshi, 2016; WHO Ebola Response Team, 2014). While timely surveillance and treatment are important control measures, continuous and regular analysis of hygiene protocols are crucial strategies for the prevention and control of diseases (Anker & World Health Organization, 2007).

There have been numerous initiatives geared towards prevention of the spread of pandemic diseases, especially at it relates to Ebola in Nigeria and sub-Saharan Africa in general. Prominent are those initiated by the West Africa Regional Centre for Surveillance and Disease Control (RCSDC). The organization is primarily concerned with prevention of diseases especially in curbing the spread of EVD. It operated within the confine of West Africa Health Organisation (WAHO) and the Africa Centres for Disease Control (Ihekweazu & Abubakar, 2017). In addition, there were also campaigns on hygiene practices by the Ministry of Health (MoH) and other organisations (Shuaib, Gunnala, et al, 2014; Otu, Ameh, et al, 2018). Despite all these efforts, EVD still infected large number of people that include high mortality cases (Readon, 2014), including economic burden of relatively \$53.19 billion occurring only in three countries (namely, Guinea, Liberia and Sierra Leone (Huber, et al, 2018)).

In reality, the success of most health programmes or campaigns especially in sub-Saharan Africa is contingent upon community disposition (Yanti, et al, 2020; Omotayo, et al, 2020). Besides, hygiene practices remains one of the uncontested effective prevention methods against pandemic diseases, however, there are relatively little data on what behavioural changes take place in the presence of pandemic and what practices are sustained after such pandemic has been stopped or curtailed. Do people return to their former practices or sustain the mitigating or protective strategies adopted during such outbreak? The study specifically provided answers certain boggling questions such as what are the levels of knowledge and practices in the selected study areas in respect of Ebola disease; what are the levels of community preparedness to curtail or prevent its spread? The understanding the levels of knowledge and practices of Ebola disease is apt for development of policies and programs to prevent its re-occurrence and emergence of any other epidemic-prone infectious diseases in Nigeria and by extension, other countries in sub-Sahara Africa.

Since its first incidence in 1976 at the northern part of Democratic Republic of the Congo in Africa, over 38 outbreaks of Ebola virus disease have been recorded across the globe (Kamorudeen & Adedokun, 2020; Centers for Disease Control and Prevention [CDC], 2019). The resurface of the virus between 2014 and 2016 in sub saharan Africa was noted to be worst first recorded outbreak of Ebola virus disease in Africa was in 1976 in the. The emergence of the disease that hit adversely several countries in West African coast such as Guinea, Sierra Leone, Liberia and Nigeria between 2014 and 2016 was noted as the largest outbreak so far (Baize, Pannetier, Oestereich, Rieger, Koivogui, et al., 2014; Centers for Disease Control and Prevention, 2014; Kamorudeen & Adedokun, 2020).

Total confirmed (including probable) cases were 14124, 10678, 3814 and 20 in Sierra Leone, Liberia, Guinea and Nigeria respectively but with disease severity (fatality rate) as high as 28% (Sierra Leone), 45% (Liberia), 66.7% (Guinea) and 40% in Nigeria (Centers for Disease Control and Prevention [CDC], 2019). Reported cumulative cases of EVD in Guinea, Liberia, Sierra Leone, Nigeria and Mali totaled 28645 out of which 11,324 resulted into death (World Health Organization, 2014, 2015; Centers for Disease Control and Prevention [CDC], 2019). Ebola infection is feared among the citizenry especially due to the fact that it has no regional boundary and gender variation is a subject of controversy.

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142 Although the Nigeria experience was short lived, with the first recorded incidence
143 on July 20, 2014 and October 20th of 2014 when the WHO declared Nigeria Ebola free (World
144 Health Organization, 2014). Nigeria has been declared free from the scourge of the highly
145 contagious Ebola Virus Disease (EVD) however, the intermittent emergence prevalence of
146 the disease in other parts of sub-Saharan Africa, coupled with the incursion of Lassa fever
147 and COVID-19 has made EVD and including other pandemic serious threat in public health
148 domain. Currently, there is no declaration that the disease cannot resurface again wher-
149 ever it has been once treated or warded off. However, studies have documented wide
150 variations in gender responses to certain diseases (Manhertz, 2016; Swaan et al., 2018;
151 Vlassoff, 2007; Westervelt, 2015; World Health Organization, 2003), but statement on the
152 position of men and their roles on Ebola and other epidemic-prone infectious diseases are
153 not known especially in Nigeria. Nigeria, like other traditional African countries, is a pa-
154 triarchal society with conspicuous male dominance and men are often regarded as the
155 breadwinners of the families (Amoo et al., 2017). Men decision, especially the head of the
156 family, generally overrules other family decisions and their responses to matter of dis-
157 eases and sickness might be fundamental to the survival of the family and the society as
158 a whole. Thus investigating the men's role towards Ebola or other epidemic-prone infec-
159 tious diseases could enhance speedy achievement of sick-free families (SGD-), as well as
160 the societal wellbeing.

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167 are meant for individuals that are one year and older (World Health Organisation [WHO],
168 2021). Ebola and Lassa fever belong to the same category viral haemorrhagic fever often
169 characterized with high case-fatality rates potential for rapid spread (Qureshi, 2016; WHO
170 Ebola Response Team, 2014). Timely surveillance and response are prominent among var-
171 ious prevention and control strategies (Anker & World Health Organization, 2007). In an
172 environment where the response and/or reporting systems could be deficient, the roles
173 of family decision-takers and environment are fundamental. However, these strategies
174 and mechanisms through which they operate are gender-sensitive (Anker & World Health
175 Organization, 2007; Qureshi, 2016; World Health Organization, 2003) and especially in
176 traditional sub-Saharan African region—

177 Reported cumulative cases of EVD in Guinea, Liberia and Sierra Leone totaled 27,443
178 out of which 11,207 resulted into death (World Health Organization, 2014, 2015). Ebola
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192 ment of sick-free families (SGD-), as well as the societal wellbeing.

193 Studies have reported that men and women do not respond to sickness and diseases
194 the same way and that the spread of certain diseases are gender-specific (Deen et al.,
195 2015)(Centers for Disease Control and Prevention [CDC], 2012; WHO, 2007). The potential

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importance of sex and gender differences in diseases transmission has also been widely studied (WHO, 2007). However, literature on the implications of men knowledge and disposition in respect of Ebola epidemic are relatively scanty in Nigeria, especially as it relates cultural diversities. The understanding of men's perspective on infectious diseases could aid holistic treatment and public intervention in the prevention and control of activities that are epidemic prone and susceptible to infectious diseases generally.

The study employed 'Social Determinants of Health framework' in the understanding and analysis of men's role in the optimization of the preparedness protocol for Ebola pandemic and thereby provide highlights on the control and prevention of communicable diseases (World Health Organization, 2010). Social determinants of health are various conditions in which men found themselves, such as place of residence or work and work place, age, wealth, and power. In addition, human health is inextricably linked to the environment and this is also crucial in Ebola spread (Altat & Atangana, 2019; Duse, 2019). As applied in this study, it refers to the conditions accorded to men by the traditional setting inherent in Nigeria and sub-Saharan Africa in general. The region of sub-Saharan Africa is entrenched with traditional gender-based roles, behaviour and power that tilted towards men as primary heads and women as secondary. The study hypothesized that since the scourge of Ebola has potential of disrupting economic activities, reduced human capital (by loss of active hours of work, loss of lives, and declining labour productivity, the outbreaks could have far reaching effect in a region where men are the predominant workforce, and economic mainstay. This effect could transcend the immediate family and entrenched to all spheres of life including the region as a whole.

The history of Ebola in Nigeria started in July 2014 when a migrant (Liberian finance ministry official Patrick Sawyer) died of the disease in Lagos few days after his arrival. Few cases that were later discovered especially among the individuals who had contact with the victim were pragmatically curtailed. Today, Nigeria has been given a clean slate by the World Health Organization but there is no declaration by the body that the disease cannot resurface if certain precautionary measures are not put in place.

Generally, infectious diseases caused more than 300 million illnesses and over five million deaths each year worldwide and more than 31% of deaths in developing countries are caused by communicable diseases (WHO, 2014a). The burden of communicable diseases in developing nations was unacceptably high before being encumbered by evolution of Ebola infection. While the current proportional mortality in percentage of total deaths for all ages due to communicable diseases are 51%, 48%, 46% and 66% for Ghana, South Africa, Afghanistan and Nigeria respectively, the rates are as low as 5%, 4% and 6% in Canada, Italy and France respectively (Young, Critchley, Johnstone & Unwin, 2010; WHO, 2014b). These premature deaths are largely preventable by adopting simple measures which reduce risk factors for communicable diseases and enable response from health systems. The global Years of Life Lost (YLL) due to communicable diseases is as high as 69% (WHO, 2010) and more than 80% of this occurred in developing countries including Nigeria. The pre-Ebola era shows that Nigeria government expenditure on health ranges between 4.6% and 9.0% of her gross domestic product, while the private expenditure on health was as high as 60% and above (Organisation for Economic Co-operation and Development (OECD), 2010; World Health Organisation, 2014; Dye, 2014; Maiyaki & Garbati, 2014). Total per capita expenditure on health as at 2013 was estimated at \$217 (WHO, 2015b). In addition to the domestic expenditure, the development assistance on health from 2000 and 2010 from donor countries is more than \$27 billion (Maiyaki & Garbati, 2014; Murray, Anderson, Burstein, Leach Kemon, Schneider, Tardif & Zhang, 2011; Dye, Mertens, Hirschall, Mpanju Sumbusho, Newman, Ravigliione, Savioli & Nakatani, 2013). These proportions must have heightened with the emergent of EVD as addition diseases without notable decline in the existing prevalent rate of other communicable diseases.

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There have been numerous initiatives geared toward to curb and prevention of the spread of pandemic diseases, especially at it relates to Ebola in Nigeria and sub-Saharan Africa in general. Prominent among the are the The West Africa Regional Centre for Surveillance and Disease Control (RCSDC) that operates within the confine of West Africa Health Organisation (WAHO) and the Africa Centres for Disease Control (Jhekweazu & Abubakar, 2017). The centre was primarily and it is concerned with activities to curb EVD. There were also emerging campaigns on hygiene practices by from the Ministry of Health (MoH) and other organisations (Shuaib, Gunnala, et al., 2014; Otu, Ameh et al., 2018). Despite, EVD has still infected large number of people that include mortality cases (Readon, 2014), including economic burden of relatively \$53.19 billions only in three countries (namely, Guinea, Liberia and Sierra Leone (Huber, et al., 2018)).

infected over 20000 human population between 2014 and 2016 only and out of which almost 11000 mortality were recorded (—). However

In reality, the success of most of these health programmes or campaigns especially in sub-Saharan Africa is contingent upon community and family disposition, environment, especially the roles of the decision taker such as the father, men in the family or community heads (Amoo, 2018, 2017, 2017). Besides, hygiene practices remains one of the uncontrollable effective prevention methods against pandemic diseases, however, there are relatively little data on the level of hygiene practices against the pandemic not only at the community level but crucially among the men who as the supposedly head, the breadwinner of the household and most community leader.

Specifically, in this part of the world, access to health care (or treatment) is controlled by males and the permission of the male household head (Anker & World Health Organization, 2007). It is therefore pertinent to provide answers to certain boggling questions: What are the levels of knowledge and practices of men in respect of Ebola disease? What are the levels of men's preparedness to curtail or prevent its spread? Specifically, what would be the role of men towards Ebola in Nigeria? The understanding the levels of knowledge and practices of men in respect of Ebola disease is apt for development of policies and programs to curtail Ebola and other epidemic prone infectious diseases in Nigeria and by extension, other countries in sub-Saharan Africa.

2. Materials and Methods

2.1. Research Design

The data were extracted from a 2015 Cross-Sectional Survey on wellness, knowledge, attitude and practices towards the control and prevention of Ebola Virus Disease. The sample locations were drawn from two local governments areas (LGA) randomly picked from Lagos and Ogun States (two states out of the 6 states in the South West geo-political zones of Nigeria. Each LGA is sub-divided into wards and the wards further divided into enumeration areas (EAs). The participants were drawn from the EAs. While Lagos is Africa's largest city, the commercial nerve center of Nigeria and a major transit hub with air and sea ports of entry for Nigeria, Ogun state is an adjoining state with also a major transit hub by road for the southwest geopolitical zone in Nigeria (Aliyu & Amadu, 2017). The dense population and overburdened infrastructure in Lagos metropolis which has created inflow of population to adjoining communities that are located in Ogun state could easily produce environment where diseases can be easily transmitted and transmission sustained (Shuaib, Gunnala, 2014, Otu, Ameh, 2018). Overall, 1093 respondents were interviewed out of which only 416 male data were extracted and analysed for this study. Although, the best data referenced could be dataset from authorities such as MEASURE-DHS (Harkare, Corsi, Kim, Vollmer & Subramanian, 2021); (e.g. World Health Organisation data WHO, UNICEF, ActionAids, MEASURE-DHS, and so on to mention but few) but the use of different strategic assessment methodologies to capture indicators of vulnera-

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bility to dangerous epidemic-prone infectious diseases like Ebola cannot be overemphasized (Harkare, Corsi, Kim, Vollmer & Subramanian, 2021). It is also noted considering the massive number of lives that the disease could affect, using diverse means research approaches that follow basic research ethics should be encouraged. Thus, the dataset is regarded as apposite and timely as a strategic rapid response towards eradication of epidemic-prone infectious diseases through male-gender approach. In addition, the psychometric evaluation of questionnaire revealed satisfactory internal reliability with Cronbach's Alpha above 0.6 for the components selected and the Test-retest reliability was found to be good, with all correlations above between 5.0 and 6.7.

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2.2. Participants and data analysis procedure

In the survey, two local government areas each from the two states were randomly selected for the study. Each Local Government Area is sub-divided into wards and the ward further divided into enumeration areas. One rural and one urban enumeration were purposively selected. Respondents were selected using simple random sampling technique within two enumeration areas (EAs) that were randomly picked with each representing urban and rural areas. An enumeration area is by the way and are denoted as EAs representing an operational geographic areas for the collection, collation and dissemination of census data (Al Zakak & Goujon, 2017; National Population Commission [NPC] & ICF Macro, 2019, 2009). These enumeration areas are often used as a national sampling frame for various types of surveys and censuses (NPC, 2019). Respondents were selected using simple random sampling technique within two enumeration areas (EAs) that were randomly picked with each representing urban and rural areas.

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Using the same approach, Similarly the households were chosen using the same random pattern and only one male respondent in the family was interviewed. The research instruments and procedure were duly approved by the sponsoring institution ethical board—Covenant University Centre for Research, Innovation and Discovery (Ref: CUCRID-RG 008-11-14/FS 2014/2015).

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Data analysis procedures

Data were analysed using only both descriptive and inferential analytical techniques. Specifically, a three level of statistical analysis procedure was undertaken, namely univariate, bivariate and multivariate analysis. The univariate profiled the basic characteristics of the respondents and other individual variables of interest. The bivariate was employed to compute cross-tabulation between the identified changes in behavioural practices during and after the outbreak. The logistic regression employed at the multivariate level, tested the model formulated on the responsiveness of susceptibility of respondents to EVD with respect to changes in certain hygienic practices, and the results presented in Charts and table in order to present real life observations to the general society without much statistical assumptions or inferences.

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3. Results

3.1. Background information of the Respondents

Background variables selected include gender, age distribution, usual place of residence, educational attainment, resident status and marital status. These were analysed according to the locations of study.

The proportion of men is 44.6% against the women data of 55.4%. The proportion is relatively the same between the two states. The rural/urban dichotomy reflected 47.6% (rural) and 52.4% (urban) for the total population but 51:49 and approximately 44 vs 56 in Lagos and Ogun state respectively as shown in Table 1. The unmarried in the two states were 31.9% (Lagos) and 36.4% (Ogun) and about 34% as the total percentage

for the two states. Secondary education is the highest in terms of school enrolment of the communities. The proportion without formal education is lower (4.2%) in Lagos state compared with Ogun State (9.4%) as shown in Table 1. Overall, while individuals without formal education is 6.9%, primary education is 12.1, more than half of the respondents have attained secondary education, while those with tertiary education are only 24.8% for the states.

One out of every four respondents is trading one form of business and the others. The proportion is 40.3% (Lagos state) and 46.6% (Ogun state). The proportion of individuals that are civil servants or professionals in Lagos (34.7%) is relatively higher than that of Ogun state (31.2%) as highlighted in Table 1. The question on the residency identified that 95.1% and 91.9% of the targeted population are residents of the study areas while only 4.9% and 8.1% in Lagos and Ogun states, respectively are persons who moved into the locations of study from another countries. They were capture if they have been in country for over 6 months.

The gender classification shows that 55.8% are female while the male represents 44.2% of the total respondents. The estimated mean age is 34.5 years. Further statistics on age distribution indicated that 17.8% are below 25 years of age distributed into 15–19 years (6.1%) and 20–24 years (11.7%). Highest proportions are in the age group above 34 years (43%), 20.7% of the respondents belongs to age group 25–29 while 18.5% are in age group 30–34 years. The urban/rural resident is in the ratio of 53:47. While 67% were married as at the time of the survey, the never married constituted 29% and the widowed, separated and divorced shared only 4% of the total sample. Almost 7% of the respondents interviewed were from other countries especially from the neighbouring countries such as Benin Republic, Niger and Cameroon. Non Nigerians were included because of the nature of the study and trans-national impact of the disease concerned. —

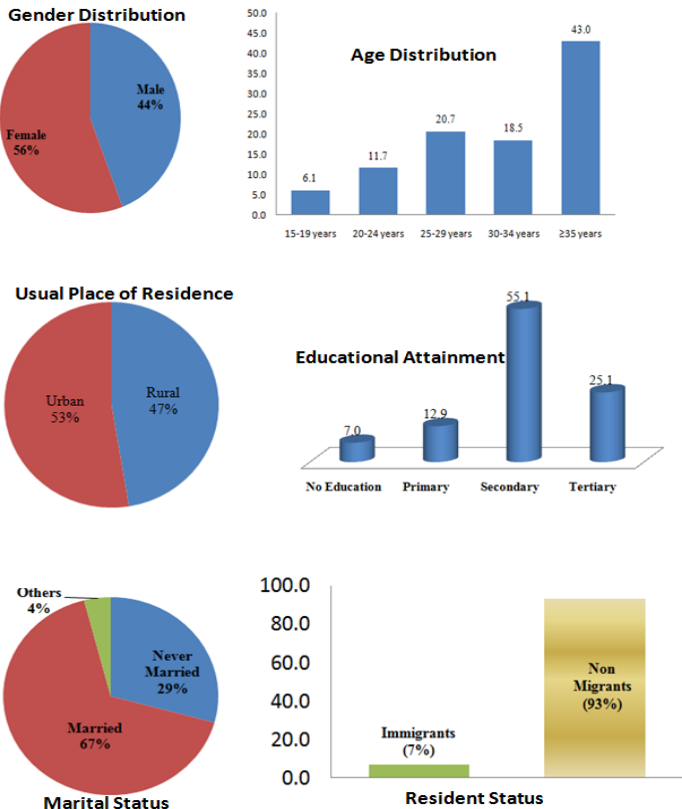


Figure 1. Background information about the respondents.

Education characteristic revealed that almost three quarters of the respondents had secondary education and below: Primary (12.9%) and Secondary (55.1%). The proportion without education is 7% while and 25.1% had Tertiary education. Higher proportions of the respondents are traders (43.1%), skilled artisans (22.9%) and full time housewives or unemployed (21.0%). The civil servant constituted only 8.2%, population in farming business are 2.1% while the unskilled represents 2.7% of the total sample.

| Table 1: Demographic profile of Respondents | | | | | | |
|---|---------------|------|----------------|------|-------|------|
| Selected demographic characteristics | Lagos (N=452) | | Ogun (N = 481) | | Total | % |
| | Frequency | % | Frequency | % | | |
| Gender | | | | | | |
| Male | 204 | 45.1 | 212 | 44.1 | 416 | 44.6 |
| Female | 248 | 54.9 | 269 | 55.9 | 517 | 55.4 |
| Marital status | | | | | | |
| Married | 308 | 68.1 | 306 | 63.6 | 614 | 65.8 |
| Unmarried | 144 | 31.9 | 175 | 36.4 | 319 | 34.2 |
| Place of residence | | | | | | |

| | | | | | | |
|--|-------------------|---------------------|-------------------|---------------------|-------------------|---------------------|
| <u>Rural</u> | <u>231</u> | <u>51.1</u> | <u>213</u> | <u>44.3</u> | <u>444</u> | <u>47.6</u> |
| <u>Urban</u> | <u>221</u> | <u>48.9</u> | <u>268</u> | <u>55.7</u> | <u>489</u> | <u>52.4</u> |
| <u>Education attainment</u> | | | | | | |
| <u>No Education</u> | <u>19</u> | <u>4.2</u> | <u>45</u> | <u>9.4</u> | <u>64</u> | <u>6.9</u> |
| <u>Primary</u> | <u>34</u> | <u>7.5</u> | <u>79</u> | <u>16.4</u> | <u>113</u> | <u>12.1</u> |
| <u>Secondary</u> | <u>280</u> | <u>61.9</u> | <u>245</u> | <u>50.9</u> | <u>525</u> | <u>56.3</u> |
| <u>Tertiary</u> | <u>119</u> | <u>26.3</u> | <u>112</u> | <u>23.3</u> | <u>231</u> | <u>24.8</u> |
| <u>Occupation distribution</u> | | | | | | |
| <u>Trading</u> | <u>182</u> | <u>40.3</u> | <u>224</u> | <u>46.6</u> | <u>406</u> | <u>43.5</u> |
| <u>Skilled Artisan</u> | <u>113</u> | <u>25.0</u> | <u>107</u> | <u>22.2</u> | <u>220</u> | <u>23.6</u> |
| <u>Others (Civil servants, professionals, etc)</u> | <u>157</u> | <u>34.7</u> | <u>150</u> | <u>31.2</u> | <u>307</u> | <u>32.9</u> |
| <u>Migration status</u> | | | | | | |
| <u>In-Migrant</u> | <u>22</u> | <u>4.9</u> | <u>39</u> | <u>8.1</u> | <u>61</u> | <u>6.5</u> |
| <u>Native</u> | <u>430</u> | <u>95.1</u> | <u>442</u> | <u>91.9</u> | <u>872</u> | <u>93.5</u> |
| <u>Total</u> | <u>452</u> | <u>100.0</u> | <u>481</u> | <u>100.0</u> | <u>933</u> | <u>100.0</u> |
| Source: Authors computation from 2015 fieldwork | | | | | | |

~~3.2. Knowledge, Attitude and Practices in both Pre and Post EVD Outbreak~~

Table 2. Knowledge and Attitude on Ebola Virus Disease (EVD)

The respondents knowledge in terms the fact and information they have on Ebola disease, including its transmission and the skills they have in the prevention of the spread or control. Various indicators used include ever heard about EVD, respondent's level of information possess on EVD, belief, ability to recognize signs and symptoms of EVD, information about the EVD treatment centers, the specific hygiene practice, perception of respondents on hand washing, handling of corpses and susceptibility of respondents to EVD.

The analysis revealed overwhelming level of awareness with 92.8%, 94% level of awareness in Lagos and Ogun state, respectively. Relatively the level of non-awareness is 1.2% higher in Lagos than Ogun state. The rating of awareness level recorded higher level for Lagos (very much, 23.5%, moderately as 36.3% and individuals with little knowledge constituted up to 36.3%. Similar ratings was also recorded for Ogun state with 20.7%, 24.4% and, 49.8% for total respondents with very much knowledge, moderately and little knowledge on EVD, respectively.

Relatively, overwhelming proportion of the respondents believed that EVD existed. While the proportion is relatively the same in both countries, the proportion is higher by 1.1% in Ogun state compared to the rate in Lagos state. Notwithstanding that the understanding of signs and symptoms of EVD is higher for both countries, 11.1% (Ogun state) and 3.5% (Lagos state) indicated that don't know how identify of signs and symptoms of EVD.

However, despite the high level of awareness and the belief of EVD existence, only 40.2% and 24% of the respondents are aware of any quarantine or treatment centre in Lagos and Ogun respectively. Basic hygiene

practices identified are hand washing but in various dimensions which include: washing hands with soap, washing hands with water only, washing hand with salt and washing hands with water and sanitiser. Proportion that are not practice handwashing is higher in Lagos (15.4%) compared to 12.9% in Ogun state. Washing with water only is higher in Ogun state (35.6%) compared to Lagos (23.4%) while hand wash with soap is higher in Lagos (15.4%) compared with 8.3% in Ogun state. The use of sanitiser is low and more reduced by 1.2% for Ogun state than Lagos state. Further filtering questions used in the study showed that 29.7% of the respondents from Lagos disagreed with the question whether someone who handles or touches corpse can contract EVD. The statistic is 27.8% for Ogun State (see Table 2). The result also revealed that relatively one in three respondents hold the view that handling of corpse is not related to possibility of being infected with EVD. The proportions that answer Yes or No to the question: Do you think you are susceptible to contract EVD are 61.9% and 60.6% in both Lagos and Ogun, respectively (Table 2).

The selected indicators of knowledge, attitude and practices are considered essential in understanding the preparedness of the community against the spread of communicable diseases the result revealed that virtually everyone has heard about Ebola Virus in the studied locations. It is widely believed that the disease is real and over 90% were able to mention one or more symptoms of EVD. Apart from hospital where relatively 94.5% of the respondents indicated as the place for treatment, 70% are not sure of any other place where suspected victim could be referred to (Table 2Table 1). While more than half of the respondents indicated that they have good knowledge of EVD, further filtering questions used showed that 28% disagreed with the question can someone who handles or touches corpse contract EVD. About 67.5% affirmed positive while 4.5% were not sure (Table 2Table 1). Similarly, while 81.2% indicated that food cooked might not be safe for eating, 18.8% of the subject believed that they cannot contract EVD through cooked food as shown in Table 2.

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| Table 2. Knowledge and Attitude on Ebola Virus Disease (EVD) | | | | |
|---|------------------------|--------------|-----------------------|--------------|
| Selected indicators of knowledge and Attitude | Lagos (N = 452) | | Ogun (N = 481) | |
| Ever Heard about Ebola Virus Disease | Number | % | Number | % |
| Yes | 411 | 92.8 | 438 | 94.0 |
| No | 32 | 7.2 | 28 | 6.0 |
| Total | 443.0 | 100.0 | 466.0 | 100.0 |
| Level of Knowledge | | | | |
| Very Much | 104 | 23.5 | 97 | 20.7 |
| Moderately | 161 | 36.3 | 114 | 24.4 |
| Very Little | 161 | 36.3 | 233 | 49.8 |
| Not at all | 17 | 3.8 | 24 | 5.1 |
| Total | 443 | 100.0 | 468 | 100.0 |
| Believe that EVD existed | | | | |
| Yes | 388 | 87.2 | 407 | 88.3 |
| No | 57 | 12.8 | 54 | 11.7 |
| Total | 445 | 100 | 461 | 100 |
| Know the signs and symptoms of EVD | | | | |
| Yes | 383 | 96.5 | 343 | 88.9 |
| No | 14 | 3.5 | 43 | 11.1 |

| | | | | |
|---|------------|--------------|------------|--------------|
| Total | 397 | 100 | 386 | 100 |
| Know EVD treatment centre | | | | |
| Yes | 181 | 40.2 | 115 | 24.0 |
| No | 269 | 59.8 | 365 | 76.0 |
| Total | 450 | 100 | 480 | 100 |
| Washed Hands the last time you used Toilet | | | | |
| Not at all | 69 | 15.4 | 62 | 12.9 |
| With water only | 105 | 23.4 | 171 | 35.6 |
| With water and salt | 165 | 36.7 | 169 | 35.1 |
| With water and soap | 69 | 15.4 | 40 | 8.3 |
| With sanitizer | 41 | 9.1 | 37 | 7.7 |
| Total | 452 | 100 | 479 | 100.0 |
| Who handles the corpse can contract EVD | | | | |
| Yes | 303 | 70.3 | 322 | 72.2 |
| No | 128 | 29.7 | 124 | 27.8 |
| Total | 431 | 100 | 446 | 100 |
| Think you are susceptible to contracting EVD | | | | |
| Yes | 276 | 61.9 | 289 | 60.6 |
| No | 120 | 26.9 | 141 | 29.6 |
| Total | 446 | 100.0 | 477 | 100.0 |

The proportions that answer Yes or No to the question: Do you think you are susceptible to contract EVD are 60.2% and 39.8% respectively. Further information on knowledge revealed that 14.9% of the respondents did not washed or cleaned their hands the last time they used toilet, 28.1% washed their hand with water only, 50.2% used water and salt and only 6.8% indicated they used sanitizer the last time they visited toilet (Table 2).

3.2. Knowledge, Attitude and Practices in both Pre- and Post EVD Outbreak

The analysis on practices before and after Ebola outbreak revealed that some changes have taken place over few practices out of selected indicators investigated. The practice of handshaking reduced from 58.5% to 30.9% with a buffer on refusal to practices handshake which increase from 18.7% to 32.9%. Also, while it can be reported that changed occurred in the practice of hand-washing, the practice increased from 9.4% to 20.9% among the respondents. However, in terms of hand-washing with soap, only 4% change was observed. Specifically, from relatively 12.3% of the sample that used to wash hand with soap to only 16.3% as at the time of the survey.

In terms of the use of toilet and hand-washing, only a marginal 1% changed was recorded in washing hand with ordinary water after using toilet while the use of soap and water in washing hand increased from 54.2% to 59.9% (an increase change of 5.7%) as shown in Table 3. Regular washing hand with soap shows a change from 41.4% to 46.4 (5% change). Observation on the use of sanitizer revealed overall percentage change of only 3% (Table 3). Those who use hand sanitizer after handshake or people's contact increased from 7.6% to 10.8%, individuals who use sanitizer after using toilet increased from 10.4% to 14.1, the proportion who use sanitizer ordinarily to clean hands increased

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to 10.8% from 6.9% (Table 3).— However, the proportion that eats hunted animals decreased marginally by 6.9% (from 26.1% to 19.1) in the period before Ebola outbreak and post Ebola outbreak (Table 3).

Table 2. Knowledge and Attitude on EVD.

| Ever Heard about Ebola Virus Disease | Frequency | % | Level of Knowledge | Frequency | % |
|---|-----------|-------|---|-----------|-------|
| Yes | 974 | 89.1 | Very Much | 240 | 22.6 |
| No | 67 | 6.1 | Moderately | 320 | 30.2 |
| Total | 1041 | 95.2 | Very Little | 447 | 42.2 |
| Q21 Believe EVD exist | | | Not at all | 53 | 5.0 |
| Yes | 921 | 87.0 | Total | 1060 | 100.0 |
| No | 138 | 13.0 | | | |
| Total | 1059 | 100.0 | | | |
| Knows signs and symptoms of Ebola Virus Disease | | | Washed/Cleaned Hands the last time you used Toilet | | |
| Yes | 832 | 92.0 | Not at all | 161 | 14.9 |
| No | 72 | 8.0 | With water only | 304 | 28.1 |
| Total | 904 | 100.0 | With water and salt | 544 | 50.2 |
| Knowledge of EVD treatment Location | | | With sanitizer | 74 | 6.8 |
| Hospital | 1022 | 94.5 | Total | 1083 | 100 |
| Church /Mosque | 7 | 0.6 | Can Someone who handles corpse contract EVD? | | |
| Herbalist | 11 | 1.0 | Yes | 722 | 67.5 |
| An isolated place | 28 | 2.6 | No | 299 | 28 |
| Others | 13 | 1.2 | Don't Know | 48 | 4.5 |
| Total | 1081 | 100.0 | Total | 1069 | 100 |
| Know any community centre for EVD Treatment | | | Whether food cooked is safe for eating | | |
| Yes | 351 | 32.4 | Yes | 203 | 18.8 |
| No | 731 | 67.6 | No | 875 | 81.2 |
| Total | 1082 | 100.0 | Total | 1078 | 100 |
| Q89 Do you think you are susceptible to contracting EVD | | | Maintaining clean environment/personal hygiene help reduces EVD | | |
| Yes | 643 | 60.2 | Yes | 1020 | 95.3 |
| No | 425 | 39.8 | No | 50 | 4.6 |
| Total | 1068 | 100.0 | Total | 1070 | 100 |

Source: Field Survey 2015

The figure and names have been drawn to examine the practices before and after the incidence of Ebola

Table 3. Practices before Ebola and After Ebola incidence

| Before EVD Outbreak | After EVD Outbreak |
|---------------------|--------------------|
|---------------------|--------------------|

| | Always | Sometimes | Not at all | Always | Sometimes | Not at all |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Practiced handshake/hugging | 58.5 | 22.9 | 18.7 | 30.9 | 36.1 | 32.9 |
| Washing hand with water | 9.4 | 19.2 | 71.4 | 15.5 | 30.5 | 54 |
| Washing hand with water and soap | 12.3 | 20.3 | 67.4 | 16.3 | 32.3 | 51.4 |
| Wash your hand with only water after using the toilet | 43.9 | 36.6 | 19.5 | 44.9 | 36.8 | 18.3 |
| Washing hand with water and soap after using the toilet | 54.2 | 38.3 | 7.5 | 59.9 | 35.7 | 4.4 |
| Washing hand with water only when I feel they are dirty | 32.2 | 48.6 | 19.3 | 34.1 | 46.4 | 19.6 |
| Washing hand with water and soap when I feel they are dirty | 41.4 | 46 | 12.6 | 46.4 | 43.1 | 10.5 |
| Use Sanitizer after hand shake/direct contact with people | 7.6 | 11.5 | 80.9 | 10.8 | 22.5 | 66.7 |
| Use hand sanitizer after using the toilet | 10.4 | 13.8 | 75.8 | 14.1 | 19.9 | 66.0 |
| Use hand sanitizer when I feel my hands are dirty | 6.9 | 11.7 | 81.3 | 10.8 | 20.5 | 68.7 |
| Handling or eating hunted wild animals | 26.1 | 31.2 | 42.7 | 19.2 | 27.0 | 53.8 |
| Source: Field Survey 2015 | | | | | | |

[The hypothesis formulated illustrate respondent's susceptibleness to EVD with respect to some practices using a binary logistic regression](#)

4. Discussion

Knowledge, attitude, practices and environment are crucial in the analysis, understanding and safeguarding the spread of communicable diseases (Duse, 2019; Setia, Gambhir, Kapoor, Jindal, Garg & Setia, 2013). The study therefore provided a quicker way of responding to epidemic-prone infectious diseases challenges especially by giving oversight into what is needful in curtailing its spread. The result of the analysis generated general traditional quantitative information on community activities that may be more prone to rapid spreading of communicable diseases. Thus, the time was brief, notwithstanding that the coverage was wide and the results are presented with statistical simplicity.

At the multivariate level, the model formulated tested the responsiveness of susceptibility of respondents to EVD with respect to changes in certain hygienic practices. As earlier indicated, the dependent variable is the perception of self-susceptibility to EVD, captured as susceptibility =1, no susceptibility =0. The test technique employed is binary logistic and the independent variables are the identified different hygienic practices by the respondents. The results are presented in Table 5. The result revealed that those who practice handshaking or hugging sometimes or not at all are 0.566, and 0.624 (respectively) less likely to be susceptible to EVD compared to those who always observed the practice. The statistics specifically reflected odds ratio (OR) = 0.566, 95%CI (0.40-0.81), and OR = 0.624, 95%CI 0.43-0.90, respectively, and with correlation coefficients (r) = -0.569 and -0.472, respectively also. The practice of using water and soap to wash hand sometimes have negative likelihood of susceptibility to EVD. The correlation coefficient (r) shows -0.165, and odd ration and confidence level (OR=0.848, 95%CI 0.49-1.48). However, those who do not was hand with water and soap are more 1.353 times more likely to be susceptible to EVD (OR=1.353, 95%CI 0.84-2.18).

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Those who sometimes wash their hands with soap after using toilet are less likely to be susceptible to EVD with ($r = -0.022$), while the odds ratio shows less likelihood ($OR = 0.99$, 95%CI 0.47-2.06) against those that avoid such practice with ($r = 0.589$; $OR = 1.80$, CI 2.89-3.64) as shown in Table 5. Those that use sanitizer sometimes are less likely to be vulnerable to EVD ($OR = 0.86$, 95%CI 0.52-1.42), the correlation statistics shows ($r = -0.151$). Those who do not use sanitizer would however be more 1.183 times more likely to be vulnerable to EVD ($OR = 1.183$, 95%CI 0.66-2.12), the correlation coefficient reveals $r = 0.168$, implying a positive association between those would not use sanitizer and susceptibility to epidemic. A similar test was also performed on the practice of using sanitizer whenever the hands are dirty. The analysis shows that this practice is negatively related ($r = -0.050$) to susceptibility to diseases. The supported evidences indicated ($OR = 0.951$, 95%CI 0.56-1.61). Those who do not observe this practice are however more likely to be exposed to epidemic disease ($OR = 1.445$, 95%CI 0.77-2.72), the correlation coefficient is positive ($r = 0.368$). The result of the analysis on the handling or contact with bush meat or animals reflects a mix result. While there are negative correlations ($r = -0.235$) with susceptibility to disease ($OR = 0.791$, 95%CI 0.44-1.41), indicating less likelihood of being susceptible to epidemic. The analysis also brought out a negative correlation ($r = -0.13$) and the odds ratio suggesting less probability of experiencing epidemic if such respondents are not in contact with animals ($OR = 0.987$, 95%CI 0.70-1.39).

Binary logistic regression illustrating respondent's susceptibleness to EVD with respect to some practices

| Selected practices | | | | |
|--------------------|------------------|---------------|--------------|------------------|
| Always | | | | |
| Sometimes | \blacktriangle | <u>-.569</u> | <u>.002</u> | <u>.566</u> |
| Not at all | | <u>-.472</u> | <u>.011</u> | <u>.624</u> |
| Always | | | | <u>0.40-0.81</u> |
| Always | | | | |
| Sometimes | \blacktriangle | <u>-.165</u> | <u>.563</u> | <u>.848</u> |
| Not at all | | <u>.302</u> | <u>.214</u> | <u>1.353</u> |
| Always | | | | <u>0.49-1.48</u> |
| Sometimes | \blacktriangle | <u>-.022</u> | <u>.955</u> | <u>.979</u> |
| Not at all | | <u>.589</u> | <u>.101</u> | <u>1.802</u> |
| Always | | | | <u>0.47-2.06</u> |
| Always | | | | |
| Sometimes | \blacktriangle | <u>-1.065</u> | <u>.000</u> | <u>.345</u> |
| Not at all | | <u>.247</u> | <u>.338</u> | <u>1.280</u> |
| Always | | | | <u>0.20-0.58</u> |
| Sometimes | \blacktriangle | <u>-.151</u> | <u>.558</u> | <u>.860</u> |
| Not at all | | <u>.168</u> | <u>.573</u> | <u>1.183</u> |
| Always | | | | <u>0.77-2.12</u> |
| Sometimes | \blacktriangle | <u>-.023</u> | <u>.931</u> | <u>.977</u> |
| Not at all | | <u>.080</u> | <u>.779</u> | <u>1.083</u> |
| Always | | | | <u>0.57-1.66</u> |
| Sometimes | \blacktriangle | <u>-.050</u> | <u>.853</u> | <u>.951</u> |
| Not at all | | <u>.368</u> | <u>.254</u> | <u>1.445</u> |
| Always | | | | <u>0.56-1.61</u> |
| Sometimes | \blacktriangle | <u>-0.235</u> | <u>0.427</u> | <u>0.791</u> |
| Not at all | | | | <u>0.44-1.41</u> |

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| | | | | | |
|---|-------------------|--------------|---|--------------|------------------|
| | <u>Not at all</u> | <u>-.013</u> | <u>.940</u> | <u>.987</u> | <u>0.70-1.39</u> |
| | <u>Constant</u> | <u>1.559</u> | <u>.000</u> | <u>4.756</u> | |
| <hr/> | | | | | |
| <u>-2 Log likelihood = 1162.417^a</u> | | | <u>Cox & Snell R Square = 0.091</u> | | |
| | | | <u>Nagelkerke R Square = 0.123</u> | | |
| <hr/> | | | | | |
| <u>Source: 2015 Community attitude, knowledge and practices Survey on Ebola virus disease</u> | | | | | |
| <hr/> | | | | | |

Preliminary literature indicated that the outbreak of epidemic has been a consistent challenge of developing countries. Notwithstanding that sub-Saharan Africa is endowed with resources (human and natural minerals deposits), the region suffers great losses due to diseases and their management. In 2006 alone, almost 63% the population infected with HIV worldwide resided in sub-Saharan Africa in addition to the huge death rate caused by HIV and other communicable infections (Young, Critchley, Johnstone & Unwin, 2010). While Ebola prevalence has been currently halted (Healthcare Magazine, 2015), guiding against the spread by monitoring of suspected indicators is important. While the immigrants were not probed for their residential or migration details, the existing lapses at various borders of developing nations and more especially in relation to inter-land and massive expanse of Saharan desert that links countries together suggest that the prevalence of immigrants in the locations of study could be dangerous (Akinyemi, 2013). The point is more relevant when one considers unabated ravage of the diseases in neighbouring countries of Guinea, Liberia and Sierra Leone (WHO, 2015). The role of men as the head in the community seems indispensable. Men play oversea role on their families' health and wellbeing (Amoo, 2017, 2017, 2018), hence the analysis of their perception is highly relevant to combating the disease. It is also very vital in relation to lack of infection control measures at various borders and especially due the nature of Ebola and its trans-national impacts. The high proportion of respondents (75%) who have no or lower level of education also suggests how far any intervention can succeed. Similar observations were made on the occupation distribution where larger number are unemployed, full time housewives and unskilled artisans.

The most important way to reduce the spread of infections is hand washing. Washing hands with soap and running water is best practice because of the removal action of soap and water on transient microorganisms (WHO, 2014). Also important is to get a vaccine for those infections and viruses that have one, when available and consistent environmental sanitation exercises (Altaf & Atangana; Duse, 2019). However, only little changes were observed in the practice of hand-washing especially with soap in the communities studied. The usage of sanitiser is also not encouraging. While this could be due to low socio-economic status among the respondents such as low educational level and peasant occupation, proper understanding of the burden of infection might enhance a change in such attitude.

The knowledge of respondents on EVD symptoms and referral information indicated that little information on Ebola treatment centres are not available taking into cognisance over 90% that believe their hospital is the best place to go if EVD strikes. It is obvious that majority of the respondents may not know that the disease requires specialized centres for such infection. The observation also suggests that the facility may be completely unavailable. The knowledge on location of health facilities is vital when assessing the risk of a potential public health emergency. It indicates the possibility of rapid health seeking behaviour (Amoo, 2018; Garrett, 2015; Siedner, Gostin, Cranmer & Kraemer, 2015). Specifically, respondents' knowledge of the community people about infectious is very vital

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in the management and control of disease outbreak. Notwithstanding any breakthrough in vaccines or campaign to sensitise the residents it is important that they should know of what to do and what not to do for enduring prevention. Considering the observed low knowledge and relatively little changes in certain practices, much is still required on public enlightenment concerning the disease.

Table 3. Practices before Ebola and After Ebola.

| Practices | Before EVD Outbreak | | | After EVD Outbreak | | |
|---|---------------------|-----------|------------|--------------------|-----------|------------|
| | Always | Sometimes | Not at all | Always | Sometimes | Not at all |
| Practiced handshake/hugging | 58.5 | 22.9 | 18.7 | 30.9 | 36.1 | 32.9 |
| Washing hand with water | 9.4 | 19.2 | 71.4 | 15.5 | 30.5 | 54 |
| Washing hand with water and soap | 12.3 | 20.3 | 67.4 | 16.3 | 32.3 | 51.4 |
| Wash your hand with only water after using the toilet | 43.9 | 36.6 | 19.5 | 44.9 | 36.8 | 18.3 |
| Washing hand with water and soap after using the toilet | 54.2 | 38.3 | 7.5 | 59.9 | 35.7 | 4.4 |
| Washing hand with water only when I feel they are dirty | 32.2 | 48.6 | 19.3 | 34.1 | 46.4 | 19.6 |
| Washing hand with water and soap when I feel they are dirty | 41.4 | 46 | 12.6 | 46.4 | 43.1 | 10.5 |
| Use Sanitizer after hand shake/direct contact with people | 7.6 | 11.5 | 80.9 | 10.8 | 22.5 | 66.7 |
| Use hand sanitizer after using the toilet | 10.4 | 13.8 | 75.8 | 14.1 | 19.9 | 66.0 |
| Use hand sanitizer when I feel my hands are dirty | 6.9 | 11.7 | 81.3 | 10.8 | 20.5 | 68.7 |
| Handling or eating hunted wild animals | 26.1 | 31.2 | 42.7 | 19.2 | 27.0 | 53.8 |

Source: Field Survey 2015

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5. Conclusion and recommendations

The study provides helpful information for public health policy intervention especially in terms of behavioral risk factors that can make the community dwellers less susceptible to Ebola virus infections and other communicable diseases. It specifically represents a baseline study that can guide in social mobilization strategies and activities towards reduction of the spread of EVD. Given the hundreds of travelers that travel to, from Nigeria to neighbouring countries through roads and paths, crowded nature of various communities, unsanitized environment practices, sharing of toilets and open dump sites, appropriate guidance is necessary for effective intervention by governments and other stakeholders on how to reduce the risk of transmitting infections that are possibly spread through contact with body fluids or contaminated surfaces.

The study emphasised regular hand washing with soap and the use of sanitising agents that could be helpful in preventing the occurrence or re-occurrence of pandemic. It also highlighted that importance of availability of responsive treatment centers. The protocols identified in this study could be relevant to both medical personnel and the community for adoption especially as the unlikelihood of pandemic re-emergence have not been established. Also, the report from this study would also be interesting and beneficial to scientific community especially in the relevance of not just handwashing but sustained handwashing with soap.

The study emphasises on regular hand washing with soap and sanitizing agents are crucial forms of hygienic practices against general infections transmittable through body contact. While affordable drugs and vaccines could be developed, precautions through basic hygiene and health seeking attitude would reduce EVD spread and other diseases of its kind. It is also recommended that availability of treatment centres and vaccines are fundamental to effective response and in curtailing health emergencies.

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Conflicts of Interest: The authors declare no conflict of interest.

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