Community perceptions of COVID-19 prevention and control measures in Nigeria and Sierra Leone: multi-site, community-led qualitative study

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Introduction

In April 2020, "shielding" (separate living spaces with enhanced infection control support for groups at high risk of severe COVID-19 disease), was proposed for COVID-19 prevention in settings where lockdown is not feasible (i.e. displaced persons camps). MSF used qualitative methods to explore community perceptions of shielding and other potential COVID-19 prevention measures applicable in settings where it works. Nigeria and Sierra Leone served as initial pilot sites for this multi-site study that ultimately included 13 countries.

Methods

We carried out qualitative assessments between April and August 2020 within 9 MSF-supported sites in Nigeria and Sierra Leone, with the aim of exploring community perceptions of potential COVID-19 prevention measures. Sites in Nigeria included internally displaced camps in two states, and in Sierra Leone, an open village setting. We conducted multiple rounds of participant-led individual in-depth qualitative interviews in the study sites between April-August 2020. We recruited participants purposively, ensuring participants recruited were representative of underlying demographic and ethnic diversity. Data were coded by hand on paper copies of transcripts and in NVivo12 and analyzed for key themes. Findings were built on through iteration with participants.

Ethics

This study was approved by the MSF Ethics Review Board and by the Ethical Review Boards of Benue State, Nigeria, Zamfara State, Nigeria, and the District Health Management team, Tonkolilli, Sierra Leone.

Results

Participants reported that access to both COVID-19 and non-COVID-19 care was challenging due to fear of infection and practical difficulties attending care facilities. Key priorities noted by participants included obtaining food, masks and handwashing, and continuing to get access to non-COVID-19 healthcare. In Nigeria, shielding (providing separate dwellings for high-risk people) was described as a challenge. Reasons for this included close living conditions affecting practicality, its impact on mental health, and the community's inter-generational reliance. Shielding was only seen as feasible with sustained provision of resources for shielded persons including COVID testing, food from the family, mobile phones, and socially distanced visitation. For Sierra Leone, previous experiences (e.g. war, Ebola) influenced fears of separation and the possibility of infection from contact with strangers and health workers or health facilities. Lockdowns and school closures have a negative effect on support networks and local economies, and in Sierra Leone increased the perceived risk of sexual and gender-based violence and exploitation. Participants reported the desire for self-management of contact tracing and transmission prevention activities within their communities. Context-specific activities to address these priorities were implemented in response.

Conclusion

The community-based feedback provided a better understanding of attitudes towards and feasibility of COVID-19 control measures. Commonalities were reported across sites, while differences in findings across sites highlighted the importance of context-specific engagement. Early and continued community engagement allowed context-specific activities to address these priorities to be implemented in partnership with communities in response. Implemented activities included enhancement of handwashing points, subsidizing locally-produced cloth masks, and reinforcement of prevention and control for non-COVID diseases such as malaria.

Conflicts of interest

None declared.

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Emily Briskin is currently an MSF Operational Research Advisor where she coordinates and conducts research with a focus on paediatric health and surgical interventions. She was previously the Flying Epidemiology Activity Manager for some of MSF's Nigeria field projects. Prior to working for MSF, Emily worked as a malaria research epidemiologist for the Clinton Health Access Initiative in Kampala, Uganda. Emily completed a Master's in Public Health focusing on epidemiology of infectious diseases and global health at Yale University in the United States.

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