Perceptions and risk: understanding the divide between Lassa fever messaging and lived experiences in Ebonyi State, Nigeria

Daniel Hernandez[1] Paul Grohma[2], Umberto Pellecchia[1,2], Temmy Sunyoto[1,2], Hilde de Clerck[1], Mia Østrup Nordentoft[1], Robinson Chukwudi Onoh[3], Hyacinth Okwe Ebenyi[4], Sylvia Lim[1,2]

[1]Médecins Sans Frontières (MSF), Brussels, Belgium; [2]MSF, Luxembourg City, Luxembourg; [3]Alex Ekwueme - Federal University Teaching Hospital, Abakaliki, Nigeria; [4]Ebonyi State Ministry of Health, Abakaliki, Nigeria

Introduction

Lassa fever (LF) is a viral haemorrhagic disease endemic to West Africa. Delayed diagnosis and therapeutic constraints can lead to high case fatality. Recurrent seasonal outbreaks persist in Nigeria despite ongoing public-health efforts. Risk perception remains understudied outside healthcare worker perspectives, highlighting the need to understand how it affects disease response and health pathways.

This study examined how knowledge, lived experiences, and social context shape risk perception, fear, and stigma around LF in outbreak-affected areas of Ebonyi State, Nigeria. **In-depth interviews** (n=18) and **focus group discussions** (n=14) were conducted among **LF survivors, caregivers, healthcare workers, and community members.**

A resident in an Ebonyi State community prepared a meal in the cooking structure in a household compound. Taken by Daniel Hernandez.

> ***What scares me about this illness is… stigmatisation. If an infected person is taken to the hospital, people run away from them.***
>
> **FGD_Community**

Findings

Uncertainty about LF transmission

Most participants demonstrated general knowledge about the disease. However, understanding of transmission, symptoms, and treatment was fragmented. Confusion about human-to-human transmission, including fears of airborne and sexual spread, contributed to heightened anxiety and stigma. Several survivors and healthcare workers could not identify how infection occurred, reinforcing perceptions that the risk of LF is unpredictable and difficult to control.

Every day risk and rodent exposure

Rodents were widely believed to be the primary cause of LF, often reduced to the assumption that eating rats leads to infection. Yet, human–rodent interactions are embedded in daily rural life. The framing of health promotion activities conflicted with lived experience and weakened confidence in prevention messages. At the same time, policies that prohibit practices such as prolonged contact with the dead or burying pregnant women with their foetuses, contributed to resistance, secrecy and sometimes violence between communities and health actors.

Fear drives risk perception and stigmatisation

Fear emerged as the dominant psychological response to LF, shaped by proximity to cases and circulating misinformation. It motivated early care-seeking for some but led to avoidance, fatalism, or disengagement from others. Risk was frequently projected onto “others”, such as rural, poorer, or less educated groups, allowing individuals to downplay their own vulnerability. This social distancing simultaneously reinforced stigma and obscured shared exposure.

Attitudes influence care seeking

Three dominant attitudes shaped responses to LF: belief in curability with early treatment, fatalistic perceptions of inevitable death, and scepticism of biomedical explanations in favour of spiritual or poisoning narratives. These orientations strongly influenced prevention practices and care-seeking behaviour. While hospital care was generally viewed as effective, most patient journeys were indirect and delayed. In addition, structural barriers such as financial barriers, long distances, and limited primary care capacity pushed many toward self-medication or local providers before reaching specialised care.

> ***I do not know how it started. I was thinking: is there any way this thing can get to me? And then suddenly it got me. I kept thinking, where did it come from?***
>
> **IDI_Survivor**

Key takeaways

- Understanding of Lassa fever transmission was fragmented and uncertain; difficulties recognising early symptoms fuelled fear, stigma, and delayed care-seeking.
- Risk perceptions were shaped primarily by lived experience, social position, and trust in health systems, rather than by formal health messages alone.
- Effective Lassa fever prevention requires participatory, community-anchored communication that engages with people’s lived realities and existing explanatory frameworks.

Conclusion

Risk perception around Lassa fever is shaped by uncertainty, daily socio-ecological realities, and structural constraints. Difficulties in tracing infection, even among healthcare workers, undermined confidence in prevention, while routine human-rodent contact made narrow prevention messages feel disconnected from lived experiences, reinforced fear, stigma, and delayed care-seeking. Understanding and recognising local explanatory models and lived realities through participatory, community-anchored communication and integrated psychosocial support are needed to strengthen trust in healthcare services, improve health literacy and increase early linkage to care.

Acknowledgements

A special thanks to all participants who consented to take part in this study. We also thank Uzoma Benjamin, Oniakem Charles, Chidinma Arua, Ibezim Jane and Doris Ajah-Okohu for their community engagement, transcription, and translation inputs.