Knowledge and Attitude of Indigenous People towards COVID-19 Pandemic in Ebonyi State, Southeastern, Nigeria

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Abstract **Objective:** The COVID-19 pandemic came like a storm that shook the whole world. The response of many government was lockdown and restriction in movement. But in most rural communities information on the actual reasons for the lockdown were scanty. Many were rather curios as their markets, schools, transportation and social lives were disrupted by the government without adquate enlightment. This study was done to asses the level of knowledge and attitude of the indigenous rural dwellers in Ebonyi State towards the COVID-19 pandemic. **Methods:** Descriptive statistics was adopted to asses the knowledge and attitude of the rural dwellers towards COVID-19. One community each from the three senatorial zone were selected. Out of 150 respondents, 86% are men and 64% are women. Structured questionaire were administered directly to responders after due explanation. The questionnaire was completed and given back to the researcher. **Result -** Three communities were covered for the 150 respondents, 58% of the respondents are in the age group of 20-35 years, 30% are in the age group of 36-55 years, only 12 % is from the age group of above 56- and above years. Awareness- Only 40.3% of the respondents are aware of the Corona Virus disease. 36% of the respondents are heard from radio, 37% of them heard from friends, 35.5% heard from government agency, 48% heard from community health workers, 49% heard from social media. Only 20% knew the causative agent of COVID-19, while 13.3% knew about the signs and symptoms, 10% of responders knew about the methods of transmission. 16.7% are aware of the possible prevention methods. 38.7% considered it a new disease, while 30% considered it a health challenge. Knowledge of the preventive measures such as: Handwashing regularly with soap and water, use of hand sanitizers and face mask and social distancing protocol were also negative. **Conclussion:** There were paucity of knowledge and negative attitude of indigenous rural dwellers towards COVID-19 pandemic among the indigenous rural dwellers in Ebonyi State.

Keywords: *knowledge, attitude, COVID-19, rural dwellers*

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1. Background

COVID-19 is a novel viral infection that caused an outbreaks recently resulting in major outbreaks with significant public health and economic impacts. As of April 13, 2020, the outbreak has resulted in an estimated 52,000 cases and 1000 deaths in Nigeria. In Ebonyi State data shows that 973 people across 13 local governments were confirmed to have COVID-19 with 971 recoveries and 27 fatalities (data from NCDC as time of this research). As part of effort on containment, the government introduced ĺock down and movement restriction to curb the spread of COVID 19. With movement restriction and maintaining "physical distance", telephone COVID-19 is caused by severe acute respiratory syndrome corona virus 2 (SARS-CoV-2). The virus belongs to the family of Coronaviridae, which is RNA viruse. In 2019, this novel virus was implicated as the cause of upper and lower respiratory tract infections in Wuhan, a city in the Hubei Province of China. This infection rapidly spread, to other areas of China and eventually to other countries, resulting in an epidemic throughout China and in pandemic proportions. It has affected almost every continent in this world, except Antarctica [1]. It was in 2020, that the World Health Organization designated the disease COVID-19, which stands for corona virus disease 2019 [1].

The name "coronavirus" is derived from the Latin corona and the Greek refers to crown or halo which signifies the the characteristic appearance of the virions when seen with electron microscope. The host tropism of the virus is determined by the spikes found around the envelope [2].

Long before the SARS-CoV-2 outbreak, coronaviruses were only associated with mild and self-limiting

respiratory infections in humans [3]. Some of the coronaviruses are endemic in the human populations causing mild respiratory tract infections especially in neonates and elderly or persons with underlying illnesses [4]. A very important aspect of the virus is their genetic variability. It has been widely accepted in the scientific world that SARS-CoV originated in bats due to large number of Chinese horseshoe bats that contain SARS segment that is related Corona virus [5,6].

In rural communities the impact was enormous arising from the lockdown, especially as the trusted community leaders and local governments were faced with several demands. Both social and religious activities were brought to a sudden halt in most rural communities during the lockdown. The situation got to a crisis scale in many licalities as most locales found themselves trapped between hunger and a ravaging pandemic. [6]

The government quickly responded with some palliative measures. But the distribution of these palliatives were most often disrupted by the politicians who diverted them to their cronies. There was no established system in place to handle such crises. There are no well established systems for emergency support and rapid assistance to communities. A community-driven development programs, which puts citizens at the center of designing their own solutions, could have provided a fast and flexible way to deliver cash and basic services to the poorest and most vulnerable. [6]

A number of organizations, including the CDC and the World Health Organization, recognize the important role that communities play in responding to pandemics. The lessons from previous pandemics, including the 2014-16 Ebola outbreak, highlight the importance of social responses to crisis management and recovery to complement medical efforts [7]. In the case of COVID-19 there was no such support system in most rural communities. Zhong et al has suggested that a good partnerships among communities, healthcare systems, local governments, and the private sector could have a critical role in slowing the spread, mitigating impacts, and supporting local recovery. These partnerships support communications and behavior change for prevention, provide a rapid emergency response in the short term and mitigate economic impacts and build resilience for the future. [7]

The spread of the COVID-19 pandemic has posed a great challenge to humanity especially among the indigenous people in rural area of low income communities. The virus has indeed brought untold hardship to low income earners and dislocated their means of living through government restriction in movemet and social gathering. As the pandemic came in a wave, the governnent responded by imposing restriction on travels, ceremonies, worship and other activities that involve mass gathering. This restriction has threatened the social life and freedom of community dwellers thereby challenging the very fabric of their existence. [7]

Although the virus spread round the globe, its impact on indigenous community life was more pronounced especially in poor economies of the world. The spread of the pandemic was shocking to the rural dwellers as many viewed it with disbelieve what they considered as mere speculation from the high minded elites and government officials. Many considered the pronouncement from the scientific world as a myth designed to impose more hardship on the vulnerable people. In many rural communities, it took several deaths and media reports and advocacy for the reality to sink into the populace of the danger posed by this pandemic. [8]

Most of the high political office holders did not help matters in the manner of giving contracdictory public opinion on the pandemic. While many showed open disbelief, others pretended to ignore the raging pandemic. One State governor in Nigeria, while reacting to the death of highly placed citizens described the COVID-19 pandemic as an artificial creation aimed at causing fear and panic among the people [8]. This ambivalent attitude of government officials made it easy for some to claim that it was a mere propanganda and diversionary tactics from the scientific world to creat panic. Many still insisted that the pandemic is a disease that has been imported, propagated and forced on the people for no just cause and to shorten their life.

Ebonyi State is located in southeastern part of Nigeria. It has a population, of about 2.6million people based on 2006 census figure. Majority of the people live on rural areas where they engage in subsistence agriculture and trading. The state is among those classified as educational backward in Nigeria even though it has a number of tertiary institutions. Several infections and deaths from COVID-19 has been recorded in the state. The government has made several effort to creat awareness on the pandemic but it has became clear that villages at the front lines need to be equipped with information and systems to leverage a community-based response. With fake information a tangible obstacle, there was no effective monitoring system in place and villages became overwhelmed. The government is also facing difficulty disseminating information about COVID-19 as guidance and programs rapidly change. [6,7]

The consequence of this lack of knowledge and poor attitude was further reinforced by the emergence of divergent opinions even from religious leaders. Some religious leaders who could not tolerate the ban on mass gathering and religious worship became apprehensive and began to key into the theory of satanic influence. Some even keyed into the theory of radiation from expanded telecommunication radiowave which considered the pandemic as a mere diversionary tactics from the government. [8]

Generally most rural dwellers depend so much on their religious leaders major decission affecting their life. Several of the religious leaders have tried to misinform the community dwellers that covid-19 is an elite disease that came as a result of sin and impunity. The misinformation even extended to discouraging them from following social distancing protocols The grip of religion in low income settings can be strong, as many hold on their religious leaders as spokesmen of God whoses utterances must be obeyed. The reality of the situation began to dawn on them when their neighbours become infected and isolated as a challenge to their faith. [9]

As the pandemic progress to community transmission it has become more imperative to highlight major obstacles that may hinder the compliance to social distancing protocol and other preventive measures. As the lockdown

begins to ease, many infected individuals who could travel from one location to another can spread the infection [12] Many of such could become superspreader. However transmission will depend on some combination of factors including pathogen burden, the individual immune status and their environment. It has been observed that some infected individuals might shed more virus into the environment than others. In addition, asymptomatic individuals which can make up to 50% of all those who get COVID-19 will continue their normal activities but inadvertently infecting more people. It has been proved that even people who ultimately show symptoms are capable of transmitting the virus during a pre-symptomatic phase. [15]

As the lockdown begins to ease, travelling will increase and a person's behaviors, travel patterns and degree of contact with others can also contribute to spreading of the virus. Researchers in Hong Kong examined a number of disease clusters by using contact tracing to track down everyone with whom individual COVID-19 patients had interacted. In the process, they identified multiple situations where a single person was responsible for as many as six or eight new infections. [15]

1.1. Statement of the Problem

The Covid-19 pandemic has become a global issue, but unfortunately many rural dwellers are yet to come to terms with reality of the devastating consequences of the disease due to wrong perception.

This study was taken to evaluate the level of attitude and knowledge of the COVID-19 pandemic especially as the disease has entered the second phase of the spread within communities.

1.2. Purpose of the Study

The main purpose of this study is to asses the attitude and knowledge of rural dwellers in Ebonyi State to COVID-19 pandemic. This study will specifically ascertain the following:

1. The level of Knowledge of indigenous rural dwellers on COVID-19 pandemic in Ebonyi State.

2. Attitude of indigenous rural dwellers to the use of face mask in Ebonyi State.

3. Attitude of Indigenoue rural dwellers to the use of hand sanitizers

4. Attitude of Indigenous rural dwellers to Compliance to social distancing protocol

1.3. Rsearch Questions

The key research question which the researcher shall endeavour to answer include;

1. What is the level of knowledge of the indigenous rural dwellers towards COVID-19 in Ebonyi State?

2. What is the attitude of Indigenous rural dwellers towards the use of face mask in Ebonyi State?

3. What is the attitude of Indigenous rural dwellers towards the use of hand sanitizers in Ebonyi State?

4. What is the attitude of indigenous rural dwellers towards social distancing protocol in Ebonyi State?

1.4. Hypothesis

1. There is no sifigificant difference in the knowledge of indigenous rural dwellers in Ebonyi State towards the COVID-19 pandemic

2. There is no siginificant difference in the attitude of the indigenous rural dwellers in Ebonyi State towards COVID-19 pandemic.

2. Materials and Method

Study location: This study was carried in three rural communities in Ebonyi State, Southeastern Nigeria. The state has a population of 2.6million people and has recorded 485 positive cases of COVID-19 at the time of this research with potential for increase due to the low level of information among the rural dwellers. The major occupation of the rural dwellers is agriculture and trading.

2.1. Aims and Objectives of the Study

1. The primary aim of this study was to determine the level of knowledge on COVID-19 among the indigenous rural dwellers in Ebonyi State. The study has also exposed the factors that shaped people's perception about the disease.

2. This study also assesed the attitude of rural dwellers towards COVID-19 pandemic with respect to social distancing protocol and use of personal protection equipment.

2.2. Significance of the Study

1. This study will provide information on the basic understanding and knowledge of the indigenous rural dwellers to COVID-19 pandemic in Ebonyi State'

2. It will also provide a baseline data on the inherent challenges associated with compliance to social distancing protocol in rural areas.

2.3. Scope of the Study

This study was carried carried out using questionaire administered to 150 respondents in 3 rural communities from three senatorial zones of Ebonyi State.

2.4. Elegibility Criteria

Only indigenous rural dwellers in the three designated communities were elegible for this study.

The study population:

The population of study consisted of indigenous rural dwellers in three Local Government Area selected randomly from three senatorial zones. The population size was one thousand five hundred indigenous rural dwellers in Ebonyi State. The population of study was stratified in communities each from the three senatorial zone of the state.

The sample size was 150 persons, representing 10% of the population based on 50 persons from each of the three communities of study. Comprising of 86 males and 64 females. From the selected communities the male and female population ratio for A, B, and C communities, were as follow A 32:18, B 28:22 and C 26:24.

The ages of the subjects ranged from 18-60 years. Sample was randomly selected from the three rural community dwellers

2.5. Sampling Technique

This study adopted descriptive survey research design acording to Iwuagwu and Ofuebe (2007) which is considered as appropriate for investigating situation as they exist in natural setting. The sample size was determined by using Taro Yamane formular acording to Uzuagulu (2011). Multi-stage sampling technique was adopted in this study acording to Nworgu (2006).

2.6. Instrument of Research

The instrument was self structured questionaire bothering on the study objective. The instrument had 3 parts containing the variables of study. The responses were on 2 points rating of "Yes and No" All participant gave consent to complete the instrument. The items in the instrument were interpeted to the illitrate ones. On completion, the instruments were collected back immediately to ensure that non was lost. The instrument was given content validation by experts in the Department of Statistics in Alex Ekwueme University.

The questionnaire was structured to examine the knowledge and attitude of indigenous rural dwellers towards the COVID-19 pandemic. The self-completed survey designed for this study included questions on demographics (age, education, religion).

Ethical Approval: The approval for this study was obtained from the Institution Based Ethics Committee of Alex Ekwueme Federal University.

2.7. Analyses

Statistical analysis. The completed and collected data were analysed using both descriptive and inferential statistics. The descriptive statistics involved frequency and percentages, while the inferential statistics involved the use of Chi-square; ($x2$) was used to test the hypothesis at 0.5 level of significance. All statistical analysis was done using the Statiatical Package for Social Sciences (SPSS) version 21. Frequency and percentage were used to analyze research question one. In determining the level of knowledge of the indigenous rural dwellers towards COVID-19, we adopted the Ashur's (1997) as modified by Okafor (1997) criteria for determining knowledge was used. By using this criteria, scores below 20 percent was considered very low level of knowledge, while 20-39 percent was considered as low level of knowledge and 40-59 percent was considered as average level of knowledge, 60-80 percent was considere as high level of knowledge, while scores above 80 percent was considered very high level of knowledge.

For questions two three, and four, mean score and standard deviation was used to analyze the answers. For this a mean score of 2.5 and above was regarded as oositive, while mean scores less than 2.5 was considered as negative. The null hypothesis for knowledge and attitude of indigenous rural dwellers to COVID-19 was tested at 0.5 level of significance at the appropriate level of freedom using ANOVA for research hypothesis one and Chi-square for hypothesis two

3. Result

Research Question one: What is the knowledge of indigenous rural dwellers to COVID-19 in Ebonyi State

Table 1 showing average mean percentage of 22.8% which indicates very low knowledge of COVID19 among indigenous rural dwellers in Ebonyi State. Specific question of 4, 5, 6, 7, 8, 9, 10 and 12, which relate to the basic knowledge of COVID-19 were within the values of 5-30% indicating very low knowledge (VLK). The result in Table 1, further indicate that item questions number 1 and 2 indicates high knowledge(HK), while questions numbers 11 and 13 indicates average knowledge (AK) and wuestions 1 and 2 indicates very high knowledg (VHK).

Table 1. Knowledge of Indigenous rural dwellers to COVID-19 in Ebonyi State (N=150)

Variables	Freq. Positive responses	%	Freq of negative responses	%
1. Have you heard of COVID-19?	58	40.3	92	61.3
2. Did you hear of COVID-19 through radio?	50	36.7	80	53.3
3. Did you hear of COVID-19 through friends	56	37.3	94	62.7
4.Did you hear of COVID-19 through government agency?	51	35.5	99	64.5
5. Did you hear of COVID-19 through health workers?	60	48	90	62
6. Did you hear of COVID-19 through social media?	64	49	86	61
7. Do you know the causative agent of COVID-19?	30	20	120	80
8. Do you know any of the signs and symptom of COVID-19?	20	13.3	130	86.7
9. Do you know how COVID-19 can be transmitted or contracted?	15	10	135	90
10. Do you know how to prevent infection of COVID-19?	25	16.7	125	83.3
11.,Do you know any person who had contacted or had died of COVID-19?	10	6.7	140	93.3
12. Do you know the origin of COVID-19?	05	3.3	145	96.7
13. Do you think that COVID-19 kills people?	25	16.7	125	83.3
14. Do you think COVID-19 is actually a new diseases?	58	38.7	92	61.3
15. Do you think COVID-19 is spreading in your locality?	20	13.3	130	86.7
16.,Do you consider COVID-19 as a health challenge in your locality?	45	30	105	70
Grand Mean Frequency and Percentage	34.4	22.8%	116.4	76.8%

Key: below 20%= very low knowledge(VLK), 20-39=low level knowledge (LK), 40-59%=average knowledge (AK), 60-80=high knowledge (HK), and greater than 80%=very high level of knowledge (VHK).

Research Question 2. What is the attitude of Indigenous rural dwellers towards the use of face mask?

Table 2. Attitude of Indigenous rural dwellers to the use of face mask in Ebonyi State (N=150)

Variables	Mean X	SD	Decission
17. Do you know what is face mask?	2.6	1.03	Positive
18. Do you have a face mask?	1.6	1.01	Negative
19. Do you use face mask?	1.5	1.03	Negative
20. Do like using face mask?	1.8	1.06	Negative
21. Do you think face mask is important in protection?	1.8	1.02	Negative
22. Do you consider face mask unnecessary burden?	1.8	0.98	Negative
23. Do you encourage my spouse and sibblings to wear face mask?	1.8	1.09	Negative
24.Do you know why it is necessary to wear face mask?	2.4	1.06	Negative
25.Do you think that face mask can protect from infection?	2.6	1.06	Positive
Grand Mean and SD	2.0	1.04	Negative

The result in Table 2, shows grand mean of 2.0 with standard deviation 1.04 which is less than the cut-off point of 2.50. This indicates that the rural dwellers have negative attitude towards the use of face mask

The table shows specifically items 15 to 20 has very low knowledge and negative attitude, while item 14 and 22 showed response above the cut-off of 2.50.

Research Question 3. What is the attitude of Indigenous rural dwellers toward the use of hand sanitizers?

Table 3. Attitude of Indigenous rural dwellers towards the use of hand sanitizers in Ebonyi State

Variables	Mean X	SD	Decission
26. Do you know what is hand sanitizers?	1.8	0.89	Negative
27. Do you use hand sanitizer?	1.5	0.78	Negative
28. Do you have hand sanitizer?	1.7	0.80	Negative
29. Do you like using hand sanitizer?	2.5	0.93	Positive
30. Do you know the importance of hand sanitizer?	1.8	0.78	Negative
31. Do you encourage your spouse or sibblings to use hand sanitizers?	1.9	0.67	Negative
32. Do you think hand sanitizers can protect from infection?	2.6	0.56	Negative
33. Do you consider hand sanitizer is necesisary?	2.5	0.67	Positive
34. Covering mouth and nose with a clean cloth while coughing or sneezing and wash hands after	2.2	0.56	Negative
35. Do you avoid touching eyes, nose and mouth with hand/fingers	2.60	0.87	Positive
36. Do you washing hands regularly with soap and water (20 sec each time)	2.83	0.89	Positive
Grand Mean and SD	2.04	0.76	Negative

The result in Table 3, shows grand mean of 2.04 with standard deviation 0.76 which is less than the cut-off point of 2.50. This indicates that the rural dwellers have negative attitude towards the use of hand sanitizers

Research Question 4. What is the attitude of Indigenous rural dwellers to Social Distancing Protocol in Ebonyi State?

Table 4. Attitude of Indigenous rural dwellers to Social Distancing Protocol in Ebonyi State

Variables	N=150	Mean X	SD	Decission
36. Do you know about social distancing?		1.9	0.67	Negative
37. Do you attend public functions?		2.5	0.86	Positive
Do you avoid large gathering		1.4	0.56	Negative
38. Do you attend church services?		2.6	0.65	Positive
39. Do you attend community meetings?		2.9	0.55	Positive
40. Do you attend burial ceremonies?		2.8	0.56	Positive
41. Do you avoid close contact with any one who is sick, especially those with cold or fever or sneezing		1.5	0.76	Nagative
42. Do you keep enough distance from other people in a crowded place?		1.5	0.81	Negative
43. Do you think there is danger in not maintaining enough distance from another person?		1.5	0.09	Negative
44' Do you avoid Shaking Hands with others		1.8	0.86	Negative
45. Do you like keeping to social distancing in churches?		1.9	1.08	Negative
46. Do you encourage my spouse or sibblings to keep social distance in gatherings?		1.8	0.97	Negative
Grand Mean and SD		2.2	0.69	Negative

The result in Table 4, shows grand mean of 2.2 with standard deviation 0.69 which is less than the cut-off point of 2.50. This indicates that the rural dwellers have negative attitude towards social distancing protocol.

Data presented in Table 4, shows answers to questions 36 to 46. The respondents had negative responses to the keeping to social distancing protocol as enunciated by NCDC. This implies that they all had negative attitude to the matters like keeping safe distances. Social distancing protocol were not kept in churches and other mass gathering events

Research Hypothesis 1. There is difference in the attitude of Indigenous rural dwellers towards COVID-19 based on age

Table 5. One-way Analysis of Variance (ANOVA). Testing the hypothesis of attitude of Indigenous rural dwellers based on age (N=150)

Age	Sum of Squares	Degree of freedom	Mean Square	F	P-value	Decission
Between groups	640.845	3	190.322	.416	.276	Accepted
Within groups	96244.433	106	956.637			
Total	9745.085	108				

Table 5 above shows a probablity value of 0.276, which is greater than 0.05 (p > 0.05). Therefore there is no significant in the attitude of indigenous rural dwellers to COVID-19 in Ebonyi State with respect to age.

Research Hypothesis 2. There is no significance difference in the attitude of Indigenous rural dwellers towards COVID_19 based on gender

Table 6. Chi-Square: Goodness of fit Test Statistics testing the attitude of indigenous rural dwellers to COVID-19. Based on gender (N=150)

Gender	Observed (N)	Expected (N)	Degree of freedom	P-value	Decission
Male	86	75	1	0.386	Accepted
Female	64	75			

Table 6 above shows the probability value of 0.386 which is greater than p-0.05(p>0.05), hence the null hypothesis was accepted; that the attitude of indigenous rural dwellers in Ebonyi State towards COVID-19 is not dependent on gender.

4. Discussion

The findings from Table 1, showed that a grand mean percentage of 22.8% which indicates very low level of knowledge of COVID-19 among the indigenous rural dwellers in Ebonyi State. The finding is however not surprising judging from the low level of advocacy and awareness in most rural areas. The result in Table 1 clearly showed that only 40.3 % of the respondents have actually heard of COVID-19. It also showed that the highest information aboug the disease was gotten from the rural health workers who lives among them with 48% responding so. While the information of COVID19 that came from government agency, friends, social media were 35.5, 37.3 and 49% respectively. Based on the information in Table 1, only 20% of respondents knew the causative agent of the COVID-19, while the knowledge on source of transmission, preventive methods, signs and symptoms were only known to 10, 16.7, and 13.3% respectively. Only 6.7% accepted to have seen a COVID-19 patient, while 38.7%considered it as a new disease with potential health challenge. Among the respondents, only 16.7% believed that the disease can kill. The origin of COVID-19 remained unclear to the rural dwellers as only 3.3% responded to knowing the origin. From the foregoing, it is clear that there is low level of knowledge of COVID-19 among the indigenous rural dwellers in Ebonyi State.

In the Table 2, we recorded a grand mean score of 2.0(SD1.04), which is below the cut-off value of 2.5. This indicates that the indigenous rural dwellers in Ebonyi State has negative attitude towards the use of face mask. The table clearly showed that although people claim to know about face mask and believing that it can prevent infection, the general attitude towards usage were all in the negative. They were not considering it as important in their routine interaction. Many considered face mask as uncessary.

The result in Table 3, shows a grand mean score of 2.04 (SD 0.76) which is below the cut-off value of 2.50 hence indicating negative attitude towards the use of hand sanitizers among the indigenous rural dwellers. Hand sanitizer is a very important item in the control of COVID-19, but the indigenous rural dwellers seem to consider it unnecessary. This can be seen in the negative result seen in the respondents

In Table 4, the result presented shows grand mean of 2.2 with (SD 0.69). This is beloe the cut-off value of 2.50, which by implication indicates negative attitude of the indigenous rural dwellers to the social distancing protocols as enunciated by CDC.

In Table 5, it indicates the probability value of .276 (p greater than 0.05) which is greater than the alpha value of 0.05(p>0.05) which indicates that the attitude if the rural dwellers were not dependent on age.

In Table 6, it shows a probability value of .386 (p > 0.05) which is greater than the alpha value of 0.05 (p>0.05), indicating that the attitude of indiginous dwellers was independent of gender

Only 34.40% of the respondents are aware of the Corona Virus disease and about 35% of the respondents heard of the diseases from the government agency. While 49% claimed to have heard of the disease through social media outlet. Women had low awareness of COVID 19 protection measures with 30% as against men with 42%. Only 30% considered the disease a major health challenge to worry about. Thus, there is need to spread awareness drive for communities. Health workers are the major source of information and are most trusted. The social networks and news media are another source of information. Religious leaders and community elders are considered as trust worthy. The government can strp up effort in enlightenment and create more awareness on the danger of COVID-19 aming the rural dwellers. People should be given feedback through posters and other communication tools. It is also important to consider their level of education and social status.

In conclusion this research shows that the knowledge of the indigenous rural dwellers in Ebony State of COVID-19 remains very low. In addition their attitude to basic protective protocol is poor. This can be attributed to poor information disemination in the rural areas. People are not totally aware of preventive measures like proper hygiene practices, physical distancing (social distancing) and restricted movements avoidance of mass gatherings would reduce the risk of COVID 19.

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