Awareness and perception of COVID-19 in Nkhata Bay, Malaŵi: Case Study of Chintheche Small Town

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Abstract
Since its first detection in Wuhan, China in late 2019, the severe acute respiratory syndrome coronavirus 2 (*SARS-CoV-2*) which causes the Coronavirus Disease-2019 (COVID-19), has been globalized as a result of the unfettered movement of people between countries, cities, and villages. Until February 2020, it appeared that Africa had been spared from the pandemic. This gave a false impression that Africans were immune to COVID-19. Even when some large economies in Africa reported a surge in infections, in poorer countries people went about their normal business. In Malaŵi, at political campaign rallies political leaders openly dismissed the covid-19 threat. Some institutions, such as *Mdawuku wa aTonga* (MWATO), joined the government and the international community in sensitizing the people. This study used Chintheche Small Town in Nkhata Bay District as a case to learn how the Tonga people understood and perceived COVID-19. The findings show that the interviewees are aware of covid-19, its causative agent, the danger it poses but nearly half of them doubt its presence in Malaŵi. Others were completely dismissive, describing COVID-19 as a 'hoax' or 'a white man's disease'. The study recommends, inter alia, a) continued intensified public awareness and b) mandatory use of preventative measures through village bylaws.

Key words: *COVID-19,* Coronavirus*, Chintheche, WASH, Malawi*

1.0 Introduction and rationale

Since its first detection in Wuhan, China in late 2019, the severe acute respiratory syndrome coronavirus 2 (*SARS-CoV-2*) which causes the Coronavirus Disease-2019 (COVID-19), has been globalized as a result of the free movement of people between countries, cities, and villages. By mid-July 2020, the World Health Organisation (WHO)[1] reported that nearly 13.4 million people worldwide had contracted the new virus and

[1] WHO Coronavirus Disease (COVID-19) Dashboard. https://covid19.who.int/ accessed 18 July 2020.

over 580,000 had succumbed to COVID-19 while approx. 8 million recoveries had been recorded[2]. The Americas topped the infection log table (>7 million), followed by Europe (approx. 3 million), Eastern Mediterranean (>1.3 million), South-East Asia (approx. 1.2 million), Africa (>520 thousand) and Western Pacific (approx. 250 thousand). Until February 2020, it appeared that Africa had been spared from the pandemic. This gave a false impression that Africans were immune to COVID-19. In Africa, South Africa has the largest infection rate at >320 thousand with 4600 deaths and 166 thousand recoveries. It would appear that the more connected internationally a country or city is the higher the coronavirus risk of infection.

In Malaŵi, at political campaign rallies, political leaders openly dismissed the covid-19 threat (see for example, Moyo, 2020) while locals violently protested against any government measures to prevent the spread of the virus and in some cases damaged infrastructure meant to quarantine those detected with the coronavirus. (Aljazeera, 2020). In May 2020, over 400 returnees, 46 of whom had tested positive for coronavirus, escaped the quarantine centre in Blantyre (Masina, 2020). At almost the same time, Zimbabwe also experienced a mass escape (100 persons) from one COVID-19 quarantine location (TRT World, 2020). The Institute for Public Opinion and Research (IPOR) (2020) reported that slightly above 81% of its survey respondents feared hunger more than they feared COVID-19. From April 2020, when the first three coronavirus cases were detected, Malawi has recorded an exponential rise in coronavirus infections, recoveries, and COVID-19 deaths. By Mid-July, Malawi had >2700 confirmed positive cases with 51 deaths and >1073 recoveries (Ministry of Health-Malawi, 2020)[3]. UNICEF (2020) observes that in Malawi, there are twice as many local coronavirus transmissions as imported cases.

In Nkhata Bay, the number of reported cases has increased from five (5) in June 2020 to 71 in July 2020 (UN-Malawi, 2020; Ministry of Health –Malawi, 2020). However, the situation in small towns is not known as the reported figures at district or city levels tend to be aggregate and do not specify the local practices that contribute to the spread of the coronavirus.

[2] https://www.worldometers.info/coronavirus/ puts the number of world covid-19 recoveries at 8,293,613 while https://www.statista.com/statistics/1087466/covid19-cases-recoveries-deaths-worldwide/https://www.statista.com/statistics/1087466/covid19-cases-recoveries-deaths-worldwide/puts the recovery figure at 7852461, accessed 17 July 2020. Note that the WHO did not give cumulative figures for worldwide COVID-19 recoveries.

From May 20 to 21, 2020, a rapid appraisal was conducted at Chintheche, a small town in Nkhata Bay, to learn how the Tonga people understood and perceived COVID-19 and its causative agent, SARS-COV 19 or novel coronavirus. The study was a follow up on a two-week COVID-19 awareness radio campaign the *Mdawuku wa aTonga* (MWATO)[4] had conducted from May 1 to May 14, 2020.

Chintheche is one of the most active business and marketing areas in Tongaland[5] and attracts daily and seasonal migrant traders from all over Malawi, but, particularly from the districts of Mzimba, Rumphi, Karonga, Nkhota Kota, Mangochi, and Salima. Some of these migrant traders, particularly fishers and their families, have established a permanent presence along the Chintheche fish landing areas – *ugoŵi* – of Lake Malawi. These seasonal traders (and permanent fishers and their families) freely mingle with locals who also sell their own wares at the small town. With regard to the Covid-19 pandemic, Chintheche became a national spotlight when a positive patient escaped from an isolation hospital in Karonga (300km away) and started to deliberately mix with unsuspecting people in drinking joints, shops, and villages until when local people apprehended him. He was only rescued by Chintheche police.[6] Chintheche had about 10,000 people in 2008 and the population is estimated to have doubled by 2018 (see NSO, 2018). Like in other small towns in Malawi, Chintheche also hosts a weekly roadside market that attracts people from several local places, making the place cosmopolitan.

2.0 Method

The study used a questionnaire that had seven multiple choice questions and an eighth one that captured the interviewees' misgivings, questions, opinions, and perceptions. The questionnaire was administered on site by two interviewers. Due to financial limitations only 40 in-depth interviews were conducted. These may not be enough to merit generalization of observations to all Tongaland, but they were deemed sufficient to provide insights to guide the planning of Covid-19 interventions locally. As Stake (2005) has argued, case study findings are internally generalizable to the case in question – the

[4] MWATO is registered with the Malawi Government as a heritage association promoting and preserving tangible and intangible heritage of the Tonga people of Malawi. These include Tonga culture, traditions, customs, religion, shrines, language, dance, music, creations, and innovations.

[5] Tonga land – land of the Tonga, a term used by early European colonialists to refer to present day districts of Nkhata, Mzimba and Likoma (see Pachai, B. 1973, *Malawi: The history of the Nation*. London: Longman)

[6] Malawi News Agency (2020 May 13). COVID-19 patient escapes quarantine in Karonga, found in Chintheche. https://www.kulinji.com/article/news/health/2020/covid-19-patient-escapes-quarantine-karonga-found-chintheche accessed 16 July 2020

Chintheche Small Town (in our case) – and may provide a window to the larger society. The respondents of this study were identified systematically to the extent that no two people had a chance of colluding in providing answers.

The questionnaire had two broad categories. The first category sought to enumerate adherence to COVID-19 prevention guidelines published by the Malawi Presidential Task Force on COVID-19 in consultation with the Ministry of Health with information from the World Health Organization (WHO)[7]. The second category contained seven questions on demographics and the AKAP[8] chain and one on perceptions.

3.0 Findings

3.1 Conformity to COVID-19 prevention measures

A transect walk of the Chintheche Small Town, including the fish landing areas where migrant fishers have pitched semi-permanent' homes (*vihewelu*) was undertaken on 20 May 2020 to enumerate adherence to the Malawi's COVID-19 prevention measures. ***Table 1*** captures the findings:

Table 1: Adherence to anticovid-19 measures, Chintheche Small town 20 May 2020

Q	Anti-COVID measure	Available	Out of (#) establishments
1	How many washing facilities (with soap) do the following facilities have?		
•	• Chintheche rural hospital	3	1
•	• Pharmacies	3	3
•	• Magistrate's court	0	1
•	• Private clinics	3	3
•	• Markets shops (main)	4	25
•	• Markets (ad hoc)	5	5
•	• Drinking joints/pubs	0	5
•	• Fish landing sites/beaches	0	5
•	• Filling station	1	1
•	• Shops	3	107
2	Have you seen anyone wearing a face mask?	7	>1000 pax
3	Are people practicing physical distancing (at least 2 metres apart)?	0	NA

[7] https://www.health.gov.mw/index.php/downloads/category/7-covid19-information accessed 16 July 2020

[8] AKAP = Awareness Knowledge Attitudes and Practices/Behaviour. Sequentially, awareness should lead to knowledge which should change individual and societal attitudes and finally engender adoption of new practices and behaviours. Had the May 2020 radio campaign succeeded in one or all these aspects?

4	Are people practicing social distancing (no handshakes, hugs, sharing drinks)?	0	NA
5	Are there places where masks are made?	4	NA
6	Any covid-19 posters, banners, information boards?	1	NA

Source: Field work, May 2020

It is clear from ***Table 1*** that public and private medical and health service providers, and the ad hoc markets (*salula*), have responded positively and adhered to the prevention measures by at least providing handwashing facilities in their precincts. Also, the local tailors have responded creatively by starting to sew facemasks for sale. However, the most frequently visited places, such as drinking pubs and fish landing sites, had no handwashing facilities and did not take physical distancing precautions. Only 3 of the >100 immobile shops had hand washing facilities. Only 7 out of approximately 1000 people that day were observed with a mask on. There was no social and no physical distancing as ***Figure 1*** illustrates:

Figure 1: No physical distancing. Chigumbuli Beach fish landing, May 20 2020

3.2 Awareness, knowledge, attitudes and practices (AKAP)

As noted, systematically selected interviewees were asked to answer seven questions and provide their understanding and perceptions of COVID-19. The first three questions sought to record respondents' basic demographic information: sex, age, and formal education attainment. These are captured in ***Tables 2*** **and** ***3.***

3.3 Sex and age of interviewees

Table 2: *Sex and age of interviewees*

Sex & age of interviewees (N=40)		
Age	**Female**	**Male**
15-24	4	9
25-34	2	5
35-44	8	3
45-54	4	0
55-older	2	3
	20	**20**

Source: Field work, May 2020

As ***Table 2*** indicates, most of the respondents (31 =77.5%) ranged from 15 years to the early 40s. Those older than 44 years were very few (9 = 22.5%). There were more male interviewees aged under 35 interviewees (17 =42.5%) than their female counterparts (14 =35%). This could reflect the fact that young male people; the very people that are mostly found drinking joints, frequent the small town more than older men. Among the women, the older interviewees (>35 years) were more (14) than younger ones (6). These were mostly women that sell fish, vegetables and other farm produce, and usually leave the small town around dusk and are unlikely to frequent drinking joints but they are more present at other places or events, such as funerals, where social distancing is rarely, if ever, observed. The fact that equal numbers of female and male persons were interviewed gave investigators a round picture of the views and perceptions of COVID-19 from both sexes.

3.4 Educational Status

Table 3: Highest level education attained

Highest education level attained	**N=40**
None	2
Primary	16
Secondary	15
Post Sec	6
Declined to answer	1

Source: Field work, May 2020

Table 3 shows that the majority of the interviewees were primary and secondary school leavers. There was an almost even number of primary and secondary school leavers. Six

others were post-secondary school leavers. Apart from the two who had no formal education and one person who declined to answer, the majority of the interviewees (37 = 92.5%) were considered well placed and educated enough to understand basic issues about disease, health, and sanitation.

3.6 Awareness of COVID-19

All the interviewees (40 = 100%) reported that they had heard about COVID-19. As ***Table 4*** shows, the sources of information about the new coronavirus and COVID-19 were varied, with national radio being the most dominant[9]. Note that the interviewees had the leeway to mention all sources of information. In case an interviewee mentioned a source that was not on the questionnaire, the list of sources was expanded.

Table 4: Sources of information on COVID-19

How did you hear about COVID-19?	#
Local community radio	4
National radio	53
Newspapers	0
Friend	16
Pastor	6
Posters and Banners	0
Internet/WhatsApp/Facebook chat group	10
TV	13
School	2

Source: Field work, May 2020

These findings (***Table 4***) confirm observations by several previous studies that radio is the most preferred and treasured source of information in Africa in general and Malaŵi in particular (Genderlinks, 2005; Afrobarometer, 2018). Thus, for purposes of targeting the case study area, radio would be ideal. However, friends, the internet/social chat groups on such social media platforms as WhatsApp and Facebook, and TV are good contenders as sources of information. Studies have long established that word of mouth communication (WoM – such as communication among friends and in electronic chat groups – eWoM) are an excellent interpersonal source of information about goods and change of behaviours. Market research has demonstrated that endorsement by close

[9] National radio here refers to those radio stations that have a national geographical coverage (such as MBC and ZBS) and can be received in the Chintheche area, Nkhata Bay District.

friends and closed network members leads to high purchase of goods (Sharifpour et al, 2016).

These findings are also an indictment of the role faith leaders (pastors)have so far played in the COVID-19 information dissemination and prevention drive as no respondent mentioned pastors as sources of COVID-19 prevention information. Previous studies, such as those by Afrobarometer (2014), have indicated that in Malaŵi, chiefs and religious leaders, the military, and the judiciary are the most respected and trusted sources of information. However, in the fight against COVID-19 some religious or faith leaders and senior politicians have worsened the situation by publicly dismissing COVID-19 as a hoax or at least non-existent in Malaŵi (see Moyo, 2020; Mandowa, 2020). The findings also suggest that using newspapers and posters to target rural areas, such as Chintheche, would be a waste of financial resources and time because none of the respondents mentioned newspapers or posters and banners as a source of information on COVID-19 even though during the transect walk one COVID-19 poster was noted.

3.7 Knowledge of COVID-19

Awareness and knowledge are often conflated but in this study, awareness refers to having information while knowledge is about ability to recall, think and do something about the information from the source.

Tables 5: Definitions of COVID-19

From what you have heard, what's COVID-19?	
HIV/AIDS	0
TB	1
Cough	9
Malaria	5
FLUE (*chifuŵa cha mumphunu*)	2
New respiratory disease	25
Didn't understand message	2
Headache	1
Fever	1

Source: Field work, May 2020

Table 6: Causes of COVID-19

How is COVID-19 caused?	
The new coronavirus	31
HIV/AIDS	0
Witchcraft (*ulowi*)	1
The Malaŵi government	0
The Opposition	0
Other (imported from abroad - China)	2
Don't know	6

Source: Field work, May 2020

Tables 5* and *6 above illustrate that the interviewees were aware and understood that COVID-19 is a respiratory disease caused by the new coronavirus (*SARS-CoV-2)*, which are both locally called *kolona*. However, there were some interviewees who thought COVID-19 was a cough (9 = 22.55%) or malaria (5 = 12.5%). In the context of COVID-19, cough and malaria should be understood as coughing, sneezing, and fever, which are some of the symptoms of the disease as communicated by the WHO and the Ministry of health of Malaŵi[10]. Among the Tonga, malaria and fever are often treated as the same. Therefore, even these can be said to have understood COVID-19 because they could define it through symptoms. Others (6 = 16%) did not know the cause but two thought it was caused by China[11]. Only one person thought it was caused by witchcraft (*ulowi*).

3.8 Prevention

The interviewees were asked how they thought catching the coronavirus, the causative agent of COVID-19, could be avoided. They were asked to list as many as they could. Their answers are captured in ***Figure 2***:

[10] See https://www.health.gov.mw/index.php/downloads/category/7-covid19-information accessed 18 July 2020.

[11] USA president Donald Trump has consistently referred to the *SARS-CoV-2* as the Wuhan virus or Chinese virus. Recently, he has accused China of deliberately unleashing the coronavirus on the USA and the world (see Cortney Moore, Trump blames China for unleashing coronavirus https://www.foxbusiness.com/politics/trump-china-unleashed-coronavirus). Could these interviewees have been influenced by such conspiracy theories?

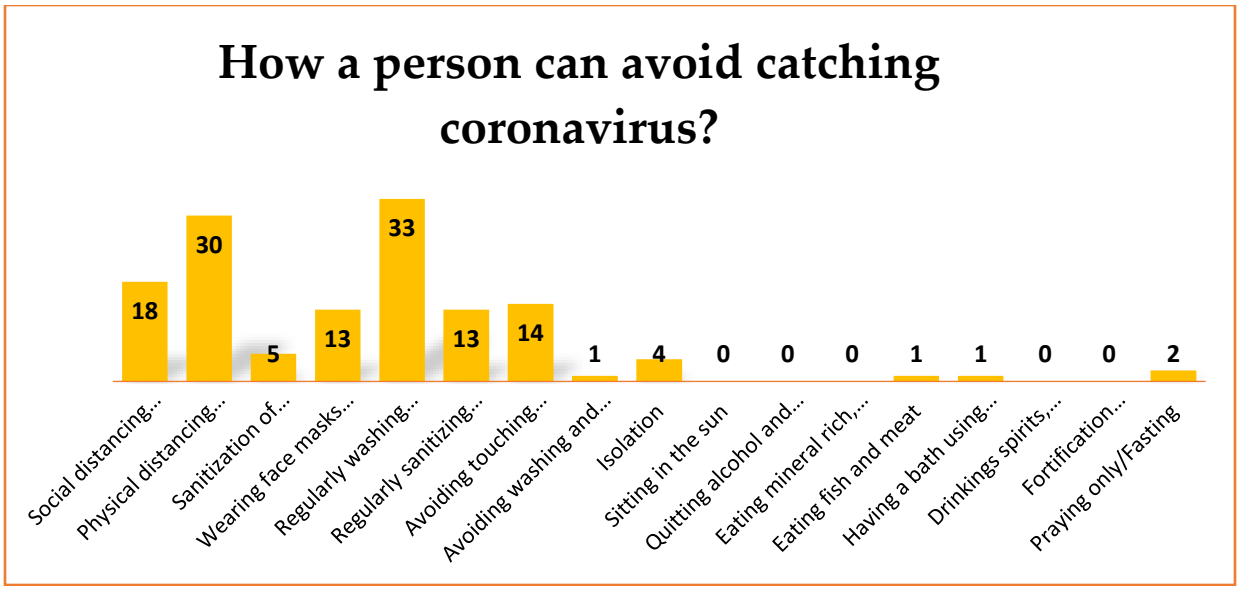

Figure 2: Ways a person can avoid new coronavirus. **Source: Field work, May 2020**

The information in ***Figure 2*** shows that apart from isolation, people had understood that social distancing, physical distancing, sanitization, and handwashing with soap were the best means of preventing the spread of the new coronavirus. However, dangerous practices, such as washing and touching bodies of dead people with bare hands, alcohol and smoking, were not mentioned. Praying, fasting, traditional fortification (*kukhwima*), sitting in the sun, bathing with chemical detergents, and drinking spirits were correctly not considered good enough to prevent COVID-19.

> … people … understood that social distancing, physical distancing, sanitization, and handwashing with soap were the best means of preventing the spread of the new coronavirus…

3.9 Perceptions and doubts about COVID-19

Interviewees were also asked about what they personally thought about COVID-19. ***Figure 3*** sums up their responses.

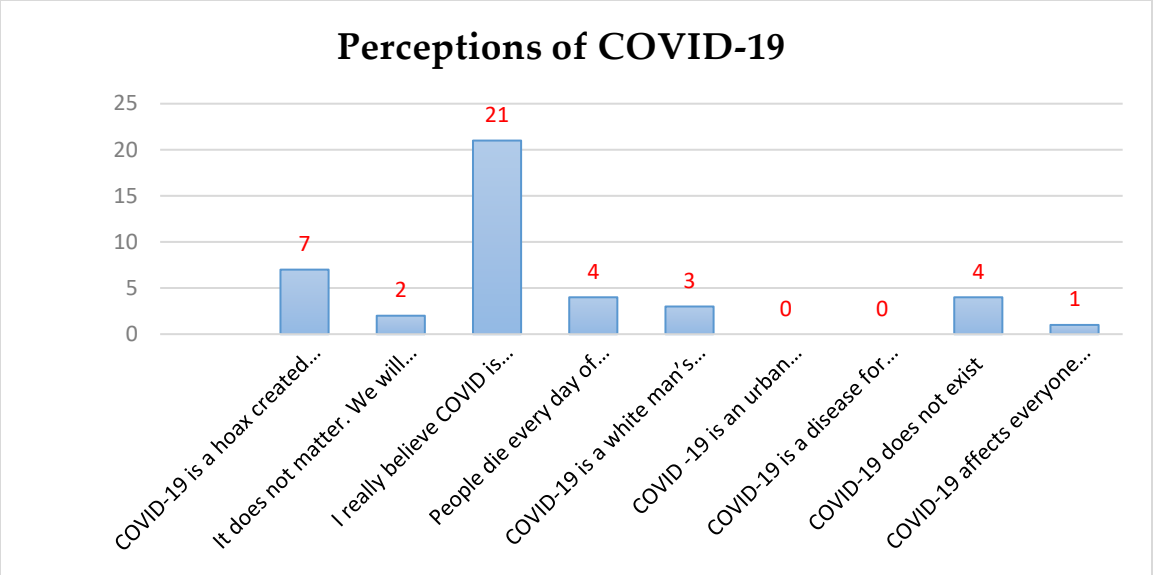

Figure 3: Perceptions of COVID-19 **Source: Field work, May 2020**

The majority (22 = 55%) of the interviewees were convinced that COVID-19 is dangerous/affects everyone and every race, and taking preventive precautions is necessary. But, if those of who consider COVID-19 a hoax (7 = 17.5%), those who are fatalistic and say everybody will die (anyway)/ people die of other disease (4 = 10%), COVID-19 is a white man's disease (3 = 5%), and COVID-19 does not exist (4 = 10%) are put together, the number of doubters is very high (18 = 45%), which is almost half of the respondents).

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The interviewees were further asked to provide their in-depth feelings vis-à-vis COVID-19. These are captured in ***Table 7*** and grouped into themes arrived at using thematization or thematic analysis techniques proposed by Kvale (1996) and Boyatzis (1998).

Table 7: Themes from qualitative statements

Theme 1: Government lying/preparing mentally preparing people for COVID-19	
I don't know how true it is because they don't show those who have tested positive to the public. In south Africa, TV stations cover how people tested positive are quarantined. I have not witnessed it in Malawi.	COVID-19 is not here. They (govt.) just want to tease/prepare us so that when it crosses the border, we would have been used to prevention measures.
COVID-19 killed many in Western Countries in a few months. Since it got reported in Malawi only 3 people have died. This makes me wonder. If the disease is real in Malawi, why are political leaders and govt. officials loose in observing prevention measures during campaign rallies? They just want to play with our minds.	The government is careless. They don't monitor those who test COVID-19
Theme 2: Gimmick for seeking foreign aid	
Government wants money from donors	They just want to use it to seek foreign aid
Theme 3: COVID-19 is a white man's disease/can't affect us/Africans are invincible/indomitable	
White (*aZungu*)[12] people have weak immunity	
Theme 4: People & Government working to fight COVID-19	
People are following precautions to protect themselves	Officials are strong enough to overcome the pandemic

Source: Field work, May 2020

Themes 1- 3 are easy to understand. Themes 1 and 2 are about 'governmental lies' while theme 3 is an uninformed celebration of African immunity and infallibility to COVID-19, but theme 4 is rather loaded. On the surface, the statements denote praise for Malawi government/international community and local people's efforts to fight the COVID-19

[12] AZungu refers to any non-bantu people (traditionally the term was reserved for people such as Europeans/Americans). Asiatics (Chinese, Japanese, etc) are called maChaina who are distinguished from Indians (aMwenye) and Arabs (maArabu, aLuya or aLungwana).

and stop the further spread of the novel coronavirus. With such efforts, COVID-19 will be defeated, the messages suggest. It is a message of hope and endorsement of preventive interventions. The deep or connotative meaning could, however, be fatalistic and defeatist, that is, that the Malaŵi government/international community and the local people are already doing enough and if they fail, it will mean that COVID-19 prevention is beyond human effort.

4.0 Conclusion

The foregoing information (statistics and qualitative statements) indicates that people are aware of covid-19 and have a fair understanding of the dangers COVID-19 poses. To that extent alone, it can be claimed that the national and localized MWATO public awareness effort has worked. Nevertheless, the misgivings by nearly half of the interviewees, though not generalizable nationwide, could be indicative of the areas that need to be addressed for COVID-19 to be defeated. Fatalism and defeatism (we will all die anyway/people die every day… – *see Figure 3*), a false sense of natural security (Covid-19 is a Whiteman's disease, Africans have indomitable immunity) and the wrong perception that government is lying about the COVID-19 situation in Malawi are detrimental. These need immediate attention and address. The WHO has warned that the new coronavirus may not go away soon (or at all) and the human race will have to adapt to a new normal (Picard, 2020).

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5.0 Recommendations

While working on the identified attitudes and perceptions, such as fatalism and defeatism, is encouraged, the most preferred intervention should be to reinforce and reward positive knowledge and attitudes so that they translate into anti-COVID-19 behaviours. Insights from the theory and practice of Appreciative Inquiry (Cooperrider and Whitney, 2005) and Positive Psychology indicate that emphasizing and rewarding what works (strengths) is more beneficial to behaviour change than concentrating on correcting wrongs or solving problems (weaknesses). Therefore, we recommend the following actions:

a. Continue public awareness of COVID-19 to ensure the current gains are not lost. Awareness messages should be delivered in prayer houses, at funerals, and beach fish landing areas. The key message should emphasize that COVID-19 is deadly but preventable and treatable.

b. Make critical preventive measures mandatory through local bylaws issued by local chiefs. The bylaws should oblige households to observe covid-19 preventing measures.
c. Support local production of masks by local tailors and designers which will also help create local employment and boost local economies.
d. In designing COVID-19 interventions, organisations should promote safe Water, Sanitation and Hygiene (WASH) practices.
e. A similar study should be conducted in larger urban centers to inform national and local interventions.

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