A population survey on behavioural insights on COVID-19 in Sri Lanka: A quantitative analysis on perceptions, behaviours, opinions, trust and affect to inform pandemic outbreak response

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Abstract

Background The COVID-19 pandemic outbreak is placing insurmountable challenges and burden on health systems and authorities demanding responses with effective and appropriate policies and interventions. Wrong decision making, lack of foresightedness and preparation in the acute and transition phases can threaten the gains collectively achieved. Understanding the behaviours, perceptions and feelings of the population is imperative in management decisions. Not much evidence is available on such behavioural insights to inform the COVID-19 response in countries. This study is expected to contribute to the evidence-informed understanding on effective management of the outbreak.

Methods This was a cross sectional observational study with entirely voluntary online participation. The study protocol and the questionnaire, originally prepared by a WHO collaboration, were adjusted to match the local setting and resource availability. The study explored 14 variables including perceptions, trust and behaviours in relation to COVID-19. Data was collected during the first wave of COVID-19 in early May 2020 and statistically analysed to see the associations and comparisons between chosen variables.

Results N = 1001 with 65.63% from the age range 18–29 years and 65% from the non-health care worker category. Basic or postgraduate degree holders were 64.7%. Participants were from 23 out of the 25 districts in SL with 34.07% from high-risk districts. They were in general, knowledgeable (e.g., > 95% correctly identified common symptoms of COVID19) and majority (99.5%) reported conforming to the health recommendations. They trusted government health bodies including hospitals (90.8%) but majority (63.8%) had poor confidence in media in the ability to manage the outbreak. Stigma around COVID-19 was not a concern for the majority of 78.9%. Participants less than 30 years believed in conspiracies around COVID-19 more than older counterparts.

Conclusion The perceptions, affect and behaviour of the study population gives insights on information dissemination, gaps in health message delivery, alternative approaches in responding and policy making helping to improve the pandemic response.

Background

The coronavirus is new, with various emerging information on its behaviour and no vaccine or known effective treatment. The case fatality rates are still uncertain and variable. All these lead to high uncertainty in community about the likelihood of contracting the disease, its potential severity, ability to take control over the process by preventive measures and the trust they can place in their authorities to control the pandemic. The pandemic response with its restrictions have serious implications on mental and physical well-being, social interactions, economy as well as individual and community resilience and trust [1]–[5].

In order to manage a pandemic effectively it is crucial to understand the risk perception of the population and their trusted sources of information to enable effective communication and formulating key messages [3]. Informing should be evidence-based and address misinformation and induce rational, adaptive and protective behaviour [6]. However, not much is known about the complex interplay of changing epidemiology, media conduct, control measures, risk perception and public health behaviour in the context of a pandemic of this scale. A study conducted during the influenza A(H1N1) pandemic in 2009/2010 shows an “asynchronicity between media curves and epidemiological curves.” and it is suspected that the public risk perceptions and behaviours may have followed media logic, rather than epidemiological logic [7] There is also evidence that the uncertainty about the situation, inconsistency in recommendations and perceived exaggeration were associated with a reduced compliance with the recommended protective behaviours during the 2009/10 flu pandemic [8]. However, the knowledge acquired during the last pandemics is only of limited value and the communities need the present-day insights to guide crisis responses in the current outbreak. Thus, the dynamics of risk perceptions, fears, misinformation and protective behaviours and also the understanding which protective measures are known and which information is lacking need to be updated based on changes in epidemiology, media reports, information and misinformation and such insights are also relevant for preparedness and protective behaviour [3], [9].

The WHO Europe's Insights Unit and Health Emergencies Program have offered a study protocol, tools and guidance urging the researchers from WHO member countries to use them to do research in order to gain local insights and then share the information gained with other researchers from across the states [10]. The Sri Lankan study was developed based on that study framework and used an individual-centered approach where insights into perceptions, behaviours and other variables inform COVID-19 response in the country.

Methods

The primary objectives of this study were to gain insights on variable perceptions, behaviours, fears and others, identify associations and gaps between variables, to evaluate the opinions on policies implemented and inform the COVID-19 response of the country.

A secondary objective is to utilize the insights gained to inform subsequent waves / post-outbreak responses and share them with fellow WHO countries thereby contributing to the continued regional/global efforts to better understand mechanisms of crisis response.

Ethical approval was obtained from the Ethical Review Committee, Faculty of Medicine, University of Peradeniya. All participants gave their informed consent before filling the questionnaire and authors assert that all procedures contributing to this work comply with the ethical standards of the committee.

Sample and inclusion criteria

This was a cross sectional observational study with entirely voluntary participation of individuals over 18 years of age. We used a purposive sampling method and a sample size of 1000 was planned to obtain a high level of congruence between the distribution of the demographics in the sample and the population (i.e. age, gender and living area).

Scientific review and validation of tool

The protocol and questionnaire were originally prepared by University of Erfurt, Germany, and subsequently reviewed by a group of leading global experts in behavioural insights research for health and in developing and validating survey tools similar to the current one. To the degree possible, already validated items from previous surveys conducted were included in the questionnaire and the questionnaire as a whole has been validated through six rounds of data collection in Germany which led to adjustments of the questionnaire [10]. The protocol and questionnaire were adjusted where relevant to match the local socio-cultural setting and resource availability as permitted and requested by the German and WHO collaboration. The adapted questionnaire was reviewed by two national peer reviewers for the accuracy and the sociocultural adaptation efficacy. Reviewers endorsed the final protocol and questionnaire upon revision. The questionnaire was pre-tested with a sample of respondents representing different age groups, occupation categories, sexes, urban/rural living with a focus on their easy understanding of the questions before broad use. It was translated into Sinhala and Tamil the main two languages used apart from English.

Variables included in the questionnaire were socio-demographic data, risk perceptions, knowledge perceptions, probability and severity perceptions, preparedness and perceived self-efficacy, affect, trust in/use and type of information sources, trust in institutions/personals, opinion on policies, decisions, measures and resilience, stigma, behaviours, worries and fears, confusions and rumours and comparisons of COVID-19

to cough, cold and fever. Some variables included a combination of knowledge and behavioural questions. (asking people to what degree they are following recommended prevention interventions such as hand washing) The other constructs were more complex and required validated questions to accurately assess risk perception, self-efficacy, trust, affect, fairness, prevention, resilience, worry and conspiracy thinking.

Data collection and analysis

The questionnaire was administered using the google form platform and shared with the public through e-mail and social media. Data collection period lasted for 14 days from 6.5.2020 till 20.5.2020, 8–10 weeks into the pandemic in SL [11].

It took place entirely online due to the prevailing travel restrictions and the risk of virus spread during the time. Average time to complete the questionnaire was 25–35 minutes. Data was analysed using SPSS 21 and associations between the variables and the demographic data was explored using the bivariate analysis using the Chi-square test and Fisher's exact. All the variables were categorized into two, on logical basis. The neutral categories (e.g., Undecided") were not considered in the analysis for checking associations. The exact considerations for the categorizations are given under each analysis in results. The p value of less than 0.05 was considered as significant.

To compare the susceptibility and severity perceptions between the COVID-19 and cough, cold and fever, the variables were assessed in Likert scales. Since the Likert scales had more than 5 (7) points it was assumed as a continuous variable for the statistical testing. The P values of Kolmogorov-Smirnov and Shapiro-Wilk tests were < .000 indicating a statistically significant difference from the normal distribution. Therefore, all four variables were concluded as non-normally distributed, hence a non-parametric statistical test applied to assess the differences between COVID-19 and cough, cold and fever.

Results

A. Demographic data of the study population

Thousand and six (1006) individuals have responded but the consent to take part was given by 1001, only.

The female to male ratio was 1.07:1. Health care workers (HCW) consisted of 35.06% and 64.7% were the degree and postgraduate degree holders. (Table 1) Study population came from 23 out of the 25 districts with 34.07% from districts identified as high risk (Colombo, Kaluthara, Puttalam and Gampaha) due to high case load of COVID-19. Mannar and Mullaitivu districts were not represented. (Fig. 1)

Table 1
Demographic data of the study population (N = 1001)

Age category (years)	Gender		Occupation			Level of education					Total
	Male (%)	Female (%)	Other (%)	HCW (%)	Non HCW (%)	0 to 9 (%)	10 to 12 (Completed A/L) (%)	> 12 Diploma or Higher education (%)	> 12 Graduated (%)	> 12 Post graduated (%)	
18 to 29	284 (43.16)	373 (56.69)	1(.15)	232(35.26)	426(64.74)	2(0.3)	64(9.4)	212(32.2)	339(51.5)	41(6.2)	658(100)
30 to 39	121(57.34)	88(41.71)	2(.95)	77(36.49)	134(63.51)	0 (0)	3 (1.4)	23(10.9)	123(58.3)	62(29.4)	211(100)
40 to 49	37(59.68)	25(40.32)	0 (0)	19(30.65)	43(69.35)	0 (0)	8(12.9)	12(19.4)	7 (11.3)	35(56.5)	62(100)
50 to 59	27(52.94)	24(47.06)	0 (0)	21(41.18)	30(58.82)	1 (2)	8(15.7)	11(21.6)	5 (9.8)	26(51.0)	51(100)
60 to 69	10(76.92)	3(23.08)	0 (0)	2(15.38)	11(84.62)	0 (0)	5(38.5)	1(7.7)	2 (15.4)	5 (38.5)	13(100)
70 to 79	1(33.33)	2(66.67)	0 (0)	0(0)	3(100)	0 (0)	1(33.3)	0(0)	0(0)	2(66.7)	3(100)
80 and above	1(33.33)	2(66.67)	0 (0)	0(0)	3(100)	1(33.3)	2(66.7)	0(0)	0(0)	0(0)	3(100)
Total	481(48.05)	517(51.64)	3(.29)	351(35.06)	650(64.94)	4(0.4)	91(9.1)	259(25.9)	476(47.6)	171(17.1)	1001(100)
Education level is given in years of education											

B. Risk perceptions

Our sample consisted of a majority who believed either they or their immediate environment are free from the infection of the COVID-19 virus (80.63% and 76.53% respectively) In perception of self-infected status the number of participants in categories, infected and confirmed + suspected to be infected but not confirmed, were negligible. (Fig. 2)

C. Knowledge

Out of the participants 83.3% perceived their overall knowledge on prevention as to be good and very good. (Fig. 3). The perception of overall knowledge on prevention was not significantly different according to age, district, education level or the occupation. More than 95% of participants had correctly identified individual symptoms, fever, cough, shortness of breath and sore throat as related to COVID-19 infection (Fig. 4). HCW had statistically significant higher knowledge about some of the symptoms not so commonly discussed (body aches, headache, fatigue, diarrhoea and inability to sense smell and taste), compared to non-HCW (Table 2). A majority as high as 92.90% correctly knew that there is no drug or vaccine available against the COVID-19 infection during the study period. That knowledge was not significantly associated with age, living district, education and occupation of the participants. Both 14 and 21 days were marked by our population as the incubation period (Fig. 5). The knowledge about incubation period was significantly higher in participants who were below 30 years compared to participants who were older than 30 years of age.

Table 2
Perception of knowledge about individual symptoms of COVID 19 against basic demographics

Variable		Age		District			Education			Occupation	
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker
Fever	Correctly known	628 (96.6%)	332 (98.5%)	960 (97.3%)	323 (96.4%)	637 (97.7%)	960 (97.3%)	88 (94.6%)	872 (97.5%)	960 (97.3%)	345 (98.2%)
	Unknown	22 (3.4%)	5 (1.5%)	27 (2.7%)	12 (3.6%)	15 (2.3%)	27 (2.7%)	5 (5.4%)	22 (2.5%)	27 (2.7%)	6 (1.8%)
Total		650 (100.0%)	337 (100.0%)	987 (100.0%)	335 (100.0%)	652 (100.0%)	987 (100.0%)	93 9 (100.0%)	94 (100.0%)	987 (100.0%)	351 (100.0%)
Chi square		3.014 (.083)			1.366 (.243)			(0.168)			2.156 (.142)
Cough	Correctly known	639 (97.5%)	332 (98.2%)	971 (97.7%)	324 (96.4%)	647 (98.5%)	971 (97.7%)	86 (93.5%)	885 (98.2%)	971 (97.7%)	346 (98.8%)
	Unknown	16 (2.5%)	6 (1.8%)	22 (2.3%)	12 (3.6%)	10 (1.5%)	22 (2.3%)	6 (6.5%)	16 (1.8%)	22 (2.3%)	4 (1.2%)
Total		655 (100.0%)	338 (100.0%)	993 (100.0%)	336 (100.0%)	657 (100.0%)	993 (100.0%)	92 (100.0%)	901 (100.0%)	993 (100.0%)	350 (100.0%)
Chi square		.459 (.498)			4.310 (.038)			(0.012)			2.871 (.090)
Shortness of breath	Correctly known	636 (97.8%)	328(98.5%)	964 (98.0%)	324 (97.3%)	640 (98.3%)	964 (98.0%)	91 (98.9%)	873 (98.0%)	964 (98.0%)	344 (98.0%)
	Unknown	14 (2.2%)	5 (1.5%)	19 (2.0%)	8 (2.3%)	11 (1.7%)	19 (2.0%)	1 (1.1%)	18 (2.0%)	19 (2.0%)	7 (2.0%)
Total		650 (100.0%)	333 (100.0%)	983 (100.0%)	332 (100.0%)	651 (100.0%)	983 (100.0%)	92 (9.4%)	891 (100.0%)	983 (100.0%)	351 (100.0%)
Chi square		.494 (.482)			.601 (.438)			(1.000)			.011 (.917)
Sore throat	Correctly known	628 (97.3%)	325(97.3%)	953 (97.3%)	326 (97.0%)	627 (97.0%)	953 (97.3%)	90 (98.9%)	863 (97.2%)	953 (97.3%)	342 (98.3%)
	Unknown	17 (2.7%)	9 (2.7%)	26 (2.7%)	10 (3.0%)	16 (3.0%)	26 (2.7%)	1 (1.1%)	25 (2.8%)	26 (2.7%)	6 (1.7%)
Total		645 (100.0%)	334(100.0%)	979 (100.0%)	336 (100.0%)	643 (65.7%)	979 (100.0%)	91 (100.0%)	888 (100.0%)	979 (100.0%)	348 (35.5%)
Chi square		.003 (.957)			.203 (.652)			(0.502)			1.813 (.178)
Runny nose	Correctly known	395 (68.2%)	202 (65.6%)	597 (67.3%)	198 (65.8%)	399 (68.0%)	597 (67.3%)	59 (67.8%)	538 (67.3%)	597 (67.3%)	224 (72.3%)
	Unknown	184 (31.8%)	106 (34.4%)	290 (32.4%)	103 (34.2%)	187 (32.0%)	290 (32.4%)	28 (32.2%)	262 (32.7%)	290 (32.2%)	86 (27.7%)
Total		579 (100.0%)	308 (100.0%)	887 (100.0%)	301 (100.0%)	586 (100.0%)	887 (100.0%)	87 (100.0%)	800 (100.0%)	887 (100.0%)	310 (100.0%)
Chi square		.635 (.425)			.481 (.488)			.011 (.915)			5.312 (.021)
Body aches	Correctly known	446 (80.9%)	262 (83.7%)	708 (81.9%)	241 (82.8%)	467 (69.4%)	708 (81.9%)	61 (73.5%)	647 (82.8%)	708 (81.9%)	287 (89.1%)
	Unknown	105 (19.1%)	51 (16.3%)	156 (18.1%)	50 (17.2%)	206 (30.6%)	156 (18.1%)	22 (26.5%)	134 (17.2%)	156 (18.1%)	35 (10.9%)
Total		551 (100.0%)	313 (100.0%)	864 (100.0%)	291 (33.7%)	673 (100.0%)	864 (100.0%)	83 (100.0%)	781 (100.0%)	864 (100.0%)	322 (100.0%)
Chi square		1.029 (.310)			.226 (.634)			4.432 (.035)			17.915 (.000)
Headache	Correctly known	450 (81.8%)	252 (81.3%)	702 (81.6%)	245 (81.1%)	457 (81.9%)	702 (81.6%)	64 (78.0%)	638 (82.0%)	702 (81.6%)	276 (87.6%)
	Unknown	100 (18.2%)	58 (18.7%)	158 (18.4%)	57 (18.9%)	101 (18.1%)	158 (18.4%)	18 (22.0%)	140 (18.0%)	158 (18.4%)	39 (12.4%)
Total		550 (100.0%)	310 (100.0%)	860 (100.0%)	302 (100.0%)	558 (100.0%)	860 (100.0%)	82 (100.0%)	778 (100.0%)	860 (100.0%)	315 (100.0%)
Chi square		.037 (.848)			.078 (.780)			.774 (.379)			11.857 (.001)

Bold values = (p < 0.005), Correctly known = Identified as related to COVID 19, Unknown = Identified as not related to COVID 19.

Variable		Age		District				Education			Occupation	
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	
Fatigue	Correctly known	515 (88.9%)	276 (88.5%)	791 (88.8%)	269 (89.0%)	522 (88.6%)	791 (88.8%)	79 (87.8%)	712 (88.9%)	791 (88.8%)	303 (92.7%)	
	Unknown	64 (11.1%)	36 (11.5%)	100 (11.2%)	33 (11.0%)	67 (11.4%)	100 (11.2%)	11 (12.2%)	89 (11.1%)	100 (11.2%)	24 (7.3%)	
Total		579 (100.0%)	312 (100.0%)	891 (100.0%)	302 (100.0%)	589 (100.0%)	891 (100.0%)	90 (100.0%)	801 (100.0%)	891 (100.0%)	327 (100.0%)	
Chi square		.048 (.827)				.040 (.841)		.100 (.752)			7.821 (.005)	
Diarrhoea	Correctly known	304 (59.3%)	197 (68.2%)	501 (62.5%)	170 (64.6%)	331 (61.4%)	501 (62.5%)	46 (59.7%)	455 (62.8%)	501 (62.5%)	226 (76.3%)	
	Unknown	209 (40.7%)	92 (31.8%)	301 (37.5%)	93 (35.4%)	208 (38.6%)	301 (37.5%)	31 (40.3%)	270 (37.2%)	301 (37.5%)	70 (23.7%)	
Total		513 (100.0%)	289 (100.0%)	802 (100.0%)	263 (100.0%)	539 (100.0%)	802 (100.0%)	77 (100.0%)	725 (100.0%)	802 (100.0%)	296 (100.0%)	
Chi square		6.255 (.012)				.786 (.375)		.270 (.603)			38.565 (.000)	
Inability to sense smell and taste	Correctly known	473 (85.2%)	271 (87.7%)	744 (86.1%)	254 (86.7%)	490 (85.8%)	744 (86.1%)	60 (82.2%)	684 (86.5%)	744 (86.1%)	297 (92.5%)	
	Unknown	82 (14.8%)	38 (12.3%)	120 (13.9%)	39 (13.4%)	81 (14.2%)	120 (13.9%)	13 (17.8%)	107 (13.5%)	120 (13.9%)	24 (7.5%)	
Total		555 (100.0%)	309 (100.0%)	864 (100.0%)	293 (100.0%)	571 (100.0%)	864 (100.0%)	73 (100.0%)	791 (100.0%)	864 (100.0%)	321 (100.0%)	
Chi square		1.018 (.313)				.124 (.725)		1.024 (.312)			17.560 (.000)	
Bold values = (p < 0.005), Correctly known = Identified as related to COVID 19, Unknown = Identified as not related to COVID 19.												

D. Probability and severity perceptions

Out of the participants 50.9% believed that they are likely to get infected with COVID-19 (Fig. 6). Those above 30 years of age and HCW had perceived their probability of getting infected with COVID-19 as significantly likely, compared to those who are below 30 and non HCW (Table 3). The single highest category of participants belonged to the undecided category in relation to the severity perception. Yet the study sample swayed towards perceiving COVID-19 as severe (Fig. 7). There was a significant association between the perceived severity of the infection and presence of a chronic illness. (Table 4)

Table 3
Perception of the probability of getting infected with COVID 19 against basic demographics and the presence of a chronic illness

Variable		Age		District			Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Self-susceptibility	Unlikely	267 (47.5%)	97 (31.1%)	364 (41.7%)	127 (41.2%)	237 (41.6%)	364 (41.7%)	49 (55.1%)	315 (40.2%)	364 (41.7%)	91 (29.6%)	273 (48.6%)
	Likely	295 (52.5%)	214 (68.8%)	509 (58.3%)	176 (58.1%)	333 (58.4%)	509 (58.3%)	40 (44.9%)	469 (59.6%)	509 (58.3%)	216 (70.3%)	289 (51.4%)
Total		562 (100.0%)	311 (100.0%)	873 (100.0%)	303 (100.0%)	570 (100.0%)	873 (100.0%)	89 (100.0%)	784 (100.0%)	873 (100.0%)	307 (100.0%)	562 (100.0%)
Chi square		21.933 (.000)			.009 (.924)			7.277 (.007)			28.300 (.000)	
Bold values = (p < 0.005), Unlikely = Extremely unlikely + Unlikely + Somewhat unlikely, Likely = Somewhat likely + Likely + Extremely likely.												

Table 4
Perception of the severity of contracting COVID 19 against basic demographics and presence of a chronic illness

Variable		Age		District			Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Expected severity	Not severe	90 (25.6%)	50 (26.2%)	140 (25.8%)	49 (33.1%)	91 (26.3%)	140 (25.8%)	13 (21.7%)	127 (26.3%)	140 (25.8%)	62 (32.6%)	78 (22.1%)
	Severe	262 (74.4%)	141 (73.8%)	403 (74.2%)	148 (75.1%)	255 (73.7%)	403 (74.2%)	47 (78.3%)	356 (73.7%)	403 (74.2%)	128 (67.4%)	275 (77.9%)
Total		352 (100.0%)	191 (100.0%)	543 (100.0%)	197 (100.0%)	346 (100.0%)	543 (100.0%)	60 (100.0%)	483 (100.0%)	543 (100.0%)	190 (100.0%)	353 (100.0%)
Chi square		.024 (.874)			.134 (.715)			.597 (.440)			7.164 (.007)	
Bold values = (p < 0.005), Severe = Less severe + severe + very severe, Not severe = Very mild disease + Not severe + Not severe at all.												

E. Preparedness and perceived self-efficacy

Out of the participants 82.22% were having good confidence in the ability to protect self from COVID-19 (Fig. 8). A high percentage of 99.5% claiming to have good compliance with the recommendations from authorities (Fig. 9). There was no demonstrable statistically significant relationship between the compliance with recommendations and individual demographics. (Table 5) The majority (more than $\geq 90\%$) has followed the most recommended preventive measures indicated in bold text (Table 6) Six preventive measures commonly discussed were cross tabulated against the basic demographics. The use of herbal supplements was significantly higher in participants below the age of 30 and in non HCW. The disinfection of mobile phones was significantly higher in participants above 30 years of age, educated above Advanced Level and in HCW category (Table 7). We analysed the traditional and alternative preventive methods in relation to age and the living area. Drinking ginger tea was significantly higher in the less than 30 age group compared to the above 30-year group, and in the participants from rural areas compared to those in urban areas (Table 8). In our population 63.1% and 81.1% had good coping in not seeing family and friends respectively, during the pandemic (Fig. 10).

Table 5
Compliance with recommendations from authorities against basic demographics

Variable		Age		District			Education			Occupation	
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker
Following recommendations	Do not follow	1 (.2%)	1 (.3%)	2 (.2%)	1 (.3%)	1 (.2%)	2 (.2%)	0 (0.0%)	2 (.2%)	2 (.2%)	1 (.3%)
	Follow	659 (99.8%)	337 (99.7%)	996 (99.8%)	338 (99.7%)	658 (99.8%)	996 (99.8%)	94 (100.0%)	902 (99.8%)	996 (99.8%)	348 (99.7%)
Total		660 (100.0%)	338 (100.0%)	998 (100.0%)	339 (100.0%)	659 (100.0%)	998 (100.0%)	94 (100.0%)	904 (100.0%)	998 (100.0%)	349 (100.0%)
Chi square		(1.000)			(1.000)			(1.000)			(1.000)
Follow = Follow to some extent + I follow + Very much so, Do not follow = Not at all + I do not follow much.											

Table 6
Preventive measures taken to prevent infection from COVID 19

Preventive Measure taken	Yes	No	Does Not Apply
Hand washing for 20 seconds	950 (94.9%)	45 (.4%)	6 (.6%)
Avoiding touching Face	899 (89.8%)	91 (9.1%)	11 (1.1%)
Use of Hand rubs	897 (89.6%)	76 (7.6%)	28 (2.8%)
Staying home when you were sick or when you had a cold	848 (84.7%)	68 (6.8%)	85 (8.5%)
Not travelling abroad	786 (78.5%)	38 (3.8%)	177 (17.7%)
Herbal supplements (Ginger, Koththamalli, Garlic, 'Paspanguwa', 'Weniwel gata')	696 (69.5%)	249 (24.9%)	56 (5.6%)
Covering your mouth when you cough/ sneeze.	976 (97.5%)	14 (1.4%)	11 (1.1%)
Ensuring a balanced diet	818 (81.7%)	139 (13.9%)	44 (4.4%)
Avoiding close contact with someone who is infected	876 (87.5%)	32 (3.2%)	93 (9.3%)
Safe Handling of Polythene packages	813 (81.2%)	154 (15.4%)	34 (3.4%)
Avoiding eating meat	175 (17.5%)	705 (70.4%)	121 (12.1%)
Hanging 'Kohomba' branches in front of the house.	95 (9.5%)	794 (79.3%)	112 (11.2%)
Using 'Perum kayan'	115 (11.5%)	787 (78.6%)	99 (9.9%)
Sprinkling Turmeric mixed water.	124 (12.4%)	786 (78.5%)	91 (9.1%)
Regular exercises.	507 (50.6%)	438 (43.8%)	56 (5.6%)
Wearing a mask	963 (96.2%)	29 (2.9%)	9 (.9%)
Using antibiotics	38 (3.8%)	850 (84.9%)	113 (11.3%)
Using homeopathic remedies	405 (40.5%)	520 (51.9%)	76 (7.6%)
Drinking ginger tea	483 (48.3%)	450 (45.0%)	68 (6.8%)

The recommendations in bold = the most frequently disseminated ones

Preventive Measure taken	Yes	No	Does Not Apply
Steam inhalation	357 (35.7%)	588 (58.7%)	56 (5.6%)
Burning Kohomba leaves and lime leaves to produce smoke inside the house.	151 (15.1%)	766 (76.5%)	84 (8.4%)
Social distancing	959 (95.8%)	36 (3.6%)	6 (.6%)
Self-quarantine	497 (49.7%)	372 (37.2%)	132 (13.2%)
Disinfecting surfaces.	689 (68.8%)	279 (27.9%)	33 (3.3%)
Disinfecting the mobile phone.	657 (65.3%)	323 (32.3%)	21 (2.1%)
Increasing the consumption of Turmeric, Garlic, lime and pepper.	417 (41.7%)	513 (51.2%)	71 (7.1%)
The recommendations in bold = the most frequently disseminated ones			

Table 7
Some preventive measures taken to prevent infection from COVID 19 against basic demographics

Some preventive measures taken to prevent infection from COVID-19 against basic demographics												
Variable		Age			District			Education			Occupation	
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Non HCW
Hand washing	Yes	626 (95.4%)	324 (95.6%)	950 (95.5%)	328 (97.0%)	622 (94.7%)	950 (95.5%)	84 (90.3%)	866 (96.0%)	950 (95.5%)	339 (97.1%)	611 (94.6%)
	No	30 (4.6%)	15 (4.4%)	45 (4.5%)	10 (3.0%)	35 (5.3%)	45 (4.5%)	9 (9.7%)	36 (4.0%)	45 (4.5%)	10 (2.9%)	35 (5.4%)
Total		656 (100.0%)	339 (100.0%)	995 (100.0%)	338 (100.0%)	657 (100.0%)	995 (100.0%)	93 (100.0%)	902 (100.0%)	995 (100.0%)	349 (100.0%)	646 (100.0%)
Chi square		.011 (.915)			2.900 (.089)			(0.030)			3.419 (.064)	
Avoid touching face	Yes	589 (90.5%)	310 (91.4%)	899 (90.8%)	310 (92.0%)	589 (90.2%)	899 (90.8%)	85 (90.4%)	814 (90.8%)	899 (90.8%)	320 (92.0%)	579 (90.2%)
	No	62 (9.5%)	29 (8.6%)	91 (9.2%)	27 (8.0%)	64 (9.8%)	91 (9.2%)	9 (9.6%)	82 (9.2%)	91 (9.2%)	28 (8.0%)	63 (9.8%)
Total		651 (100.0%)	339 (100.0%)	990 (100.0%)	337 (100.0%)	653 (100.0%)	990 (100.0%)	94 (100.0%)	896 (100.0%)	990 (100.0%)	348 (100.0%)	642 (100.0%)
Chi square		.251 (.616)			.852 (.356)			.018 (.893)			.844 (.358)	
Herbal supplements	Yes	492 (78.5%)	204 (64.1%)	696 (73.7%)	242 (75.2%)	454 (72.9%)	696 (73.7%)	69 (75.9%)	627 (73.4%)	696 (73.7%)	204 (62.6%)	492 (79.5%)
	No	135 (21.5%)	114 (35.9%)	249 (26.3%)	80 (24.8%)	169 (27.1%)	249 (26.3%)	22 (24.1%)	227 (26.6%)	249 (26.3%)	122 (37.4%)	127 (20.5%)
Total		627 (100.0%)	318 (100.0%)	945 (100.0%)	322 (100.0%)	623 (100.0%)	945 (100.0%)	91 (100.0%)	854 (100.0%)	945 (100.0%)	326 (100.0%)	619 (100.0%)
Chi square		22.288 (.000)			.570 (.450)			.245 (.621)			31.451 (.000)	
Wearing face masks	Yes	637 (97.4%)	326 (96.5%)	963 (97.1%)	319 (95.5%)	644 (97.9%)	963 (97.1%)	89 (96.7%)	874 (97.1%)	963 (97.1%)	336 (96.6%)	627 (97.4%)
	No	17 (2.6%)	12 (3.5%)	29 (2.9%)	15 (4.5%)	14 (2.1%)	29 (2.9%)	3 (3.3%)	26 (2.9%)	29 (2.9%)	12 (3.4%)	17 (2.6%)
Total		654 (100.0%)	338 (100.0%)	992 (100.0%)	334 (100.0%)	658 (100.0%)	992 (100.0%)	92 (100.0%)	900 (100.0%)	992 (100.0%)	348 (100.0%)	644 (100.0%)
Chi square		.710 (.399)			4.360 (.037)			(0.746)			.520 (.471)	
Disinfecting mobile phones	Yes	403 (62.5%)	254 (75.8%)	657 (67.0%)	231 (69.6%)	426 (65.7%)	657 (67.0%)	38 (42.2%)	619 (69.6%)	657 (67.0%)	254 (73.8%)	403 (63.4%)
	No	242 (37.5%)	81 (24.2%)	323 (33.0%)	101 (30.4%)	222 (34.3%)	323 (33.0%)	52 (57.8%)	271 (30.4%)	323 (33.0%)	90 (26.2%)	233 (36.6%)
Total		645 (100.0%)	335 (100.0%)	980 (100.0%)	332 (100.0%)	648 (100.0%)	980 (100.0%)	90 (100.0%)	890 (100.0%)	980 (100.0%)	344 (100.0%)	636 (100.0%)
Chi square		17.758 (.000)			1.463 (.226)			27.626 (.000)			11.081 (.001)	
Steam inhalation	Yes	240 (38.6%)	117 (36.2%)	357 (37.8%)	136 (43.2%)	221 (35.1%)	357 (37.8%)	30 (34.5%)	327 (38.1%)	357 (37.8%)	113 (34.1%)	244 (39.8%)
	No	382 (61.4%)	206 (63.8%)	588 (62.2%)	179 (56.8%)	409 (64.9%)	588 (62.2%)	57 (65.5%)	531 (61.9%)	588 (62.2%)	219 (65.9%)	369 (60.2%)
Total		622 (100.0%)	323 (100.0%)	945 (100.0%)	315 (100.0%)	630 (100.0%)	945 (100.0%)	87 (100.0%)	858 (100.0%)	945 (100.0%)	331 (100.0%)	613 (100.0%)
Chi square		.505 (.477)			5.855 (.016)			.443 (.506)			3.048 (.081)	
Bold values = (p < 0.005) were considered as statistically significant												

Table 8
Traditional methods of prevention against age and living area

Traditional methods of prevention against age and living area							
Variable		Age			Living area		
		Below 30	30 and above	Total	Rural	Urban	Total
Hanging kohomba (neem) leaves	Yes	65 (11.2%)	30 (9.8%)	95 (10.7%)	36 (11.0%)	59 (10.5%)	95 (10.7%)
	No	517 (88.8%)	277 (90.2%)	794 (89.3%)	292 (89.0%)	502 (89.5%)	794 (89.3%)
Total		582 (100.0%)	307 (100.0%)	889 (100.0%)	328 (100.0%)	561 (100.0%)	889 (100.0%)
Chi square		.411 (.522)			.046 (.831)		
Using perum kayam (Asafoetida)	Yes	77 (13.1%)	38 (12.2%)	115 (12.7%)	38 (11.6%)	77 (13.4%)	115 (12.7%)
	No	513 (86.9%)	274 (87.8%)	787 (87.3%)	291 (88.4%)	496 (86.6%)	787 (87.3%)
Total		590 (100.0%)	312 (100.0%)	902 (100.0%)	329 (100.0%)	573 (100.0%)	902 (100.0%)
Chi square		.139 (.709)			.670 (.413)		
Sprinkling turmeric water	Yes	72 (12.2%)	52 (16.4%)	124 (13.6%)	43 (13.0%)	81 (14.0%)	124 (13.6%)
	No	520 (87.8%)	266 (83.6%)	786 (86.4%)	289 (87.0%)	497 (86.0%)	786 (86.4%)
Total		592 (100.0%)	318 (100.0%)	910 (100.0%)	332 (100.0%)	578 (100.0%)	910 (100.0%)
Chi square		3.086 (.079)			.202 (.653)		
Homeopathic remedies	Yes	267 (43.8%)	138 (43.8%)	405 (43.8%)	179 (52.2%)	226 (38.8%)	405 (43.8%)
	No	343 (56.2%)	177 (56.2%)	520 (56.2%)	164 (47.8%)	356 (61.2%)	520 (56.2%)
Total		610 (100.0%)	315 (100.0%)	925 (100.0%)	343 (100.0%)	582 (100.0%)	925 (100.0%)
Chi square		.000 (.991)			15.638 (.000)		
Drinking ginger tea	Yes	337 (55.3%)	146 (45.1%)	483 (51.8%)	198 (57.7%)	285 (48.3%)	483 (51.8%)
	No	272 (44.7%)	178 (54.9%)	450 (48.2%)	145 (42.3%)	305 (51.7%)	450 (48.2%)
Total		609 (100.0%)	324 (100.0%)	933 (100.0%)	343 (100.0%)	590 (100.0%)	933 (100.0%)
Chi square		8.942 (.003)			7.710 (.005)		
Herbal smoke	Yes	107 (17.7%)	44 (14.1%)	151 (16.5%)	67 (20%)	84 (14.4%)	151 (16.5%)
	No	497 (82.3%)	269 (85.9%)	766 (83.5%)	268 (80%)	498 (85.6%)	766 (83.5%)
Total		604 (100.0%)	313 (100.0%)	917 (100.0%)	335 (100.0%)	582 (100.0%)	917 (100.0%)
Chi square		2.005 (.157)			4.790 (.029)		
Consuming Turmeric, garlic, pepper	Yes	284 (46.8%)	133 (41.2%)	417 (44.8%)	170 (50.3%)	247 (41.7%)	417 (44.8%)
	No	323 (53.2%)	190 (58.8%)	513 (55.2%)	168 (49.7%)	345 (58.3%)	513 (55.2%)
Total		607 (100.0%)	323 (100.0%)	930 (100.0%)	338 (100.0%)	592 (100.0%)	930 (100.0%)
Chi square		2.684 (.101)			6.393 (.011)		
Bold values = (p < 0.005)							

F. Affect

Though the outbreak was worrying in nature to the majority (67.1%), many (61.2%), did not feel helpless either (Fig. 11). The feeling states were explored against the selected demographic variables for any associations and COVID-19 virus felt close to HCW more significantly than to the non HCW. None of the other associations were found to be statistically significant (Table 9).

Table 9
Effect of COVID 19 on the individual's affect against basic demographics

Variable		Age		District			Occupation			Presence of a chronic illness			Total
		Below 30	30 and above	Total	High risk	Low risk	Total	Health care worker	Other	Total	Known	Not known	
Close to me	Yes	177 (40.5%)	121 (51.5%)	298 (44.3%)	101 (42.0%)	197 (45.6%)	298 (44.3%)	146 (57.5%)	152 (36.3%)	298 (44.3%)	41 (54.0%)	257 (43.1%)	298 (44.3%)
	No	260 (59.5%)	114 (48.5%)	374 (55.7%)	139 (58.0%)	235 (54.4%)	374 (55.7%)	108 (42.5%)	266 (63.4%)	374 (55.7%)	35 (46.0%)	339 (56.9%)	374 (55.7%)
Total		437 (100.0%)	235 (100.0%)	672 (100.0%)	240 (100.0%)	432 (100.0%)	672 (100.0%)	254 (100.0%)	418 (100.0%)	672 (100.0%)	76 (100.0%)	596 (100.0%)	672 (100.0%)
Chi square		7.473 (.006)			.774 (.379)			28.546 (.000)			3.201 (.074)		
Fear inducing	Yes	392 (61.9%)	185 (57.0%)	577 (60.2%)	191 (58.4%)	386 (61.1%)	577 (60.2%)	185 (55.9%)	392 (62.5%)	577 (60.2%)	62 (64.0%)	515 (60.0%)	577 (60.2%)
	No	242 (38.1%)	139 (43.0%)	381 (39.8%)	136 (41.6%)	245 (38.9%)	381 (39.8%)	146 (44.1%)	235 (37.5%)	381 (39.8%)	35 (36.0%)	346 (40.0%)	381 (39.8%)
Total		634 (100.0%)	324 (100.0%)	958 (100.0%)	327 (100.0%)	631 (100.0%)	958 (100.0%)	331 (100.0%)	627 (100.0%)	958 (100.0%)	97 (100.0%)	861 (100.0%)	958 (100.0%)
Chi square		2.003 (.157)			.686 (.407)			3.974 (.046)			.613 (.434)		
Media hyped	Yes	335 (57.8%)	185 (59.2%)	520 (58.2%)	178 (60.0%)	342 (57.7%)	520 (58.2%)	56 (59.0%)	464 (58.2%)	520 (58.2%)	190 (60.1%)	330 (57.2%)	520 (58.2%)
	No	245 (42.2%)	127 (40.8%)	372 (41.8%)	121 (40.0%)	251 (42.3%)	372 (41.8%)	39 (41.0%)	333 (41.8%)	372 (41.8%)	126 (39.9%)	246 (42.8%)	372 (41.8%)
Total		580 (100.0%)	312 (100.0%)	892 (100.0%)	299 (100.0%)	593 (100.0%)	892 (100.0%)	95 (100.0%)	797 (100.0%)	892 (100.0%)	316 (100.0%)	576 (100.0%)	892 (100.0%)
Chi square		.197 (.657)			.283 (.595)			.019 (.892)			.675 (.411)		
Stressful	Yes	302 (48.6%)	162 (48.8%)	464 (48.7%)	163 (49.5%)	301 (48.2%)	464 (48.7%)	167 (50.2%)	297 (47.9%)	464 (48.7%)	41 (43.2%)	423 (49.3%)	464 (48.7%)
	No	319 (51.4%)	170 (51.2%)	489 (51.3%)	166 (50.5%)	323 (51.8%)	489 (51.3%)	166 (49.8%)	323 (52.1%)	489 (51.3%)	54 (56.8%)	435 (50.7%)	489 (51.3%)
Total		621 (100.0%)	332 (100.0%)	953 (100.0%)	329 (100.0%)	624 (100.0%)	953 (100.0%)	333 (100.0%)	620 (100.0%)	953 (100.0%)	95 (100.0%)	858 (100.0%)	953 (100.0%)
Chi square		0.002 (.962)			.147 (.701)			.438 (.508)			1.292 (.256)		
Bold values = (p < 0.005), Agree = Yes and Disagree = No													

G. Information about COVID-19

Health care workers were the best (76.1%) trusted source of information of our population with websites coming second (70.7%) (Table 10). The associations between four information sources and the basic demographics were explored. Participants below the age 30 had a significantly higher trust towards private television stations than participants who were above 30 and we found no other significant associations (Table 11). More than 90% of the participants were keen to know specific virus-related health concerns with only about a quarter of the population needing to know about grooming needs (Table 12). Majority (85.6%) of participants referred to the sources of information, highly frequently (Fig. 12).

Table 10
Trust in sources of information

Media	No trust	Very little trust	Little trust	Total	Some trust	good trust	A great deal of trust	Total	Not decided
Public TV	133	157	138	428 (42.8%)	272	173	41	486 (48.6%)	87 (8.7%)
Private TV	151	147	152	450 (45.0%)	306	139	31	476 (47.6%)	75 (7.5%)
News Papers	111	152	117	380 (38.0%)	259	105	15	379 (37.9%)	242 (24.2%)
Conversations with friends and family	117	126	181	424 (42.4%)	291	112	19	422 (42.2%)	155 (15.5%)
Conversations with colleagues	104	108	144	356 (35.6%)	310	142	29	481 (48.1%)	164 (16.4%)
Conversation with health care workers	32	48	83	163 (16.3%)	226	335	201	762 (76.1%)	76 (7.6%)
Websites	62	58	75	195 (19.5%)	226	294	188	708 (70.7%)	98 (9.8%)
Social Media	250	195	181	626 (62.5%)	179	35	10	224 (22.3%)	151 (15.1%)
Search Engines	81	128	140	349 (34.9%)	290	161	56	507 (50.6%)	145 (14.5%)
Radio	115	144	123	382 (38.2%)	280	132	23	435 (43.5%)	184 (18.4%)
Government Press Releases	104	98	100	302 (30.2%)	233	236	142	611 (61.0%)	88 (8.8%)
Good trust = Some trust + Good trust + A great deal of trust, Poor trust = No trust + Very little trust + Little trust.									

Table 11
Trust in sources of information against basic demographics

Variable		Age		District			Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Public tv	Poor trust	270 (45.0%)	158 (50.2%)	428 (46.8%)	147 (47.0%)	281 (46.8%)	428 (46.8%)	36 (41.9%)	392 (47.3%)	428 (46.8%)	160 (49.5 %)	267 (45.2%)
	Good trust	329 (55.0%)	157 (49.8%)	486 (53.2%)	166 (53.0%)	320 (53.2%)	486 (53.2%)	50 (58.1%)	436 (52.7%)	486 (53.2%)	163 (50.5%)	324 (54.8%)
Total		599 (100.0%)	315 (100.0%)	914 (100.0%)	313 (100.0%)	601 (100.0%)	914 (100.0%)	86 (100.0%)	828 (100.0%)	914 (100.0%)	323 (100.0%)	591 (100.0%)
Chi square		2.143 (.143)			.004 (.952)			.940 (.332)			1.827 (.176)	
Private tv	Poor trust	276 (44.9%)	174 (55.9%)	450 (48.6%)	158 (50.5%)	292 (47.6%)	450 (48.6%)	36 (41.4%)	414 (49.3%)	450 (48.6%)	165 (50.2%)	285 (47.7%)
	Good trust	339 (55.1%)	137 (44.1%)	476 (51.4%)	155 (49.5%)	321 (52.4%)	476 (51.4%)	51 (58.6%)	425 (50.7%)	476 (51.4%)	164 (49.8%)	312 (52.3%)
Total		615 (100.0%)	311 (100.0%)	926 (100.0%)	313 (100.0%)	613 (100.0%)	926 (100.0%)	87 (100.0%)	839 (100.0%)	926 (100.0%)	329 (100.0%)	597 (100.0%)
Chi square		10.134 (.001)			.671 (.413)			2.002 (.157)			.495 (.482)	
Social media	Poor trust	418 (74.6%)	208 (71.7%)	626 (73.6%)	215 (74.9%)	411 (73.0%)	626 (73.6%)	58 (69.0%)	568 (74.2%)	626 (73.6%)	233 (77.2%)	393 (71.7%)
	Good trust	142 (25.4%)	82 (28.3%)	224 (26.4%)	72 (25.0 %)	152 (27.0%)	224 (26.4%)	26 (31.0%)	198 (25.8%)	224 (26.4%)	69 (22.8%)	155 (28.3%)
Total		560 (100.0%)	290 (100.0%)	850 (100.0%)	287 (100.0%)	563 (100.0%)	850 (100.0%)	84 (100.0%)	766 (100.0%)	850 (100.0%)	302 (100.0%)	548 (100.0%)
Chi square		.839 (.360)			.358 (.550)			1.016 (.313)			2.966 (.085)	
Search engines	Poor trust	242 (42.5%)	107 (37.4%)	349 (40.8%)	115 (39.4%)	234 (41.5%)	349 (40.8%)	31 (39.7%)	318 (40.9%)	349 (40.8%)	131 (42.8%)	218 (39.6%)
	Good trust	328 (57.5%)	179 (62.6%)	507 (59.2%)	177 (60.6%)	330 (58.5%)	507 (59.2%)	47 (60.3%)	460 (59.1%)	507 (59.2%)	175 (57.2%)	332 (60.4%)
Total		570 (100.0%)	286 (100.0%)	856 (100.0%)	292 (100.0%)	564 (100.0%)	856 (100.0%)	78 (100.0%)	778 (100.0%)	856 (100.0%)	306 (100.0%)	550 (100.0%)
Chi square		2.006 (.157)			.353 (.552)			.038 (.846)			.820 (.365)	
Bold values = (p < 0.005), Good trust = Some trust + Good trust + A great deal of trust,												
Poor trust = No trust + Very little trust + Little trust.												

Table 12
The information marked as most needed

Type of information	Yes (%)	No (%)
Symptoms of novel Coronavirus	838 (83.72)	163 (16.28)
How can I protect myself and my family from novel Coronavirus	897 (89.61)	104 (10.39)
Personal stories from others about how they cope	468 (46.75)	533 (53.25)
Scientific progress in the development of a vaccine against novel Coronavirus	908 (90.70)	93 (9.30)
Scientific progress in the development of treatment for novel Coronavirus	926 (92.50)	75 (7.50)
How can I personally prevent the spread of the disease	912 (91.11)	89 (8.89)
How can I take care of a person who is in a risk group	872 (87.11)	129 (12.89)
How can I best take care of my children's school education	577 (57.64)	424 (42.36)
The nature of the severity of the outbreak in the world.	577 (57.64)	424 (42.36)
The nature of the severity of the outbreak in my country	964 (96.30)	37 (3.70)
About the decisions taken by higher authorities.	896 (89.51)	105 (10.49)
How does this outbreak affect me economically	827 (82.62)	174 (17.38)
Details on travel restrictions	872 (87.11)	129 (12.89)
How can I buy essential goods	866 (86.51)	135 (13.49)
How can I buy my medicine	756 (75.52)	245 (24.48)
How can I get a haircut and shave	253 (25.27)	748 (74.73)
How can I get a facial and my eyebrows done	230 (22.98)	771 (77.02)
How can I take care of my mental health while at home	726 (72.53)	275 (27.47)
How can I maintain my social relationships while maintaining distance?	729 (72.83)	272 (27.17)
The type of information more than $\geq 90\%$ of the participants wanted is indicated in bold text.		

H. Trust in the institutions /personals in their ability to manage COVID-19

Sri Lankan government sector health and other authorities have gained good trust of our study population. The religious places of worship have gained a lesser trust comparatively. A notable 63.8% had stated they had poor confidence in media (Table 13).

Table 13
Confidence placed in institutions and personnel

Institution	No Confidence	Very low confidence	Low confidence	Total	Some confidence	High confidence	Very high confidence	Total	Not applicable/ Don't know
Your own Doctor	24	33	50	107 (10.7%)	266	318	127	711 (71.0%)	183 (18.3%)
Other Consultant Physicians	18	36	29	83 (8.3%)	267	375	178	820 (81.9%)	98 (9.8%)
Your Employer (Ex- Ceylon Electricity Board, Ministry of Health)	75	50	99	224 (22.4%)	311	167	53	531 (53.0%)	246 (24.6%)
Media	173	113	202	488 (48.8%)	275	77	10	362 (36.2%)	151 (15.1%)
Private Hospitals	97	115	201	413 (41.3%)	291	96	35	422 (42.2%)	166 (16.6%)
Government Hospitals	16	30	19	65 (6.5%)	219	372	318	909 (90.8%)	27 (2.7%)
Ministry of Health	36	33	50	119 (11.9%)	272	353	208	833 (83.2%)	49 (4.9%)
Medical Officer of Health (MOH)	13	28	21	62 (6.2%)	225	403	272	900 (89.9%)	39 (3.9%)
Government medical officers	18	25	25	68 (6.8%)	212	386	301	899 (89.8%)	34 (3.4%)
Allied Health Officers	21	30	28	79 (7.9%)	278	363	199	840 (83.9%)	82 (8.2%)
Public Health Inspectors (PHI)	16	30	26	72 (7.2%)	251	391	239	881 (88.0%)	48 (4.8%)
Sri Lanka Medical Council (SLMC)	25	35	29	89 (8.9%)	230	336	247	813 (81.2%)	99 (9.9%)
Sri Lanka Medical Association (SLMA)	27	37	36	100 (10.0%)	233	327	220	780 (77.9%)	121 (12.1%)
Government Medical Officers Association (GMOA)	37	33	36	106 (10.6%)	232	340	243	815 (81.4%)	80 (8.0%)
Ayurvedic Medical Council	73	53	79	205 (20.5%)	256	247	114	617 (61.6%)	179 (17.9%)
Sri Lanka College of Psychiatrists	41	33	44	118 (11.8%)	266	304	159	729 (72.8%)	154 (15.4%)
College of Community Physicians Sri Lanka	29	21	44	94 (9.4%)	237	343	199	779 (77.8%)	128 (12.8%)
Sri Lankan Government	80	73	76	229 (22.9%)	283	260	149	692 (69.1%)	80 (8.0%)
The President of Sri Lanka	76	62	57	195 (19.5%)	236	284	202	722 (72.1%)	84 (8.4%)
Sri Lanka Police	43	36	44	123 (12.3%)	262	335	212	809 (80.8%)	69 (6.9%)
Sri Lanka Armed Forces	34	37	38	109 (10.9%)	229	331	273	833 (83.2%)	59 (5.9%)
Buddhist Temples	147	73	93	313 (31.3%)	225	163	65	453 (45.3%)	235 (23.5%)
The Catholic Churches	145	81	90	316 (31.6%)	226	146	53	425 (42.5%)	260 (26.0%)
Mosques	256	89	123	468 (46.8%)	165	86	27	278 (27.8%)	255 (25.5%)
District-level state officials	94	67	112	273 (27.3%)	284	164	44	492 (49.2%)	236 (23.6%)
Grama Niladharis	94	68	122	284 (28.4%)	278	171	51	500 (50.0%)	217 (21.7%)

Good trust = some confidence + high confidence + very high confidence, Poor trust = No confidence + very low confidence + low confidence

Institution	No Confidence	Very low confidence	Low confidence	Total	Some confidence	High confidence	Very high confidence	Total	Not applicable/ Don't know
Samurdhi officers	115	74	134	323 (32.3%)	246	129	41	416 (41.6%)	262 (26.2%)
Government Universities	68	50	93	211 (21.1%)	247	254	111	612 (61.1%)	178 (17.8%)
Private Universities	130	74	127	331 (33.1%)	229	132	39	400 (40.0%)	270 (27.0%)
Government Schools	114	70	123	307 (30.7%)	209	173	63	445 (44.5%)	249 (24.9%)
Private schools	131	90	128	349 (34.9%)	219	119	40	378 (37.8%)	274 (27.4%)
Preschools	159	90	127	376 (37.6%)	187	112	35	334 (33.4%)	291 (29.1%)
Government public transport agencies (Eg: Ceylon Transport Board, Sri Lanka Railway Department)	159	137	141	437 (43.7%)	211	109	37	357 (35.7%)	207 (20.7%)
Private Bus Associations	265	139	156	560 (56.0%)	148	65	13	226 (22.6%)	215 (21.5%)
Good trust = some confidence + high confidence + very high confidence, Poor trust = No confidence + very low confidence + Low confidence									

The participants below the age of 30 were found to be placing more trust in certain institutions/ personnel (e.g., private hospitals, GMOA, SL Army) compared to the above 30 participants. While the trust in government hospitals was significantly higher among HCW compared to non HCW, the trust in private hospitals and ayurvedic medical council was significantly higher in non HCW than that of HCW. The participants who have got only school education have significantly more trust in mosques compared to those who have higher education levels (Table 14).

Table 14
Trust in institutions against basic demographics

Variable		Age			District			Education			Occupatio
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker
Own doctor	Poor trust	62 (11.2%)	45 (16.9%)	107 (13.1%)	42 (15.1%)	65 (12.1%)	107 (13.1%)	12 (14.8%)	95 (12.9%)	107 (13.1%)	29 (10.4%)
	Good trust	490 (88.8%)	221 (83.1%)	711 (86.9%)	237 (84.9%)	474 (87.9%)	711 (86.9%)	69 (85.2%)	642 (87.1%)	711 (86.9%)	251 (89.6%)
Total		552 (100.0%)	266 (100.0%)	818 (100.0%)	279 (100.0%)	539 (100.0%)	818 (100.0%)	81 (100.0%)	737 (100.0%)	818 (100.0%)	280 (100.0%)
Chi square		5.103 (.024)			1.450 (.229)			.238 (.626)			2.777 (.09)
Other physicians	Poor trust	46 (7.6%)	37 (12.5%)	83 (9.2%)	33 (11.0%)	50 (8.3%)	83 (9.2%)	7 (8.0%)	76 (9.3%)	83 (9.2%)	22 (6.6%)
	Good trust	560 (92.4%)	260 (87.5%)	820 (90.8%)	266 (89.0%)	554 (91.7%)	820 (90.8%)	80 (92.0%)	740 (90.7%)	820 (90.8%)	313 (93.4%)
Total		606 (100.0%)	297 (100.0%)	903 (100.0%)	299 (100.0%)	604 (100.0%)	903 (100.0%)	87 (100.0%)	816 (100.0%)	903 (100.0%)	335 (100.0%)
Chi square		5.657 (.017)			1.823 (.177)			.151 (.697)			4.395 (.03)
Employer	Poor trust	138 (28.8%)	86 (31.3%)	224 (29.7%)	85 (31.7%)	139 (28.5%)	224 (29.7%)	24 (34.3%)	200 (29.2%)	224 (29.7%)	57 (20.4%)
	Good trust	342 (71.2%)	189 (68.7%)	531 (70.3%)	183 (68.3%)	348 (71.5%)	531 (70.3%)	46 (65.7%)	485 (70.8%)	531 (70.3%)	223 (79.6%)
Total		480 (100.0%)	275 (100.0%)	755 (100.0%)	268 (100.0%)	487 (100.0%)	755 (100.0%)	70 (100.0%)	685 (100.0%)	755 (100.0%)	280 (100.0%)
Chi square		.533 (.465)			.835 (.361)			.788 (.375)			18.494 (.0)
Media	Poor trust	299 (54.0%)	189 (63.9%)	488 (57.4%)	177 (60.6%)	311 (55.7%)	488 (57.4%)	41 (49.4%)	447 (58.3%)	488 (57.4%)	180 (62.7%)
	Good trust	255 (46.0%)	107 (36.1%)	362 (42.6%)	115 (39.4%)	247 (44.3%)	362 (42.6%)	42 (50.6%)	320 (41.7%)	362 (42.6%)	107 (37.3%)
Total		554 (100.0%)	296 (100.0%)	850 (100.0%)	292 (100.0%)	558 (100.0%)	850 (100.0%)	83 (100.0%)	767 (100.0%)	850 (100.0%)	287 (100.0%)
Chi square		7.702 (.006)			1.868 (.172)			2.416 (.120)			4.989 (.02)
Private hospital	Poor trust	245 (44.4%)	168 (59.4%)	413 (49.5%)	134 (46.9%)	279 (50.8%)	413 (49.5%)	36 (43.9%)	377 (50.1%)	413 (49.5%)	170 (58.8%)
	Good trust	307 (55.6%)	115 (40.6%)	422 (50.5%)	152 (53.1%)	270 (49.2%)	422 (50.5%)	46 (56.1%)	376 (49.9%)	422 (50.5%)	119 (41.2%)
Total		552 (100.0%)	283 (100.0%)	835 (100.0%)	286 (100.0%)	549 (100.0%)	835 (100.0%)	82 (100.0%)	753 (100.0%)	835 (100.0%)	289 (100.0%)
Chi square		16.795 (.000)			1.184 (.277)			1.124 (.289)			15.498 (.0)
Government hospitals	Poor trust	36 (5.6%)	29 (8.7%)	65 (6.7%)	27 (8.2%)	38 (5.9%)	65 (6.7%)	4 (4.4%)	61 (6.9%)	65 (6.7%)	11 (3.2%)
	Good trust	605 (94.4%)	304 (91.3%)	909 (93.3%)	304 (91.8%)	605 (94.1%)	909 (93.3%)	86 (95.6%)	823 (93.1%)	909 (93.3%)	333 (96.8%)
Total		641 (100.0%)	333 (100.0%)	974 (100.0%)	331 (100.0%)	643 (100.0%)	974 (100.0%)	90 (100.0%)	884 (100.0%)	974 (100.0%)	344 (100.0%)
Chi square		3.365 (.067)			1.772 (.183)			.791 (.374)			10.317 (.0)
Health ministry	Poor trust	67 (10.7%)	52 (16.0%)	119 (12.5%)	50 (15.6%)	69 (10.9%)	119 (12.5%)	8 (8.9%)	111 (12.9%)	119 (12.5%)	26 (7.8%)
	Good trust	559 (89.3%)	274 (84.0%)	833 (87.5%)	270 (84.4%)	563 (89.1%)	833 (87.5%)	82 (91.1%)	751 (87.1%)	833 (87.5%)	308 (92.2%)
Total		626 (100.0%)	326 (100.0%)	952 (100.0%)	320 (100.0%)	632 (100.0%)	952 (100.0%)	90 (100.0%)	862 (100.0%)	952 (100.0%)	334 (100.0%)

Bold values = (p < 0.005), Poor trust = No confidence + low confidence + Very low confidence,

Good trust = Some confidence + High confidence + Very high confidence.

Variable		Age			District			Education			Occupatio
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker
Chi square		5.398 (.020)			4.304 (.038)			1.185 (.276)			10.460 (.0
Government MO	Poor trust	36 (5.6%)	32 (9.8%)	68 (7.0%)	29 (8.8%)	39 (6.1%)	68 (7.0%)	6 (6.7%)	62 (7.1%)	68 (7.0%)	13 (3.9%)
	Good trust	604 (94.4%)	295 (90.2%)	899(93.0%)	299 (91.2%)	600 (93.9%)	899(93.0%)	84 (93.3%)	815 (92.9%)	899(93.0%)	323 (96.1%)
Total		640 (100.0%)	327 (100.0%)	967 (100.0%)	328 (100.0%)	639 (100.0%)	967 (100.0%)	90 (100.0%)	877 (100.0%)	967 (100.0%)	336 (100.0 %)
Chi square		5.731 (.017)			2.686 (.115)			.020(.887)			7.880 (.00
MOH	Poor trust	36 (5.7%)	26 (8.0%)	62 (6.4%)	22 (6.8%)	40 (6.3%)	62 (6.4%)	7 (7.7%)	55 (14.8%)	62 (6.4%)	10 (2.9%)
	Good trust	599 (94.3%)	301 (92.0%)	900 (93.6%)	300 (93.2%)	600 (93.7%)	900 (93.6%)	84 (92.3%)	816 (85.2%)	900 (93.6%)	329 (97.1%)
Total		635 (100.0%)	327 (100.0%)	962 (100.0%)	322 (100.0%)	640 (100.0%)	962 (100.0%)	91 (100.0%)	371 (100.0%)	962 (100.0%)	339 (100.0%)
Chi square		1.864 (.172)			.120 (.739)			.259 (.611)			10.605 (.0
Allied health officers	Poor trust	37 (6.0%)	42 (13.9%)	79 (8.6%)	29 (9.4%)	50 (8.2%)	79 (8.6%)	4 (4.5%)	75 (9.0%)	79 (8.6%)	27 (8.3%)
	Good trust	579 (94.0%)	261 (86.1%)	840 (91.4%)	279 (90.6%)	561 (91.8%)	840 (91.4%)	84 (95.5%)	756 (91.0%)	840 (91.4%)	297 (91.7%)
Total		616 (100.0%)	303 (100.0%)	919 (100.0%)	308 (100.0%)	611 (100.0%)	919 (100.0%)	88 (100.0%)	831 (100.0%)	919 (100.0%)	324 (100.0%)
Chi square		15.948 (.000)			.396 (.529)			2.032 (.154)			.044 (.834
PHI	Poor trust	39 (6.2%)	33 (10.3%)	72 (12.1%)	27 (8.3%)	45 (7.2%)	72 (12.1%)	5 (5.6%)	67 (7.8%)	72 (12.1%)	13 (3.9%)
	Good trust	595 (93.8%)	286 (89.7%)	581 (92.9%)	298 (91.7%)	583 (92.8%)	881 (92.9%)	84 (94.4%)	797 (92.2%)	881 (92.9%)	318 (96.1%)
Total		634 (100.0%)	319 (100.0%)	593 (100.0%)	325 (100.0%)	628 (100.0%)	593 (100.0%)	89 (100.0%)	864 (100.0%)	593 (100.0%)	331 (100.0%)
Chi square		5.343 (.021)			.400 (.527)			.527 (.468)			9.555 (.00
SLMC	Poor trust	40 (6.6%)	49 (16.7%)	89 (9.9%)	35 (11.6%)	54 (9.0%)	89 (9.9%)	4 (4.7%)	85 (10.4%)	89 (9.9%)	26 (8.2%)
	Good trust	569 (93.4%)	244 (83.3%)	813 (90.1%)	267 (88.4%)	546 (91.0%)	813 (90.1%)	82 (95.3%)	731 (89.6%)	813 (90.1%)	291 (91.8%)
Total		609 (100.0%)	293 (100.0%)	902 (100.0%)	302 (100.0%)	600 (100.0%)	902 (100.0%)	86 (100.0%)	816 (100.0%)	902 (100.0%)	317 (100.0%)
Chi square		22.941 (.000)			1.515 (.218)			2.908 (.088)			1.524 (.21
SLMA	Poor trust	48 (8.1%)	52 (18.0%)	100 (11.4%)	37 (12.5%)	63 (10.8%)	100 (11.4%)	4 (4.8%)	96 (12.1%)	100 (11.4%)	33 (10.4%)
	Good trust	543 (91.9%)	237 (82.0%)	780 (88.6%)	258 (87.5%)	522 (89.2%)	780 (88.6%)	80 (95.2%)	700 (87.9%)	780 (88.6%)	283 (89.6%)
Total		591 (100.0%)	289 (100.0%)	880 (100.0%)	295 (100.0%)	585 (100.0%)	880 (100.0%)	84 (100.0%)	796 (100.0%)	880 (100.0%)	316 (100.0%)
Chi square		18.777 (.000)			.612 (.434)			4.018 (.045)			.415 (.520
GMOA	Poor trust	53 (8.7%)	53 (17.0%)	106 (11.5%)	42 (13.8%)	64 (10.4%)	106 (11.5%)	4 (4.8%)	102 (12.2%)	106 (11.5%)	33 (9.8%)
	Good trust	556 (91.3%)	259 (83.0%)	815 (88.5%)	262 (86.2%)	553 (89.6%)	815 (88.5%)	80 (95.2%)	735 (87.8%)	815 (88.5%)	304 (90.2%)
Total		609 (100.0%)	312 (100.0%)	921 (100.0%)	304 (100.0%)	617 (100.0%)	921 (100.0%)	84 (100.0%)	837 (100.0%)	921 (100.0%)	337 (100.0%)

Bold values = (p < 0.005), Poor trust = No confidence + low confidence + Very low confidence,

Good trust = Some confidence + High confidence + Very high confidence.

Variable		Age			District			Education			Occupatio
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker
Chi square		13.902 (.000)			2.370 (.124)			4.132 (.042)			1.538 (.21)
AMC	Poor trust	105 (19.1%)	100 (36.8%)	205 (24.9%)	70 (24.6%)	135 (25.1%)	205 (24.9%)	16 (20.3%)	189 (25.4%)	205 (24.9%)	89 (32.6%)
	Good trust	445 (80.9%)	172 (63.2%)	617 (75.1%)	214 (75.4%)	403 (74.9%)	617 (75.1%)	63 (79.7%)	554 (74.6%)	617 (75.1%)	184 (67.4%)
Total		550 (100.0%)	272 (100.0%)	822 (100.0%)	284 (100.0%)	538 (100.0%)	822 (100.0%)	79 (100.0%)	743 (100.0%)	822 (100.0%)	273 (100.0%)
Chi square		30.369 (.000)			.020 (.888)			1.025 (.311)			12.817 (.0)
Sri Lanka college of Psychiatrists	Poor trust	62 (10.8%)	56 (20.7%)	118 (13.9%)	43 (15.1%)	75 (13.3%)	118 (13.9%)	10 (12.0%)	108 (14.1%)	118 (13.9%)	33 (10.9%)
	Good trust	514 (89.2%)	215 (79.3%)	729 (86.1%)	241 (84.9%)	488 (86.7%)	729 (86.1%)	73 (88.0%)	656 (85.9%)	729 (86.1%)	269 (89.1%)
Total		576 (100.0%)	271 (100.0%)	847 (100.0%)	284 (100.0%)	563 (100.0%)	847 (100.0%)	83 (100.0%)	764 (100.0%)	847 (100.0%)	302 (100.0%)
Chi square		15.065 (.000)			.521 (.470)			.272 (.602)			3.533 (.06)
SLCCP	Poor trust	49 (8.4%)	45 (15.6%)	94 (10.8%)	37 (12.7%)	57 (9.8%)	94 (10.8%)	8 (9.5%)	86 (10.9%)	94 (10.8%)	21 (6.5%)
	Good trust	535 (91.6%)	244 (84.4%)	779 (89.2%)	254 (87.3%)	525 (90.2%)	779 (89.2%)	76 (90.5%)	703 (89.1%)	779 (89.2%)	303 (93.5%)
Total		584 (100.0%)	289 (100.0%)	873 (100.0%)	291 (100.0%)	582 (100.0%)	873 (100.0%)	84 (100.0%)	789 (100.0%)	873 (100.0%)	324 (100.0%)
Chi square		10.375 (.001)			1.723 (.189)			.150 (.699)			9.850 (.00)
SL President	Poor trust	123 (20.3%)	72 (23.2%)	195 (21.3%)	81 (26.3%)	114 (18.7%)	195 (21.3%)	16 (18.0%)	179 (21.6%)	195 (21.3%)	55 (17.2%)
	Good trust	484 (79.7%)	238 (76.8%)	722 (78.7%)	227 (73.7%)	495 (81.3%)	722 (78.7%)	73 (82.0%)	649 (78.4%)	722 (78.7%)	265 (82.8%)
Total		607 (100.0%)	310 (100.0%)	917 (100.0%)	308 (100.0%)	609 (100.0%)	917 (100.0%)	89 (100.0%)	828 (100.0%)	917 (100.0%)	320 (100.0%)
Chi square		1.075 (.300)			7.019 (.008)			.636 (.425)			4.881 (.02)
SL Government	Poor trust	145 (23.9%)	84 (26.7%)	229 (24.9%)	87 (28.4%)	142 (23.1%)	229 (24.9%)	18 (20.0%)	211 (25.4%)	229 (24.9%)	68 (21.1%)
	Good trust	461 (76.1%)	231 (73.3%)	692 (75.1%)	219 (71.6%)	473 (76.9%)	692 (75.1%)	72 (80.0%)	620 (74.6%)	692 (75.1%)	255 (78.9%)
Total		606 (100.0%)	315 (100.0%)	921 (100.0%)	306 (100.0%)	615 (100.0%)	921 (100.0%)	90 (100.0%)	831 (100.0%)	921 (100.0%)	323 (100.0%)
Chi square		.832(.362)			3.121 (.077)			1.263 (.261)			3.869 (.04)
SL Police	Poor trust	61 (9.9%)	62 (19.6%)	123 (13.2%)	53 (17.1%)	70 (11.3%)	123 (13.2%)	9 (10.0%)	114 (13.5%)	123 (13.2%)	35 (11.0%)
	Good trust	555 (90.1%)	254 (80.4%)	809 (86.8%)	257 (82.9%)	552 (88.7%)	809 (86.8%)	81 (90.0%)	728 (86.5%)	809 (86.8%)	283 (89.0%)
Total		616 (100.0%)	316 (100.0%)	932 (100.0%)	310 (100.0%)	622 (100.0%)	932 (100.0%)	90 (100.0%)	842 (100.0%)	932 (100.0%)	318 (100.0%)
Chi square		17.217 (.000)			6.165 (.013)			.889 (.346)			2.023 (.15)
SL Armed forces	Poor trust	57 (9.1%)	52 (16.3%)	109 (11.6%)	47 (14.7%)	62 (10.0%)	109 (11.6%)	10 (11.0%)	99 (11.6%)	109 (11.6%)	30 (9.4%)
	Good trust	566 (90.9%)	267 (83.7%)	833 (88.4%)	273 (85.3%)	560 (90.0%)	833 (88.4%)	81 (89.0%)	752 (88.4%)	833 (88.4%)	290 (90.6%)
Total		623 (100.0%)	319 (100.0%)	942 (100.0%)	320 (100.0%)	622 (100.0%)	942 (100.0%)	91 (100.0%)	851 (100.0%)	942 (100.0%)	320 (100.0%)

Bold values = (p < 0.005), Poor trust = No confidence + low confidence + Very low confidence,

Good trust = Some confidence + High confidence + Very high confidence.

Variable	Age				District			Education			Occupatio
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker
Chi square		10.546 (.001)			64.600 (.032)			.033 (.855)			2.284 (.13)
Temple	Poor trust	167 (33.2%)	146 (55.5%)	313 (40.9%)	117 (44.0%)	196 (39.2%)	313 (40.9%)	23 (29.5%)	290 (42.2%)	313 (40.9%)	106 (41.4%)
	Good trust	336 (66.8%)	117 (44.5%)	453 (59.1%)	149 (56.0%)	304 (60.8%)	453 (59.1%)	55 (70.5%)	398 (57.8%)	453 (59.1%)	150 (58.6%)
Total		503 (100.0%)	263 (100.0%)	766 (100.0%)	266 (100.0%)	500 (100.0%)	766 (100.0%)	78 (100.0%)	688 (100.0%)	766 (100.0%)	256 (100.0%)
Chi square		35.580 (.000)			1.645 (.200)			4.650 (.031)			.047 (.828)
Church	Poor trust	174 (36.0%)	142 (55.3%)	316 (42.6%)	118 (45.9%)	198 (40.9%)	316 (42.6%)	22 (28.9%)	294 (44.2%)	316 (42.6%)	104 (41.6%)
	Good trust	310 (64.0%)	115 (44.7%)	425 (57.4%)	139 (54.1%)	286 (59.1%)	425 (57.4%)	54 (71.1%)	371 (55.8%)	425 (57.4%)	146 (58.4%)
Total		484 (100.0%)	257 (100.0%)	741 (100.0%)	257 (100.0%)	484 (100.0%)	741 (100.0%)	76 (100.0%)	665 (100.0%)	741 (100.0%)	250 (100.0%)
Chi square		25.571 (.000)			1.719 (.190)			6.496 (.011)			.168 (.681)
Mosques	Poor trust	291 (60.0%)	177 (68.1%)	468 (62.7%)	170 (65.6%)	298 (61.2%)	468 (62.7%)	36 (48.0%)	432 (64.4%)	468 (62.7%)	161 (62.6%)
	Good trust	195 (40.0%)	83 (31.9%)	278 (37.3%)	89 (34.4%)	189 (38.8%)	278 (37.3%)	39 (52.0%)	239 (35.6%)	278 (37.3%)	96 (37.4%)
Total		486 (100.0%)	260 (100.0%)	746 (100.0%)	259 (100.0%)	487 (100.0%)	746 (100.0%)	75 (100.0%)	671 (100.0%)	746 (100.0%)	257 (100.0%)
Chi square		4.872 (.027)			1.430 (.232)			7.744 (.005)			.001 (.971)
District officers	Poor trust	166 (33.4%)	107 (39.9%)	273 (35.7%)	96 (37.8%)	177 (34.6%)	273 (35.7%)	22 (27.5%)	251 (36.6%)	273 (35.7%)	84 (32.7%)
	Good trust	331 (66.6%)	161 (60.1%)	492 (64.3%)	158 (62.2%)	334 (65.4%)	492 (64.3%)	58 (72.5%)	434 (63.4%)	492 (64.3%)	173 (67.3%)
Total		497 (100.0%)	268 (100.0%)	765 (100.0%)	254 (100.0%)	511 (100.0%)	765 (100.0%)	80 (100.0%)	685 (100.0%)	765 (100.0%)	257 (100.0%)
Chi square		3.230 (.072)			.737 (.391)			2.609 (.106)			1.519 (.21)
Grama Niladharis	Poor trust	168 (32.5%)	116 (43.4%)	284 (36.2%)	103 (39.0%)	181 (34.8%)	284 (36.2%)	24 (31.2%)	260 (36.8%)	284 (36.2%)	84 (31.8%)
	Good trust	349 (67.5%)	151 (56.6%)	500 (63.8%)	161 (61.0%)	339 (65.2%)	500 (63.8%)	53 (68.8%)	447 (63.2%)	500 (63.8%)	180 (68.2%)
Total		517 (100.0%)	267 (100.0%)	784 (100.0%)	264 (100.0%)	520 (100.0%)	784 (100.0%)	77 (100.0%)	707 (100.0%)	784 (100.0%)	264 (100.0%)
Chi square		9.139 (.003)			1.342 (.247)			.945 (.331)			3.345 (.06)
Samurdhi officer	Poor trust	183 (38.3%)	140 (53.4%)	323 (43.7%)	116 (45.5%)	207 (42.8%)	323 (43.7%)	28 (37.3%)	295 (44.4%)	323 (43.7%)	102 (40.8%)
	Good trust	295 (61.7%)	121 (46.2%)	416 (56.3%)	139 (54.5%)	277 (57.2%)	416 (56.3%)	47 (62.7%)	369 (55.6%)	416 (56.3%)	148 (59.2%)
Total		478 (100.0%)	262 (100.0%)	739 (100.0%)	255 (100.0%)	484 (100.0%)	739 (100.0%)	75 (100.0%)	664 (100.0%)	739 (100.0%)	250 (100.0%)
Chi square		16.178 (.000)			.503 (.478)			1.378 (.240)			1.298 (.25)
Government university	Poor trust	113 (20.5%)	98 (36.0%)	211 (25.6%)	80 (29.5%)	131 (23.7%)	211 (25.6%)	19 (22.1%)	192 (26.1%)	211 (25.6%)	68 (23.8%)
	Good trust	438 (79.5%)	174 (64.0%)	612 (74.4%)	191 (70.5%)	421 (76.3%)	612 (74.4%)	67 (77.9%)	545 (73.9%)	612 (74.4%)	218 (76.2%)
Total		551 (100.0%)	272 (100.0%)	823 (100.0%)	271 (100.0%)	552 (100.0%)	823 (100.0%)	86 (100.0%)	737 (100.0%)	823 (100.0%)	286 (100.0%)

Bold values = (p < 0.005), Poor trust = No confidence + low confidence + Very low confidence,

Good trust = Some confidence + High confidence + Very high confidence.

Variable		Age			District			Education			Occupatio
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker
Chi square		23.011 (.000)			3.194 (.074)			.633 (.426)			.797 (.372)
Private universities	Poor trust	190 (39.3%)	141 (57.1%)	331 (45.3%)	123 (48.8%)	208 (43.4%)	331 (45.3%)	33 (42.9%)	298 (45.6%)	331 (45.3%)	116 (46.8%)
	Good trust	294 (60.7%)	106 (42.9%)	400 (54.7%)	129 (51.2%)	271 (56.6%)	400 (54.7%)	44 (57.1%)	356 (54.4%)	400 (54.7%)	132 (53.2%)
Total		484 (100.0%)	247 (100.0%)	731 (100.0%)	252 (100.0%)	479 (100.0%)	731 (100.0%)	77 (100.0%)	654 (100.0%)	731 (100.0%)	248 (100.0%)
Chi square		20.981 (.000)			1.933 (.164)			.204 (.652)			.338 (.561)
Government school	Poor trust	170 (34.2%)	137 (53.7%)	307 (40.8%)	113 (43.3%)	194 (39.5%)	307 (40.8%)	23 (28.8%)	284 (42.3%)	307 (40.8%)	112 (43.1%)
	Good trust	327 (65.8%)	118 (46.3%)	445 (59.2%)	148 (56.7%)	297 (60.5%)	445 (59.2%)	57 (71.2%)	388 (57.7%)	445 (59.2%)	148 (56.9%)
Total		497 (100.0%)	255 (100.0%)	752 (100.0%)	261 (100.0%)	491 (100.0%)	752 (100.0%)	80 (100.0%)	672 (100.0%)	752 (100.0%)	260 (100.0%)
Chi square		26.582 (.000)			1.010 (.315)			5.403 (.020)			.835 (.361)
Private schools	Poor trust	197 (41.4%)	152 (60.6%)	349 (48.0%)	127 (50.4%)	222 (46.7%)	349 (48.0%)	33 (41.8%)	316 (48.8%)	349 (48.0%)	132 (52.6%)
	Good trust	279 (58.6%)	99 (39.4%)	378 (52.0%)	125 (49.6%)	253 (53.3%)	378 (52.0%)	46 (58.2%)	332 (51.2%)	378 (52.0%)	119 (47.4%)
Total		476 (100.0%)	251 (100.0%)	727 (100.0%)	252 (100.0%)	475 (100.0%)	727 (100.0%)	79 (100.0%)	648 (100.0%)	727 (100.0%)	251 (100.0%)
Chi square		24.199 (.000)			.884 (.347)			1.380 (.240)			3.228 (.07)
Pre school	Poor trust	220 (47.0%)	156 (64.5%)	376 (53.0%)	141 (55.7%)	235 (51.4%)	376 (53.0%)	34 (45.3%)	342 (53.9%)	376 (53.0%)	141 (57.3%)
	Good trust	248 (53.0%)	86 (35.5%)	334 (47.0%)	112 (44.3%)	222 (48.6%)	334 (47.0%)	41 (54.7%)	293 (46.1%)	334 (47.0%)	105 (42.7%)
Total		468 (100.0%)	242 (100.0%)	710 (100.0%)	253 (100.0%)	457 (100.0%)	710 (100.0%)	75 (100.0%)	635 (100.0%)	710 (100.0%)	246 (100.0%)
Chi square		19.507 (.000)			1.214 (.271)			1.957 (.162)			2.871 (.09)
Public transport	Poor trust	275 (51.8%)	162 (61.6%)	437 (55.0%)	161 (58.1%)	276 (53.4%)	437 (55.0%)	32 (42.7%)	405 (56.3%)	437 (55.0%)	154 (59.5%)
	Good trust	256 (48.2%)	101 (38.4%)	357 (45.0%)	116 (41.9%)	241 (46.6%)	357 (45.0%)	43 (57.3%)	314 (43.7%)	357 (45.0%)	105 (40.5%)
Total		531 (100.0%)	263 (100.0%)	794 (100.0%)	277 (100.0%)	517 (100.0%)	794 (100.0%)	75 (100.0%)	719 (100.0%)	794 (100.0%)	259 (100.0%)
Chi square		6.337 (.009)			1.636 (.201)			5.122 (.024)			3.037 (.08)
Private bus association	Poor trust	351 (67.5%)	209 (78.6%)	560 (71.2%)	196 (72.3%)	364 (70.7%)	560 (71.2%)	43 (58.9%)	517 (72.5%)	560 (71.2%)	205 (77.1%)
	Good trust	169 (32.5%)	57 (21.4%)	226 (28.8%)	75 (27.7%)	151 (29.3%)	226 (28.8%)	30 (41.1%)	196 (27.5%)	226 (28.8%)	61 (22.9%)
Total		520 (100.0%)	266 (100.0%)	786 (100.0%)	271 (100.0%)	515 (100.0%)	786 (100.0%)	73 (100.0%)	713 (100.0%)	786 (100.0%)	266 (100.0%)
Chi square		10.530 (.001)			.235 (.628)			5.984 (.014)			6.650 (.01)
Bold values = (p < 0.005), Poor trust = No confidence + low confidence + Very low confidence,											
Good trust = Some confidence + High confidence + Very high confidence.											

I. Opinion on policies and measures

The high number of participants have agreed on the need for more screening tests (90.9%) and 3 weeks of quarantining (87.5%) and nearly 60 % of the participants did not believe the restrictions were greatly exaggerated. Majority (78.0%) were willing to take a vaccine against COVID-19 (Table 15). The below

30-year-old respondents have agreed with more coercive practices significantly than above 30 participants. The HCW and the participants with above school education have disagreed more significantly on allowing the government to restrict the access to the internet and social media (Table 16).

Table 15
Opinions on policies and measures related to COVID 19

Statement	Strongly disagree	Disagree	Disagree somewhat	Total	Agree somewhat	Agree	Strongly agree	Total	Undecided
If a vaccine becomes available and is recommended for me, I would get it.	26	32	26	84 (8.4%)	117	332	332	781 (78.0%)	136 (13.6%)
In the event of an outbreak, it's appropriate to avoid certain people based on their country of origin.	90	77	58	225 (22.5%)	170	309	209	688 (68.7%)	88 (8.8%)
If infected, the government should be allowed to coerce people to a treatment unit.	30	23	31	84 (8.4%)	135	359	360	854 (85.3%)	63 (6.3%)
Government should allow people to self-assemble (individually) in their own homes if they had contacts	76	64	43	183 (18.3%)	152	308	279	739 (73.8%)	79 (7.9%)
Government should restrict access to the Internet and social media to combat the spread of misinformation	266	164	87	517 (51.7%)	128	145	137	410 (41.0%)	74 (7.4%)
From now on, anyone moving in public areas should be required to wear a face mask	34	28	39	101 (10.1%)	118	300	438	856 (85.5%)	44 (4.4%)
More tests for coronavirus infection should be carried out in the population	20	15	18	53 (5.3%)	83	309	518	910 (90.9%)	38 (3.8%)
Anyone who has had contact should be in quarantine at a quarantine centre for 3 weeks.	26	25	29	80 (8.0%)	109	340	427	876 (87.5%)	45 (4.5%)
I think that the restrictions currently being implemented are greatly exaggerated.	290	191	118	599 (59.9%)	119	97	55	271 (27.1%)	131 (13.1%)
It should only be allowed to leave your house for professional, health or urgent reasons.	38	43	54	135 (13.5%)	138	302	369	809 (80.8%)	57 (5.7%)
Disagree = Strongly disagree + Disagree + Disagree somewhat, Agree = Strongly agree + Agree + Somewhat agree.									

Table 16
Opinions on policies and measures related to COVID 19 against basic demographics

Variable		Age		District			Education			Occupation	
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care workers
Opinion on getting vaccinated	Disagree	55 (9.8%)	29 (95.7%)	84 (9.7%)	25 (8.7%)	59 (10.2%)	84 (9.7%)	13 (16.0%)	71 (9.1%)	84 (9.7%)	33 (10.7%)
	Agree	507 (90.2%)	274 (90.4%)	781 (90.3%)	263 (91.3%)	518 (89.8%)	781 (90.3%)	68 (84.0%)	713 (90.9%)	781 (90.3%)	276 (89.3%)
Total		562 (100.0%)	303 (100.0%)	865 (100.0%)	288 (100.0%)	577 (100.0%)	865 (100.0%)	81 (100.0%)	784 (100.0%)	865 (100.0%)	309 (100.0%)
Chi square		.010 (.919)			.523 (.470)			4.095 (.043)			.514 (.475)
Opinion on avoiding people from country of origin	Disagree	138 (23.1%)	87 (27.5%)	225 (24.6%)	82 (25.9%)	143 (24.0%)	225 (24.6%)	16 (18.0%)	209 (33.5%)	225 (24.6%)	92 (30.2%)
	Agree	459 (76.9%)	229 (72.5%)	688 (75.4%)	235 (75.1%)	453 (76.0%)	688 (75.4%)	73 (82.0%)	615 (98.6%)	688 (75.4%)	213 (69.8%)
Total		597 (100.0%)	316 (100.0%)	913 (100.0%)	317 (100.0%)	596 (100.0%)	913 (100.0%)	89 (100.0%)	624 (100.0%)	913 (100.0%)	305 (100.0%)
Chi square		2.170 (.141)			.391 (.532)			2.360 (.124)			7.515 (.006)
Opinion on coercing infected people in to a treatment unit	Disagree	39 (6.3%)	45 (14.1%)	84 (9.0%)	36 (11.3%)	48 (7.8%)	84 (9.0%)	10 (11.2%)	74 (8.7%)	84 (9.0%)	27 (8.2%)
	Agree	579 (93.7%)	275 (85.9%)	854 (91.0%)	283 (88.7%)	571 (92.2%)	854 (91.0%)	79 (88.8%)	775 (91.3%)	854 (91.0%)	301 (91.8%)
Total		618 (100.0%)	320 (100.0%)	938 (100.0%)	319 (100.0%)	619 (100.0%)	938 (100.0%)	89 (100.0%)	849 (100.0%)	938 (100.0%)	328 (100.0%)
Chi square		15.539 (.000)			3.219 (.073)			.627 (.428)			.324 (.573)
Opinion on self-assembling	Disagree	114 (18.5%)	69 (22.5%)	183 (19.9%)	59 (18.9%)	124 (20.3%)	183 (19.9%)	12 (14.3%)	171 (20.4%)	183 (19.9%)	78 (24.2%)
	Agree	501 (81.5%)	238 (77.5%)	739 (79.1%)	253 (81.1%)	486 (79.7%)	739 (79.1%)	72 (85.7%)	667 (79.6%)	739 (79.1%)	244 (75.8%)
Total		615 (100.0%)	307 (100.0%)	922 (100.0%)	312 (100.0%)	610 (100.0%)	922 (100.0%)	84 (100.0%)	838 (100.0%)	922 (100.0%)	322 (100.0%)
Chi square		1.997 (.158)			.261 (.610)			1.797 (.180)			5.955 (.005)
Opinion on restricting access social media	Disagree	345 (56.7%)	172 (54.1%)	517 (55.8%)	179 (57.0%)	338 (55.1%)	517 (55.8%)	33 (37.9%)	484 (57.6%)	517 (55.8%)	210 (64.4%)
	Agree	264 (43.3%)	146 (45.9%)	410 (44.2%)	135 (43.0%)	275 (44.9%)	410 (44.2%)	54 (62.1%)	356 (42.4%)	410 (44.2%)	116 (35.6%)
Total		609 (100.0%)	318 (100.0%)	927 (100.0%)	314 (100.0%)	613 (100.0%)	927 (100.0%)	87 (100.0%)	840 (100.0%)	927 (100.0%)	326 (100.0%)
Chi square		.556 (.456)			.294 (.588)			12.388 (.000)			15.23 (.000)
Opinion on mandatory wearing of face masks	Disagree	55 (8.7%)	46 (14.2%)	101 (10.6%)	39 (12.1%)	62 (9.8%)	101 (10.6%)	10 (11.1%)	91 (10.5%)	101 (10.6%)	47 (14.2%)
	Agree	577 (91.3%)	279 (85.8%)	856 (89.4%)	284 (87.9%)	572 (90.2%)	856 (89.4%)	80 (88.9%)	776 (89.5%)	856 (89.4%)	285 (85.8%)
Total		632 (100.0%)	325 (100.0%)	957 (100.0%)	323 (100.0%)	634 (100.0%)	957 (100.0%)	90 (100.0%)	867 (100.0%)	957 (100.0%)	332 (100.0%)
Chi square		6.756 (.009)			1.194 (.275)			.033 (.857)			6.990 (.008)
Opinion on performing more tests for COVID 19	Disagree	27 (4.3%)	26 (7.9%)	53 (5.5%)	21 (6.5%)	32 (5.0%)	53 (5.5%)	9 (9.7%)	44 (5.1%)	53 (5.5%)	19 (5.6%)
	Agree	608 (95.7%)	302 (92.1%)	910 (94.5%)	304 (93.5%)	606 (95.0%)	910 (94.5%)	84 (90.3%)	826 (94.9%)	910 (94.5%)	318 (94.4%)
Total		635 (100.0%)	328 (100.0%)	963 (100.0%)	325 (100.0%)	638 (100.0%)	963 (100.0%)	93 (100.0%)	870 (100.0%)	963 (100.0%)	337 (100.0%)

Bold values = (p < 0.005), Disagree = Strongly disagree + Disagree + disagree somewhat,

Agree = Strongly agree + Agree + Somewhat agree.

Variable		Age			District			Education			Occupation
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care workers
Chi square		5.616 (.017)			.866(.352)			3.448 (.063)			.018(.961)
Opinion on quarantining individuals with contact history for 2 weeks	Disagree	40 (6.3%)	40 (12.5%)	80 (8.4%)	35 (10.8%)	45 (7.1%)	80 (8.4%)	10 (10.8%)	70 (8.1%)	80 (8.4%)	30 (9.1%)
	Agree	596 (93.7%)	280 (87.5%)	876 (91.6%)	289 (89.2%)	587 (92.9%)	876 (91.6%)	83 (89.2%)	793 (91.9%)	876 (91.6%)	301 (90.9%)
Total		636 (100.0%)	320 (100.0%)	956 (100.0%)	324 (100.0%)	632 (100.0%)	956 (100.0%)	93 (100.0%)	863 (100.0%)	956 (100.0%)	331 (100.0%)
Chi square		10.709 (.001)			3.787 (.052)			.764(.382)			.319 (.574)
Opinion whether implemented restrictions are exaggerated or not	Disagree	384 (68.2%)	215 (70.0%)	599 (68.9%)	195 (67.2%)	404 (69.7%)	599 (68.9%)	53 (63.1%)	546 (69.5%)	599 (68.9%)	210 (71.7%)
	Agree	179 (31.8%)	92 (30.0%)	271 (31.1%)	95 (32.8%)	176 (30.3%)	271 (31.1%)	31 (36.9%)	240 (30.5%)	271 (31.1%)	83 (28.3%)
Total		563 (100.0%)	307 (100.0%)	870 (100.0%)	290 (100.0%)	580 (100.0%)	870 (100.0%)	84 (100.0%)	786 (100.0%)	870 (100.0%)	293 (100.0%)
Chi square		.309(.578)			.525 (.469)			1.436 (.231)			1.640 (.202)
Opinion on leaving home only for professional health or urgent reasons	Disagree	70 (11.2%)	65 (20.4%)	135 (14.3%)	48 (15.3%)	87 (13.8%)	135 (14.3%)	12 (13.2%)	123 (14.4%)	135 (14.3%)	43 (13.2%)
	Agree	555 (88.8%)	254 (79.6%)	809 (85.7%)	266 (84.7%)	543 (86.2%)	809 (85.7%)	79 (86.8%)	730 (85.6%)	809 (85.7%)	283 (86.8%)
Total		625(100.0%)	319 (100.0%)	944 (100.0%)	314 (100.0%)	630 100.0%	944 (100.0%)	91 (100.0%)	853 (100.0%)	944 (100.0%)	326 (100.0%)
Chi square		14.511 (.000)			.373 (.541)			.102(.749)			.501 (.478)
Bold values = (p < 0.005), Disagree = Strongly disagree + Disagree + disagree somewhat,											
Agree = Strongly agree + Agree + Somewhat agree.											

When it comes to opinions on conspiracies and secrecy 48.6 % was undecided on, whether the virus is a biological weapon by China (Table 17). The participants below 30 years of age believed on conspiracies to a significant level than the above 30-year counterparts (Table 18).

Table 17
Opinions on the reasons behind policy decisions in relation to COVID 19

Policy Decision	Certainly not true	Not true	Somewhat not true	Total	Somewhat true	TRUE	Certainly true	Total	Undecided
Many very important things happen in the world, which the public is never informed about	70	191	115	376 (37.6%)	259	147	73	479 (47.9%)	146 (14.6%)
Politicians usually do not tell us the true motives for their decisions	27	43	48	118 (11.8%)	188	270	329	787 (78.6%)	96 (9.6%)
Government agencies closely monitor all citizens	71	123	127	321 (32.1%)	258	180	46	484 (48.4%)	196 (19.6%)
Events which superficially seem to lack a connection are often the result of secret activities	27	69	61	157 (15.7%)	232	210	86	528 (52.7%)	316 (31.6%)
There are secret organizations that greatly influence political decisions	26	51	45	122 (12.2%)	211	213	163	165587 (58.7%)	292 (29.2%)
This New COVID 19 viruses is a deliberate biological weapon invented in laboratories in China.	91	128	75	294 (29.4%)	121	74	26	221 (22.1%)	486 (48.6%)
The World Health Organization did not do the right thing in favour of China	104	137	94	335 (33.5%)	117	77	35	229 (22.9%)	437 (43.7%)

Table 18
Opinions on the reasons behind policy decisions in relation to COVID 19 against basic demographics.

Variable		Age		District			Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Important things happen in the world which the public is never informed	Not true	231 (41.3%)	145 (49.2%)	376 (44.0%)	129 (45.3%)	247 (43.3%)	376 (44.0%)	37 (48.7%)	339 (43.5%)	376 (44.0%)	122 (41.6%)	254 (45.2%)
	TRUE	329 (58.7%)	150 (50.8%)	479 (56.0%)	156 (54.7%)	323 (56.7%)	479 (56.0%)	39 (51.3%)	440 (56.5%)	479 (56.0%)	171 (58.4%)	308 (54.8%)
Total		560 (100.0%)	295 (100.0%)	855 (100.0%)	285 (100.0%)	570 (100.0%)	855 (100.0%)	76 (100.0%)	779 (100.0%)	855 (100.0%)	293 (100.0%)	562 (100.0%)
Chi square		4.898 (.027)			.287 (.592)			.750 (.386)			.989 (.320)	
Politicians usually do not tell us the true motives of their decisions	Not true	71 (12.1%)	47 (14.9%)	118 (13.0%)	31 (10.1%)	87 (14.6%)	118 (13.0%)	11 (12.8%)	107 (13.1%)	118 (13.0%)	40 (12.5%)	78 (13.3%)
	TRUE	518 (87.9%)	269 (85.1%)	787 (87.0%)	277 (89.9%)	510 (85.4%)	787 (87.0%)	75 (87.2%)	712 (86.9%)	787 (87.0%)	280 (87.5%)	507 (86.7%)
Total		589 (100.0%)	316 (100.0%)	905 (100.0%)	308 (100.0%)	597 (100.0%)	905 (100.0%)	86 (100.0%)	819 (100.0%)	905 (100.0%)	320 (100.0%)	585 (100.0%)
Chi square		1.441 (.230)			3.641 (.056)			.005 (.943)			.127 (.722)	
Government agencies should always monitor all the citizens	Not true	189 (36.2%)	132 (46.6%)	321 (39.9%)	120 (43.8%)	201 (37.9%)	321 (39.9%)	26 (35.1%)	295 (40.4%)	321 (39.9%)	108 (39.0%)	213 (40.3%)
	TRUE	333 (63.8%)	151 (53.4%)	484 (60.1%)	154 (56.2%)	330 (62.1%)	484 (60.1%)	48 (64.9%)	436 (59.6%)	484 (60.1%)	169 (61.0%)	315 (59.7%)
Total		522 (100.0%)	283 (100.0%)	805 (100.0%)	274 (100.0%)	531 (100.0%)	805 (100.0%)	74 (100.0%)	731 (100.0%)	805 (100.0%)	277 (100.0%)	528 (100.0%)
Chi square		8.337 (.004)			2.662 (.103)			.764 (.382)			.138 (.710)	
Events which superficially seem to lack a connection are often a result of secret activity	Not true	80 (18.3%)	77 (31.2%)	157 (22.9%)	57 (23.9%)	100 (22.4%)	157 (22.9%)	7 (11.3%)	150 (24.1%)	157 (22.9%)	66 (28.2%)	91 (20.2%)
	TRUE	358 (81.7%)	170 (68.8%)	528 (77.1%)	181 (76.1%)	347 (77.6%)	528 (77.1%)	55 (88.7%)	473 (75.9%)	528 (77.1%)	168 (71.8%)	360 (79.8%)
Total		438 (100.0%)	247 (100.0%)	685 (100.0%)	238 (100.0%)	447 (100.0%)	685 (100.0%)	62 (100.0%)	623 (100.0%)	685 (100.0%)	234 (100.0%)	451 (100.0%)
Chi square		14.898 (.000)			.219 (.640)			5.219 (.022)			5.620 (.018)	
There are secret organizations that greatly influence political decisions	Not true	63 (13.9%)	59 (23.1%)	122 (17.2%)	37 (14.8%)	85 (18.5%)	122 (17.2%)	7 (10.4%)	115 (17.9%)	122 (17.2%)	50 (20.2%)	72 (15.6%)
	TRUE	391 (86.1%)	196 (76.9%)	587 (82.8%)	213 (85.2%)	374 (81.5%)	587 (82.8%)	60 (89.6%)	527 (82.1%)	587 (82.8%)	198 (79.8%)	389 (84.4%)
Total		454 (100.0%)	255 (100.0%)	709 (100.0%)	250 (100.0%)	459 (100.0%)	709 (100.0%)	67 (100.0%)	642 (100.0%)	709 (100.0%)	248 (100.0%)	461 (100.0%)
Chi square		9.829 (.002)			1.571 (.210)			2.373 (.123)			2.336 (.126)	
New COVID 19 virus is a deliberate biological weapon invented in laboratories in China	Not true	173 (52.9%)	121 (64.4%)	294 (57.1%)	99 (58.2%)	195 (56.5%)	294 (57.1%)	22 (41.5%)	272 (58.9%)	294 (57.1%)	108 (60.7%)	186 (55.2%)
	TRUE	154 (47.1%)	67 (35.6%)	221 (42.9%)	71 (41.8%)	150 (43.5%)	221 (42.9%)	31 (58.5%)	190 (41.1%)	221 (42.9%)	70 (39.3%)	151 (44.8%)
Total		327 (100.0%)	188 (100.0%)	515 (100.0%)	170 (100.0%)	345 (100.0%)	515 (100.0%)	53 (100.0%)	462 (100.0%)	515 (100.0%)	178 (100.0%)	337 (100.0%)

Bold values = (p < 0.005), Not true = Certainly not true + Not true + Somewhat not true,

True = Certainly true + True + Somewhat true.

Variable		Age			District			Education			Occupation	
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Chi square		6.396 (.011)						5.852 (.016)			1.429 (.232)	
WHO didn't do the right thing in favour of China	Not true	203 (56.9%)	132 (63.8%)	335 (59.4%)	110 (58.8%)	225 (59.7%)	335 (59.4%)	31 (55.4%)	304 (59.8%)	335 (59.4%)	129 (62.6%)	206 (57.5%)
	TRUE	154 (43.1%)	75 (36.2%)	229 (40.6%)	77 (41.2%)	152 (40.3%)	229 (40.6%)	25 (44.6%)	204 (40.2%)	229 (40.6%)	77 (37.4%)	152 (42.5%)
Total		357 (100.0%)	207 (100.0%)	564 (100.0%)	187 (100.0%)	377 (100.0%)	564 (100.0%)	56 (100.0%)	508 (100.0%)	564 (100.0%)	206 (100.0%)	358 (100.0%)
Chi square		2.591 (.107)			.038 (.845)			.421 (.517)			1.399 (.237)	
Bold values = (p < 0.005), Not true = Certainly not true + Not true + Somewhat not true,												
True = Certainly true + True + Somewhat true.												

The majority (82.32%) agreed that the decisions taken by the Sri Lankan government to control COVID-19 were fair (Fig. 13). There was no significant association between opinion on fairness of the decisions and demographic variables (Table 19). Just above half of the population had a hard time making it through stressful events due to policies on COVID-19 (Fig. 14). The stressful experiences were not significantly associated with age, living district, education level or occupation (Table 20) and 56.4% of participants were ready to seek help for them (Fig. 15).

Table 19
Opinion on overall COVID 19 decisions taken in Sri Lanka against basic demographics

Opinion on overall COVID-19 decisions taken in Sri Lanka against basic demographics												
Variable		Age			District		Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Fairness of the decision made in the country	Disagree	83 (13.1%)	55 (16.8%)	138 (14.3%)	56 (17.1%)	82 (12.9%)	138 (14.3%)	11 (12.1%)	127 (14.6%)	138 (14.3%)	38 (11.1%)	100 (16.1%)
	Agree	551 (86.9%)	273 (83.2%)	824 (85.7%)	272 (82.9%)	552 (87.1%)	824 (85.7%)	80 (87.9%)	744 (85.4%)	824 (85.7%)	303 (88.9%)	521 (83.9%)
Total		634 (100.0%)	328 (100.0%)	962 (100.0%)	328 (100.0%)	634 (100.0%)	962 (100.0%)	91 (100.0%)	871 (100.0%)	962 (100.0%)	341 (100.0%)	621 (100.0%)
Chi square		2.378 (.123)			3.014 (.083)		.417 (.519)			4.406 (.036)		
Disagree = Strongly disagree + Disagree + disagree somewhat, Agree = Strongly agree + Agree + Somewhat agree.												

Table 20
Opinion on the difficulty in managing stressful events due to COVID 19 policies against basic demographics

Opinion on the difficulty in managing stressful events due to COVID-19 policies against basic demographics												
Variable		Age			District		Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Difficulty in making it through stressful events	Disagree	229 (39.1%)	140 (44.7%)	369 (41.1%)	119 (40.5%)	250 (41.4%)	369 (41.1%)	28 (32.2%)	341 (42.0%)	369 (41.1%)	143 (44.7%)	226 (39.1%)
	Agree	356 (60.9%)	173 (55.3%)	529 (58.9%)	175 (59.5%)	354 (58.6%)	529 (58.9%)	59 (67.8%)	470 (58.0%)	529 (58.9%)	177 (55.3%)	352 (60.9%)
Total		585 (100.0%)	313 (100.0%)	898 (100.0%)	294 (100.0%)	604 (100.0%)	898 (100.0%)	87 (100.0%)	811 (100.0%)	898 (100.0%)	320 (100.0%)	578 (100.0%)
Chi square		2.626 (.105)						3.158 (.076)			2.656 (.103)	
Statistical significance = p < 0.005												

Our population was cautious and were supporting health recommendations even upon reopening (Table 21). Participants from high-risk districts were of the opinion that the restrictions should be upheld in urban but not in rural areas. Participants below 30 years as opposed to above 30 years people, significantly believed that the prevailed restrictions should not be lifted beyond May 2020, the country's reopening month of the first wave. The non HCW agreed on obligatory mass testing to identify infected people in a statistically significant level than the HCW (Table 22).

Table 21
Opinions on policies of re- opening

Opinions on policies of re- opening	Strongly disagree	Disagree	Disagree somewhat	Total	Agree somewhat	Agree	Strongly agree	Total	Undecided
Only people over the age of 70 should stay at home	241	334	93	668 (66.8%)	107	82	50	239 (23.9%)	94 (9.4%)
The restrictions should be upheld in towns and cities, but not rural areas	229	365	136	730 (73.0%)	125	48	18	191 (19.1%)	80 (8.0%)
Restrictions should not be lifted in the regions, where more people are infected and the imposed restrictions should be lifted in other areas where less number of people are infected.	83	168	107	358 (35.8%)	261	201	88	550 (54.9%)	93 (9.3%)
Current restrictions should not be lifted, even beyond May	62	116	126	304 (30.4%)	219	208	126	553 (55.2%)	144 (14.4%)
Everyone should be obligated to wear a mask in public.	30	40	29	99 (9.9%)	133	328	375	836 (83.5%)	66 (6.6%)
Obligatory mass testing is an acceptable way to identify infected persons	33	42	36	111 (11.1%)	126	352	298	776 (77.5%)	114 (11.4%)
I will continue to live up to restrictions, even if they are no longer formal recommendations	22	44	27	93 (9.3%)	183	361	269	813 (81.2%)	95 (9.5%)

Table 22
Opinions on policies of reopening the country against basic demographics

Variable		Age		District			Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Only people over the age of 70 should stay at home	Disagree	443 (74.8%)	225 (71.4%)	668 (73.6%)	229 (75.1%)	439 (72.9%)	668 (73.6%)	64 (74.4%)	604 (73.6%)	668 (73.6%)	248 (76.5%)	420 (72.0%)
	Agree	149 (25.2%)	90 (28.6%)	239 (26.4%)	76 (24.9%)	163 (27.1%)	239 (26.4%)	22 (25.6%)	217 (26.4%)	239 (26.4%)	76 (23.5%)	163 (28.0%)
Total		592 (100.0%)	315 (100.0%)	907 (100.0%)	305 (100.0%)	602 (100.0%)	907 (100.0%)	86 (100.0%)	821 (100.0%)	907 (100.0%)	324 (100.0%)	583 (100.0%)
Chi square		1.226 (.268)			.486 (.486)			.029 (.865)			2.175 (.140)	
Restrictions should be upheld in urban but not in rural	Disagree	493 (81.4%)	237 (75.2%)	730 (79.3%)	229 (73.2%)	501 (82.4%)	730 (79.3%)	75 (83.3%)	655 (78.8%)	730 (79.3%)	267 (81.9%)	463 (77.0%)
	Agree	113 (18.6%)	78 (24.8%)	191 (20.7%)	84 (26.8%)	107 (17.6%)	191 (20.7%)	15 (16.7%)	176 (21.2%)	191 (20.7%)	59 (18.1%)	132 (22.0%)
Total		606 (100.0%)	315 (100.0%)	921 (100.0%)	313 (100.0%)	608 (100.0%)	921 (100.0%)	90 (100.0%)	831 (100.0%)	921 (100.0%)	326 (100.0%)	595 (100.0%)
Chi square					10.729 (.001)			1.006 (.316)			2.140 (.144)	
Restrictions should not be lifted in high-risk areas	Disagree	231 (39.0%)	127 (40.2%)	358 (39.4%)	122 (39.6%)	236 (39.3%)	358 (39.4%)	44 (52.4%)	314 (38.1%)	358 (39.4%)	112 (35.3%)	246 (41.0%)
	Agree	361 (61.0%)	189 (59.8%)	550 (60.6%)	186 (60.4%)	364 (60.7%)	550 (60.6%)	40 (47.6%)	510 (61.9%)	550 (60.6%)	205 (64.7%)	345 (58.0%)
Total		592 (100.0%)	316 (100.0%)	908 (100.0%)	308 (100.0%)	600 (100.0%)	908 (100.0%)	84 (100.0%)	824 (100.0%)	908 (100.0%)	317 (100.0%)	591 (100.0%)
Chi square		.118 (.731)			.007 (.936)			6.504 (.011)			3.422 (.064)	
Current restrictions should not be up lifted beyond May	Disagree	179 (32.0%)	125 (41.8%)	304 (35.5%)	109 (37.7%)	195 (34.3%)	304 (35.5%)	24 (28.6%)	280 (36.2%)	304 (35.5%)	115 (40.2%)	189 (33.0%)
	Agree	379 (68.0%)	174 (58.2%)	553 (64.5%)	180 (62.3%)	373 (65.7%)	553 (64.5%)	60 (71.4%)	493 (63.8%)	553 (64.5%)	171 (59.8%)	382 (66.0%)
Total		558 (100.0%)	299 (100.0%)	857 (100.0%)	289 (100.0%)	568 (100.0%)	857 (100.0%)	84 (100.0%)	773 (100.0%)	857 (100.0%)	286 (100.0%)	571 (100.0%)
Chi square		8.057 (.005)			.959 (.327)			1.938 (.164)			4.208 (.040)	
Obligated to wear a mask in public	Disagree	54 (8.9%)	45 (13.8%)	99 (10.6%)	37 (11.6%)	62 (10.0%)	99 (10.6%)	9 (9.8%)	90 (10.7%)	99 (10.6%)	45 (13.8%)	54 (8.9%)
	Agree	554 (91.1%)	282 (86.2%)	836 (89.4%)	281 (88.4%)	555 (90.0%)	836 (89.4%)	83 (90.2%)	753 (89.3%)	836 (89.4%)	280 (86.2%)	556 (91.0%)
Total		608 (100.0%)	327 (100.0%)	935 (100.0%)	318 (100.0%)	617 (100.0%)	935 (100.0%)	92 (100.0%)	843 (100.0%)	935 (100.0%)	325 (100.0%)	610 (100.0%)
Chi square		5.349 (.021)			.558 (.455)			.070 (.791)			5.585 (.018)	
Obligatory mass testing to identify infected people	Disagree	67 (11.7%)	44 (14.1%)	111 (12.5%)	34 (11.1%)	77 (13.3%)	111 (12.5%)	10 (11.6%)	101 (12.6%)	111 (12.5%)	53 (16.7%)	58 (10.0%)
	Agree	508 (88.3%)	268 (85.9%)	776 (87.5%)	272 (88.9%)	504 (86.7%)	776 (87.5%)	76 (88.4%)	700 (87.4%)	776 (87.5%)	265 (83.3%)	511 (89.0%)
Total		575 (100.0%)	312 (100.0%)	887 (100.0%)	306 (100.0%)	581 (100.0%)	887 (100.0%)	86 (100.0%)	801 (100.0%)	887 (100.0%)	318 (100.0%)	569 (100.0%)
Chi square		1.109 (.292)			.840 (.359)			.068 (.794)			7.808 (.005)	
Continue to live up to restrictions even they are up lifted	Disagree	64 (10.8%)	29 (9.2%)	93 (10.3%)	31 (10.0%)	62 (10.4%)	93 (10.3%)	10 (10.6%)	83 (10.2%)	93 (10.3%)	40 (12.7%)	53 (9.0%)
	Agree	526 (89.2%)	287 (90.8%)	813 (89.7%)	278 (90.0%)	535 (89.6%)	813 (89.7%)	84 (89.4%)	729 (89.8%)	813 (89.6%)	275 (87.3%)	538 (91.0%)

Bold values = p < 0.005, Disagree = Strongly disagree + Disagree + Somewhat disagree,

Agree = Strongly agree + Agree + Somewhat agree.

Variable	Age		District				Education			Occupation	
	Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Total	590 (100.0%)	316 (100.0%)	906 (100.0%)	309 (100.0%)	597 (100.0%)	906 (100.0%)	94 (100.0%)	812 (100.0%)	906 (100.0%)	315 (100.0%)	591 (100.0%)
Chi square	.623 (.430)		.028 (.868)				.016 (.900)			3.105 (.078)	
Bold values = p < 0.005, Disagree = Strongly disagree + Disagree + Somewhat disagree,											
Agree = Strongly agree + Agree + Somewhat agree.											

J. Stigma

Majority (78.9%) of our study population did not consider contracting COVID-19 virus as stigmatizing (Fig. 16). There was no significant association between the stigma of COVID-19 and the selected variables (Table 23). Out of the total population, only 823 (82.22%) have indicated their basis for stigma (Fig. 17).

Table 23
Opinion on contracting COVID 19 as stigmatizing against basic demographics

Opinion on contracting COVID-19 as stigmatizing against basic demographics												
Variable		Age		District			Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Considering contracting New COVID 19 virus as stigmatizing?	Yes	139 (21.0%)	72 (21.2%)	211 (21.1%)	71 (20.8%)	140 (21.2%)	211 (21.1%)	18 (18.9%)	193 (21.3%)	211 (21.1%)	90 (25.6%)	121 (18.6%)
	No	522 (79.0%)	268 (78.8%)	790 (78.9%)	270 (79.2%)	520 (78.8%)	790 (78.9%)	77 (81.1%)	713 (78.7%)	790 (78.9%)	261 (74.4%)	529 (81.4%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		.003 (.957)			.021 (.886)			.287 (.592)			6.763 (.009)	
Statistical significance = p < 0.005												

K. Behaviours

The behaviours our population practiced most were the ones in relation to avoiding unnecessary contact with others and the majority (> 70%) have claimed that they were not interested or engaged in panic buying behaviours. The least common (3.69%) behaviour was “drinking alcohol more than usual” (Fig. 18). The people below 30 years avoided family and friends and also blocked contact of the children with their friends to a significant level when compared with above 30 years participants (Table 24).

Table 24
Behaviours practiced in relation to COVID 19 against basic demographics

Variable		Age		District			Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Bought food supplies on a large scale	Already done or planned	199 (30.1%)	104 (30.6%)	303 (30.0%)	104 (30.5%)	199 (30.2%)	303 (30.0%)	25 (26.3%)	278 (30.7%)	303 (30.0%)	113 (32.2%)	190 (29.1%)
	Not done or not planned	462 (69.9%)	236 (69.4%)	698 (69.7%)	237 (69.5%)	461 (69.8%)	698 (69.7%)	70 (73.7%)	628 (69.3%)	698 (69.7%)	238 (67.8%)	460 (70.9%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		.025 (.875)			.013 (.910)			.777 (.387)			.948 (.330)	
Bought other everyday things on a large scale	Already done or planned	164 (24.8%)	82 (24.1%)	246 (24.6%)	80 (23.5%)	166 (25.2%)	246 (24.6%)	24 (25.3%)	222 (24.5%)	246 (24.6%)	94 (26.8%)	152 (23.1%)
	Not done or not planned	497 (75.2%)	258 (75.9%)	755 (75.4%)	261 (76.5%)	494 (74.8%)	755 (75.4%)	71 (74.7%)	684 (75.5%)	755 (75.4%)	257 (73.2%)	498 (76.9%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		.058 (.809)			.347 (.556)			.027 (.870)			1.418 (.234)	
Bought medicines on a large scale	Already done or planned	183 (27.7%)	110 (32.4%)	293 (29.3%)	115 (33.7%)	178 (27.0%)	293 (29.3%)	27 (28.4%)	266 (29.4%)	293 (29.3%)	109 (31.1%)	184 (28.1%)
	Not done or not planned	478 (72.3%)	230 (67.6%)	708 (70.7%)	226 (66.3%)	482 (73.0%)	708 (70.7%)	68 (71.6%)	640 (70.6%)	708 (70.7%)	242 (68.9%)	466 (71.9%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		2.363 (.124)			4.955 (.026)			.037 (.848)			.830 (.362)	
Bought personal protective equipment in large scales (e.g.- face masks, gloves).	Already done or planned	160 (24.2%)	105 (30.9%)	265 (26.5%)	102 (29.9%)	163 (24.7%)	265 (26.5%)	30 (31.6%)	235 (25.9%)	265 (26.5%)	88 (25.1%)	177 (27.1%)
	Not done or not planned	501 (75.8%)	235 (69.1%)	736 (73.5%)	239 (70.1%)	497 (75.3%)	736 (73.5%)	65 (68.4%)	671 (74.1%)	736 (73.5%)	263 (74.9%)	473 (72.9%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		5.142 (.023)			3.141 (.076)			1.406 (.236)			.546 (.460)	
Avoided people who come from countries where coronavirus cases have occurred, such as China or Italy	Already done or planned	431 (65.2%)	205 (60.3%)	636 (63.5%)	218 (63.9%)	418 (63.3%)	636 (63.5%)	61 (64.2%)	575 (63.5%)	636 (63.5%)	216 (61.5%)	420 (64.6%)
	Not done or not planned	230 (34.8%)	135 (39.7%)	365 (36.5%)	123 (36.1%)	242 (36.7%)	365 (36.5%)	34 (35.8%)	331 (36.5%)	365 (36.5%)	135 (38.5%)	230 (35.4%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		1.000 (.594)			.000 (1.000)			.000 (1.000)			.000 (1.000)	

Chi Square = (p < 0.005), Already done or planned = I already did that + I plan to do that,
Not done or not planned = I don't plan.

Variable		Age			District			Education			Occupation	
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
	Not done or not planned	230 (34.8%)	135 (39.7%)	365 (36.5%)	123 (36.1%)	242 (36.7%)	365 (36.5%)	34 (35.8%)	331 (36.5%)	365 (36.5%)	135 (38.5%)	230 (35.1%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		2.336 (.126)			.035 (.853)			.021 (.886)			.931 (.334)	
Exercised less	Already done or planned	187 (28.3%)	105 (30.9%)	292 (29.2%)	106 (31.1%)	186 (28.2%)	292 (29.2%)	25 (26.3%)	267 (29.5%)	292 (29.2%)	94 (26.8%)	198 (30.1%)
	Not done or not planned	474 (71.7%)	235 (69.1%)	709 (70.8%)	235 (68.9%)	474 (71.8%)	709 (70.8%)	70 (73.7%)	639 (70.5%)	709 (70.8%)	257 (73.2%)	452 (69.9%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		.730 (.393)			.917 (.338)			.414 (.520)			1.495 (.221)	
Drank more alcohol than usually do	Already done or planned	63 (9.5%)	22 (6.5%)	85 (8.5%)	21 (6.2%)	64 (9.7%)	85 (8.5%)	8 (8.4%)	77 (88.5%)	85 (8.5%)	28 (8.0%)	57 (8.8%)
	Not done or not planned	598 (90.5%)	318 (93.5%)	916 (91.5%)	320 (93.8%)	596 (90.3%)	916 (91.5%)	87 (91.6%)	889 (91.5%)	916 (91.5%)	323 (92.0%)	593 (91.2%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		2.706 (.100)			3.623 (.057)			.001 (.979)			.184 (.668)	
Ate more unhealthy food than usually do	Already done or planned	121 (18.3%)	71 (20.9%)	192 (19.2%)	55 (16.1%)	137 (20.8%)	192 (19.2%)	22 (23.2%)	170 (18.8%)	192 (19.2%)	71 (20.2%)	121 (18.5%)
	Not done or not planned	540 (81.7%)	269 (79.1%)	809 (80.8%)	286 (83.9%)	523 (79.2%)	809 (80.8%)	73 (76.8%)	736 (81.2%)	809 (80.8%)	280 (79.8%)	529 (81.5%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		.962 (.327)			3.107 (.078)			1.071 (.301)			.382 (.536)	
Avoided going to the doctor with issues that could be postponed	Already done or planned	361 (54.6%)	207 (60.9%)	568 (56.7%)	196 (57.5%)	372 (56.4%)	568 (56.7%)	48 (50.5%)	520 (57.4%)	568 (56.7%)	209 (59.5%)	359 (55.1%)
	Not done or not planned	300 (45.4%)	133 (39.1%)	433 (43.3%)	145 (42.5%)	288 (43.6%)	433 (43.3%)	47 (49.5%)	386 (42.6%)	433 (43.3%)	142 (40.5%)	291 (44.9%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		3.594 (.058)			.114 (.736)			1.653 (.199)			1.728 (.189)	
Avoided visiting family even when did not have symptoms of disease	Already done or planned	441 (66.7%)	259 (76.2%)	700 (69.9%)	225 (66.0%)	475 (72.0%)	700 (69.9%)	67 (70.5%)	633 (69.9%)	700 (69.9%)	233 (66.4%)	467 (71.1%)
	Not done or not planned	220 (33.3%)	81 (23.8%)	301 (30.1%)	116 (34.0%)	185 (28.0%)	301 (30.1%)	28 (29.5%)	273 (30.1%)	301 (30.1%)	118 (33.6%)	183 (28.9%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)

Bold values = (p < 0.005), Already done or planned = I already did that + I plan to do that,

Not done or not planned = I don't plan.

Variable		Age			District			Education			Occupation	
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Chi Square		9.554 (.002)			3.833 (.050)			.018 (.894)			3.236 (.072)	
Asked family members or friends not to visit	Already done or planned	403 (61.0%)	242 (71.2%)	645 (64.4%)	213 (62.5%)	432 (65.5%)	645 (64.4%)	63 (66.3%)	582 (64.2%)	645 (64.4%)	213 (60.7%)	432 (66.3%)
	Not done or not planned	258 (39.0%)	98 (28.8%)	356 (35.6%)	128 (37.5%)	228 (34.5%)	356 (35.6%)	32 (33.7%)	324 (35.8%)	356 (35.6%)	138 (39.3%)	218 (33.7%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		10.210 (.001)			.878 (.349)			.162 (.687)			3.320 (.068)	
Decided that child could not meet with a friend	Already done or planned	285 (43.1%)	202 (59.4%)	487 (48.7%)	162 (47.5%)	325 (49.2%)	487 (48.7%)	51 (53.7%)	436 (48.1%)	487 (48.7%)	164 (46.7%)	323 (49.5%)
	Not done or not planned	376 (56.9%)	138 (40.6%)	514 (51.3%)	179 (52.5%)	335 (50.8%)	514 (51.3%)	44 (46.3%)	470 (51.9%)	514 (51.3%)	187 (53.3%)	327 (50.5%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi Square		23.864 (.000)			.271 (.603)			1.064 (.302)			.804 (.370)	
Bold values = (p < 0.005), Already done or planned = I already did that + I plan to do that,												
Not done or not planned = I don't plan.												

L. Worries and fears

The highest number of participants (85.1%) were worried about the wellbeing of their loved ones during the pandemic. Not being able to participate in social events was the least represented worry (41.8%) (Table 25).

Table 25
Worries in relation to COVID 19

Worry	Don't worry at all	Don't worry	Don't worry much	Total	Somewhat worry	Worry	Worry a lot	Total	Undecided
Losing someone I love	68	42	66	176 (17.6%)	142	201	401	744 (74.3%)	81 (8.0%)
Health system being overloaded	30	40	39	109 (10.9%)	206	350	249	805 (80.4%)	87 (8.7%)
Government taking care of not disclosing some information to the public.	37	40	63	140 (14.0%)	259	276	162	697 (69.6%)	164 (16.4%)
My mental well being	80	86	117	283 (28.3%)	230	243	142	615 (61.4%)	103 (10.3%)
My physical well being	62	79	101	242 (24.2%)	245	277	159	681 (68.0%)	78 (7.8%)
The wellbeing of my loved ones	30	34	46	110 (11.0%)	204	320	328	852 (85.1%)	39 (3.9%)
Inability to feed my family properly	92	85	109	286 (28.6%)	180	211	168	559 (55.8%)	156 (15.6%)
Limited freedom of movement	106	108	139	353 (35.3%)	266	197	96	559 (55.8%)	89 (8.9%)
Missing out on vacation opportunities	147	112	138	397 (39.7%)	241	156	101	498 (49.8%)	106 (10.6%)
The closure of schools	142	95	127	364 (36.4%)	222	150	83	455 (45.5%)	182 (18.2%)
The closure of universities and higher education centres.	121	69	102	292 (29.2%)	214	210	176	600 (59.9%)	109 (10.9%)
Small companies running out of business	55	39	72	166 (16.6%)	266	286	143	695 (69.4%)	140 (14.0%)
Economic recession in my country	37	35	47	119 (11.9%)	228	340	229	797 (79.6%)	85 (8.5%)
Restricted access to food supplies	42	47	69	158 (15.8%)	273	325	152	750 (74.9%)	93 (9.3%)
Becoming unemployed	95	72	88	255 (25.5%)	179	244	197	620 (61.9%)	126 (12.6%)
Not being able to pay my bills	118	104	103	325 (32.5%)	205	193	133	531 (53.0%)	145 (14.5%)
Not be able to visit people who depend on me	91	93	84	268 (26.8%)	216	213	128	557 (55.6%)	176 (17.6%)
Having to defend a decision not to participate in a social event which my family or friends expect me to attend	197	116	108	421 (42.1%)	179	154	85	418 (41.8%)	162 (16.2%)
Do not worry = Don't worry at all + Don't worry + don't worry much, Worry = Worry a lot + Worry + Somewhat worry									

Participants below 30 years were significantly worried about the government not disclosing some information to the public, the closure of universities and higher educational centres and not being able to pay their bills when compared to their older counterparts. The above 30 age group was significantly worried about limited freedom of movement and missing out on vacation opportunities. The worry about closure of universities and higher education centres was significantly higher in participants who lived in low-risk districts compared to high-risk districts. The non HCW had significantly worried about becoming unemployed and not being able to pay their bills than the HCW. The thought of having to defend a decision not to participate in a social event with family or friends has caused significant worry in participants who are less than 30 years, than in the above 30 participants (Table 26).

Table 26
Worries in relation to COVID 19 against basic demographics

Variable		Age		District			Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Losing someone love	Do not worry	118 (19.5%)	58 (18.4%)	176 (19.1%)	57 (18.2%)	119 (19.6%)	176 (19.1%)	21 (23.6%)	155 (18.7%)	176 (19.1%)	55 (16.9%)	121 (20.4)
	Worry	486 (80.5%)	258 (81.6%)	744 (80.9%)	257 (81.8%)	487 (80.4%)	744 (80.9%)	68 (76.4%)	676 (81.3%)	744 (80.9%)	271 (83.1%)	473 (79.6)
Total		604 (100.0%)	316 (100.0%)	920 (100.0%)	314 (100.0%)	606 (100.0%)	920 (100.0%)	89 (100.0%)	831 (100.0%)	920 (100.0%)	326 (100.0%)	594 (100.0)
Chi square		.184(.665)			.294(.587)			1.270 (.260)			1.666 (.197)	
Health system being overloaded	Do not worry	75 (12.5%)	34 (10.9%)	109 (11.9%)	37 (11.7%)	72 (12.1%)	109 (11.9%)	12 (13.6%)	97 (11.7%)	109 (11.9%)	27 (8.4%)	82 (13.9)
	Worry	526 (87.5%)	279 (89.1%)	805 (88.1%)	280 (88.3%)	525 (87.9%)	805 (88.1%)	76 (86.4%)	729 (88.3%)	805 (88.1%)	296 (91.6%)	509 (86.1)
Total		601 (100.0%)	313 (100.0%)	914 (100.0%)	317 (100.0%)	597 (100.0%)	914 (100.0%)	88 (100.0%)	826 (100.0%)	914 (100.0%)	323 (100.0%)	591 (100.0)
Chi square		.512(.474)			.030(.863)			.271 (.602)			6.049 (.014)	
Government taking care of not disclosing some information to the public	Do not worry	72 (13.1%)	68 (23.5%)	140 (16.7%)	47 (16.3%)	93 (16.9%)	140 (16.7%)	11 (12.8%)	129 (17.2%)	140 (16.7%)	53 (18.8%)	87 (15.7)
	Worry	476 (86.9%)	221 (76.5%)	697 (83.3%)	241 (83.7%)	456 (83.1%)	697 (83.3%)	75 (87.2%)	622 (82.8%)	697 (83.3%)	229 (81.2%)	468 (84.3)
Total		548 (100.0%)	289 (100.0%)	837 (100.0%)	288 (100.0%)	549 (100.0%)	837 (100.0%)	86 (100.0%)	751 (100.0%)	837 (100.0%)	282 (100.0%)	555 (100.0)
Chi square		14.667 (.000)			.052 (.819)			1.066 (.302)			1.306 (.252)	
mental wellbeing	Do not worry	169 (28.7%)	114 (36.8%)	283 (31.5%)	100 (32.3%)	183 (31.1%)	283 (31.5%)	20 (23.5%)	263 (32.3%)	283 (31.5%)	109 (35.0%)	174 (29.6)
	Worry	419 (71.3%)	196 (63.2%)	615 (68.5%)	210 (67.7%)	405 (68.9%)	615 (68.5%)	65 (76.5%)	550 (67.7%)	615 (68.5%)	202 (65.0%)	413 (70.4)
Total		588 (100.0%)	310 (100.0%)	898 (100.0%)	310 (100.0%)	588 (100.0%)	898 (100.0%)	85 (100.0%)	813 (100.0%)	898 (100.0%)	311 (100.0%)	587 (100.0)
Chi square		6.068 (.014)			.121 (.728)			2.774 (.096)			2.753 (.097)	
physical wellbeing	Do not worry	156 (25.8%)	86 (27.0%)	242 (26.2%)	83 (25.9%)	159 (26.4%)	242 (26.2%)	16 (18.0%)	226 (27.1%)	242 (26.2%)	91 (28.3%)	151 (25.1)
	Worry	448 (74.2%)	233 (73.0%)	681 (73.8%)	237 (74.1%)	444 (73.6%)	681 (73.8%)	73 (82.0%)	608 (72.9%)	681 (73.8%)	230 (71.7%)	451 (74.9)
Total		604 (100.0%)	319 (100.0%)	923 (100.0%)	320 (100.0%)	603 (100.0%)	923 (100.0%)	89 (100.0%)	834 (100.0%)	923 (100.0%)	321 (100.0%)	602 (100.0)
Chi square		.138(.710)			.020 (.887)			3.458 (.063)			1.154 (.283)	
wellbeing of loved ones	Do not worry	71 (11.2%)	39 (11.8%)	110 (11.4%)	40 (12.4%)	70 (11.0%)	110 (11.4%)	8 (8.6%)	102 (11.7%)	110 (11.4%)	34 (10.1%)	76 (12.2)
	Worry	561 (88.8%)	291 (88.2%)	852 (88.6%)	283 (87.6%)	569 (89.0%)	852 (88.6%)	85 (91.4%)	767 (88.2%)	852 (88.6%)	304 (89.9%)	548 (87.8)
Total		632 (100.0%)	330 (100.0%)	962 (100.0%)	323 (100.0%)	639 (100.0%)	962 (100.0%)	93 (100.0%)	869 (100.0%)	962 (100.0%)	338 (100.0%)	624 (100.0)
Chi square		.073 (.787)			.433 (.511)			.816 (.366)			.973 (.324)	
Inability to feed my family properly	Do not worry	177 (33.0%)	109 (35.3%)	286 (33.8%)	92 (31.2%)	194 (35.3%)	286 (33.8%)	22 (28.6%)	264 (34.4%)	286 (33.8%)	116 (39.6%)	170 (30.8)
	Worry	355 (67.0%)	201 (64.7%)	556 (66.2%)	200 (68.8%)	345 (64.7%)	556 (66.2%)	56 (71.4%)	495 (65.6%)	556 (66.2%)	172 (60.4%)	304 (50.0)
Total		532 (100.0%)	310 (100.0%)	842 (100.0%)	292 (100.0%)	539 (100.0%)	842 (100.0%)	78 (100.0%)	759 (100.0%)	842 (100.0%)	288 (100.0%)	474 (100.0)
Chi square		.000 (.999)			.000 (.999)			.000 (.999)			.000 (.999)	

Bold values = (p < 0.005), Do not worry = Don't worry at all + Don't worry + don't worry much, Worry = Worry a lot + Worry + Somewhat worry.

Variable		Age			District			Education			Occupation	
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
	Worry	359 (67.0%)	200 (64.7%)	559 (66.2%)	203 (68.8%)	356 (64.7%)	559 (66.2%)	55 (71.4%)	504 (65.6%)	559 (66.2%)	177 (60.4%)	382 (69.2)
Total		536 (100.0%)	309 (100.0%)	845 (100.0%)	295 (100.0%)	550 (100.0%)	845 (100.0%)	77 (100.0%)	768 (100.0%)	845 (100.0%)	293 (100.0%)	552 (100.0)
Chi square		.444 (.505)			1.436 (.231)			1.053 (.305)			6.610 (.010)	
Limited freedom of movement	Do not worry	210 (35.2%)	143 (45.4%)	353 (38.7%)	119 (38.5%)	234 (38.8%)	353 (38.7%)	36 (40.4%)	317 (89.8%)	353 (38.7%)	113 (35.1%)	240 (40.7)
	Worry	387 (64.8%)	172 (54.6%)	559 (61.3%)	190 (61.5%)	369 (61.2%)	559 (61.3%)	53 (59.6%)	506 (90.5%)	559 (61.3%)	209 (64.9%)	350 (59.3)
Total		597 (100.0%)	315 (100.0%)	912 (100.0%)	309 (100.0%)	603 (100.0%)	912 (100.0%)	89 (100.0%)	823 (100.0%)	912 (100.0%)	322 (100.0%)	590 (100.0)
Chi square		9.080 (.003)			.007 (.931)			.126 (.722)			2.739 (.098)	
Missing out on vacation opportunities	Do not worry	227 (39.1%)	170 (54.0%)	397 (44.4%)	145 (47.4%)	252 (42.8%)	397 (44.4%)	40 (44.4%)	357 (44.3%)	397 (44.4%)	118 (38.2%)	279 (47.6)
	Worry	353 (60.9%)	145 (46.0%)	498 (55.6%)	161 (52.6%)	337 (57.2%)	498 (55.6%)	50 (55.6%)	448 (55.7%)	498 (55.6%)	191 (61.8%)	307 (52.4)
Total		580 (100.0%)	315 (100.0%)	895 (100.0%)	306 (100.0%)	589 (100.0%)	895 (100.0%)	90 (100.0%)	805 (100.0%)	895 (100.0%)	309 (100.0%)	586 (100.0)
Chi square		18.190 (.000)			1.727 (.189)			.000 (.986)			7.279 (.007)	
The closure of schools	Do not worry	225 (43.2%)	139 (46.6%)	364 (44.4%)	140 (50.0%)	224 (41.6%)	364 (44.4%)	35 (41.2%)	329 (90.4%)	364 (44.4%)	131 (46.5%)	233 (43.4)
	Worry	296 (56.8%)	159 (53.4%)	455 (55.6%)	140 (50.0%)	315 (58.4%)	455 (55.6%)	50 (58.8%)	405 (89.0%)	455 (55.6%)	151 (53.5%)	304 (56.6)
Total		521 (100.0%)	298 (100.0%)	819 (100.0%)	280 (100.0%)	539 (100.0%)	819 (100.0%)	85 (100.0%)	734 (100.0%)	819 (100.0%)	282 (100.0%)	537 (100.0)
Chi square		.918 (.338)			5.318 (.021)			.410 (.552)			.703 (.402)	
The closure of universities and higher education centres	Do not worry	164 (27.8%)	128 (42.4%)	292 (32.7%)	120 (39.6%)	172 (29.2%)	292 (32.7%)	22 (24.7%)	270 (33.6%)	292 (29.2%)	94 (30.3%)	198 (34.0)
	Worry	426 (72.2%)	174 (57.6%)	600 (67.3%)	183 (60.4%)	417 (70.8%)	600 (67.3%)	67 (75.2%)	533 (66.4%)	600 (67.3%)	216 (69.7%)	384 (66.0)
Total		590 (100.0%)	302 (100.0%)	892 (100.0%)	303 (100.0%)	589 (100.0%)	892 (100.0%)	89 (100.0%)	803 (100.0%)	892 (100.0%)	310 (100.0%)	582 (100.0)
Chi square		19.304 (.000)			9.831 (.002)			2.885 (.089)			1.256 (.262)	
Small companies running out of business	Do not worry	115 (20.9%)	51 (16.3%)	166 (19.3%)	59 (19.8%)	107 (19.0%)	166 (19.3%)	19 (21.8%)	147 (19.0%)	166 (19.3%)	55 (18.8%)	111 (19.5)
	Worry	434 (79.1%)	261 (83.7%)	695 (80.7%)	239 (80.2%)	456 (81.0%)	695 (80.7%)	68 (78.2%)	627 (81.0%)	695 (80.2%)	238 (81.2%)	457 (80.5)
Total		549 (100.0%)	312 (100.0%)	861 (100.0%)	298 (100.0%)	563 (100.0%)	861 (100.0%)	87 (100.0%)	774 (100.0%)	861 (100.0%)	293 (100.0%)	568 (100.0)
Chi square		2.706 (.100)			.079 (.779)			.407 (.523)			.074 (.786)	
Economic recession in my country	Do not worry	80 (13.4%)	39 (12.2%)	119 (13.0%)	44 (13.8%)	75 (12.5%)	119 (13.0%)	14 (16.0%)	105 (12.7%)	119 (13.0%)	40 (12.6%)	79 (13.2)
	Worry	517 (86.6%)	280 (87.8%)	797 (87.0%)	274 (86.2%)	523 (87.5%)	797 (87.0%)	74 (84.0%)	723 (87.3%)	797 (87.0%)	277 (87.4%)	520 (86.8)
Total		597 (100.0%)	319 (100.0%)	916 (100.0%)	318 (100.0%)	598 (100.0%)	916 (100.0%)	88 (100.0%)	828 (100.0%)	916 (100.0%)	317 (100.0%)	599 (100.0)
Chi square		.254 (.614)			.308 (.579)			.733 (.392)			.060 (.807)	

Bold values = (p < 0.005), Do not worry = Don't worry at all + Don't worry + don't worry much, Worry = Worry a lot + Worry + Somewhat worry.

Variable		Age			District			Education			Occupation	
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Restricted access to food supplies	Do not worry	97 (16.6%)	61 (18.9%)	158 (17.4%)	54 (17.4%)	104 (17.4%)	158 (17.4%)	11 (12.4%)	147 (17.9%)	158 (17.4%)	52 (16.3%)	106 (18.0%)
	Worry	488 (83.4%)	262 (81.1%)	750 (82.6%)	256 (82.6%)	494 (82.6%)	750 (82.6%)	78 (87.6%)	672 (82.1%)	750 (82.6%)	267 (83.7%)	483 (82.0%)
Total		585 (100.0%)	323 (100.0%)	908 (100.0%)	310 (100.0%)	598 (100.0%)	908 (100.0%)	89 (100.0%)	819 (100.0%)	908 (100.0%)	319 (100.0%)	589 (100.0%)
Chi square		.769(.381)			.000(.992)			1.745 (.187)			.414 (.520)	
Becoming unemployed	Do not worry	150 (26.5%)	105 (33.9%)	255 (29.1%)	93 (31.1%)	162 (28.1%)	255 (29.1%)	20 (24.7%)	235 (29.6%)	255 (29.1%)	108 (35.3%)	147 (25.9%)
	Worry	415 (73.5%)	205 (66.1%)	620 (70.9%)	206 (68.9%)	414 (71.9%)	620 (70.9%)	61 (75.3%)	559 (70.4%)	620 (70.9%)	198 (64.7%)	422 (74.1%)
Total		565 (100.0%)	310 (100.0%)	875 (100.0%)	299 (100.0%)	576 (100.0%)	875 (100.0%)	81 (100.0%)	794 (100.0%)	875 (100.0%)	306 (100.0%)	569 (100.0%)
Chi square		5.197 (.023)			.846 (.358)			.857(.355)			8.622 (.003)	
Not being able to pay my bills	Do not worry	187 (34.0%)	138 (45.0%)	325 (38.0%)	114 (38.4%)	211 (37.8%)	325 (38.0%)	24 (27.6%)	301 (39.1%)	325 (38.0%)	139 (46.3%)	186 (33.5%)
	Worry	362 (66.0%)	169 (55.0%)	531 (62.0%)	183 (61.6%)	348 (62.2%)	531 (62.0%)	63 (72.4%)	468 (60.9%)	531 (62.0%)	161 (53.7%)	370 (66.5%)
Total		549 (100.0%)	307 (100.0%)	856 (100.0%)	297 (100.0%)	559 (100.0%)	856 (100.0%)	87 (100.0%)	769 (100.0%)	856 (100.0%)	300 (100.0%)	556 (100.0%)
Chi square		9.913 (.002)			.034 (.855)			4.431 (.035)			13.726 (.000)	
Not being able to visit dependents	Do not worry	161 (32.0%)	107 (35.3%)	268 (32.5%)	91 (31.8%)	177 (32.8%)	268 (32.5%)	22 (28.6%)	246 (32.9%)	268 (32.5%)	98 (34.3%)	170 (31.5%)
	Worry	361 (68.0%)	196 (64.7%)	557 (67.5%)	195 (68.2%)	362 (67.2%)	557 (67.5%)	55 (71.4%)	502 (67.1%)	557 (67.5%)	188 (65.7%)	369 (68.5%)
Total		522 (100.0%)	303 (100.0%)	825 (100.0%)	286 (100.0%)	539 (100.0%)	825 (100.0%)	77 (100.0%)	748 (100.0%)	825 (100.0%)	286 (100.0%)	539 (100.0%)
Chi square		8.747 (.186)			.089(.766)			.593 (.441)			.633(.426)	
Having to defend a decision not to participate in a social event	Do not worry	249 (46.3%)	172 (57.1%)	421 (50.2%)	156 (53.8%)	265 (48.3%)	421 (50.2%)	33 (39.8%)	388 (51.3%)	421 (50.2%)	147 (49.7%)	274 (50.5%)
	Worry	289 (53.7%)	129 (42.9%)	418 (49.8%)	134 (46.2%)	284 (51.7%)	418 (49.8%)	50 (60.2%)	368 (48.7%)	418 (49.8%)	149 (50.3%)	269 (49.5%)
Total		538 (100.0%)	301 (100.0%)	839 (100.0%)	290 (100.0%)	549 (100.0%)	839 (100.0%)	83 (100.0%)	756 (100.0%)	839 (100.0%)	296 (100.0%)	543 (100.0%)
Chi square		9.106 (.003)			2.316 (.128)			4.000 (.045)			.049 (.825)	
Bold values = (p < 0.005), Do not worry = Don't worry at all + Don't worry + don't worry much, Worry = Worry a lot + Worry + Somewhat worry.												

M. Confusions and rumours

We considered 4 widely discussed areas of probable confusion in the time of the study and found the clarity in each area was more than the confusion (Fig. 19). There was no significant association between the confusions and basic demographics (Table 27).

Table 27
Confusions about the information on COVID 19 against basic demographics

Variable		Age		District			Education			Occupation		
		Below 30	30 and above	Total	High risk	Low risk	Total	School education only	Above school education	Total	Health care worker	Other
Whether or not to wear a face mask in public places	Yes	168 (25.4%)	100 (29.4%)	268 (26.8%)	91 (26.7%)	177 (26.8%)	268 (26.8%)	19 (20.0%)	249 (27.5%)	268 (26.8%)	99 (28.2%)	169 (26.0%)
	No	493 (74.6%)	240 (70.6%)	733 (73.2%)	250 (73.3%)	483 (73.2%)	733 (73.2%)	76 (80.0%)	657 (72.5%)	733 (73.2%)	252 (71.8%)	481 (74.0%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi square		1.828 (.176)			.002 (.964)			2.456 (.117)			.565 (.452)	
Whether or not steam inhalation is a good treatment option	Yes	259 (39.2%)	112 (32.9%)	371 (37.1%)	123 (36.1%)	248 (37.6%)	371 (37.1%)	34 (35.8%)	337 (37.2%)	371 (37.1%)	122 (34.8%)	249 (38.3%)
	No	402 (60.8%)	228 (67.1%)	630 (62.9%)	218 (63.9%)	412 (62.4%)	630 (62.9%)	61 (64.2%)	569 (62.8%)	630 (62.9%)	229 (65.2%)	401 (61.7%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100%)	650 (100%)
Chi square		3.750 (.053)			.218 (.640)			.073 (.787)			1.231 (.267)	
Whether or not herbal drinks like coriander are good treatment options	Yes	272 (41.1%)	112 (32.9%)	384 (38.4%)	125 (36.7%)	259 (39.2%)	384 (38.4%)	36 (37.9%)	348 (38.4%)	384 (38.4%)	135 (38.5%)	249 (38.3%)
	No	389 (58.9%)	228 (67.1%)	617 (61.6%)	216 (63.3%)	401 (60.8%)	617 (61.6%)	59 (62.1%)	558 (61.6%)	617 (61.6%)	216 (61.5%)	401 (61.7%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi square		6.398 (.011)			.636 (.425)			.010 (.922)			.002 (.962)	
Whether or not drinking hot water and tea would protect from novel Corona virus.	Yes	261 (39.5%)	118 (34.7%)	379 (37.9%)	117 (34.3%)	262 (39.7%)	379 (37.9%)	36 (37.9%)	343 (37.9%)	379 (37.9%)	120 (34.2%)	259 (39.8%)
	No	400 (60.5%)	222 (65.3%)	622 (62.1%)	224 (65.7%)	398 (60.3%)	622 (62.1%)	59 (62.1%)	563 (62.1%)	622 (62.1%)	231 (65.8%)	391 (60.2%)
Total		661 (100.0%)	340 (100.0%)	1001 (100.0%)	341 (100.0%)	660 (100.0%)	1001 (100.0%)	95 (100.0%)	906 (100.0%)	1001 (100.0%)	351 (100.0%)	650 (100.0%)
Chi square		2.180 (.140)			2.772 (.096)			.000 (.995)			3.101 (.078)	
Statistical significance = p < 0.005												

N. Probability and severity perception on cough cold and fever Vs probability and severity perception on COVID-19

The 57.34% of the study population thought it is likely for them to get infected with an episode of cough, cold and fever while 50.9 % who perceived it is likely to get infected with COVID-19. (Fig. 20) A fraction of 35.6% of the participants had perceived an episode of cough, cold and fever as severe whereas 40.3 % thought of COVID-19 as severe (Fig. 21).

The belief of the probability of getting infected with cough, cold and fever is statistically significant in HCW and those with chronic illnesses (Table 28). The perceived severity of getting infected with the same is also significantly higher in participants with chronic illnesses than participants who are not (Table 29). When compared with the probability and severity perceptions of cough cold and fever episode Vs the probability and severity perceptions of COVID-19 infection (Table 30) it was found our population considered COVID-19 to be more severe than common cold. However, they perceived that they are more susceptible to common cold compared to the COVID-19. Both of these differences are statistically significant.

Table 28

Perception of the probability of contracting an episode of cough cold and fever against basic demographics and the presence of a chronic illness

Variable		Age			Occupation			Presence of a chronic illness		
		Below 30	30 and above	Total	Health care worker	Other	Total	Known	Not known	Total
Probability of getting infected with cough cold and fever	Unlikely	207 (35.3%)	114 (36.9%)	321 (35.9%)	83 (26.2%)	238 (41.2%)	321 (35.9%)	18 (18.9%)	303 (37.9%)	321 (35.9%)
	Likely	379 (64.7%)	195 (63.1%)	574 (64.1%)	234 (73.8%)	340 (58.8%)	574 (64.1%)	77 (81.1%)	497 (62.1%)	574 (64.1%)
Total		586 (100.0%)	309 (100.0%)	895 (100.0%)	317 (100.0%)	578 (100.0%)	895 (100.0%)	95 (100.0%)	800 (100.0%)	895 (100.0%)
Chi square		.217 (.642)			20.008 (.000)			13.226 (.000)		
Bold values = (p < 0.005), Unlikely = Extremely unlikely + Unlikely + Somewhat unlikely, Likely = Extremely likely + Likely + Somewhat likely.										

Table 29

Perception of the Severity of an episode of cough cold and fever against basic demographics and the presence of a chronic illness

Variable		Age		Occupation			Presence of a chronic illness			
		Below 30	30 and above	Total	Health care worker	Other	Total	Known	Not known	Total
The severity of an episode of cough cold and fever	Not severe	252 (50.4%)	163 (60.1%)	415 (53.8%)	130 (50.6%)	285 (54.9%)	415 (53.8%)	29 (32.6%)	386 (56.6%)	415 (53.8%)
	Severe	248 (49.6%)	108 (39.9%)	356 (46.2%)	127 (49.4%)	229 (44.1%)	356 (46.2%)	60 (67.4%)	296 (43.4%)	356 (46.2%)
Total		500 (100.0%)	271 (100.0%)	771 (100.0%)	257 (100.0%)	519 (100.0%)	771 (100.0%)	89 (100.0%)	682 (100.0%)	771 (100.0%)
Chi square		6.719 (.010)			1.631 (.202)		18.267 (.000)			
Bold values = (p < 0.005), Severe = Very severe + Severe + Less severe, Not severe = Not severe at all + Not severe + Very mild disease.										

Table 30

Associations between the susceptibility perceptions and severity perceptions of Cough cold and fever Vs COVID-19

Variable		Mean (SD)	Median (IQR)	P value (Related Sample – Wilcoxon Signed Rank Test)
Expected Susceptibility	COVID-19	4.13 (1.539)	5 (3–5)	0.000
	Common Cold	4.35 (1.543)	5 (4–5)	
Expected Severity	COVID-19	4.51 (1.247)	4 (3–5)	0.000
	Common Cold	3.78 (1.542)	4 (2–5)	

Discussion

We aimed at a sample size of at least 1000 as it is a recommended number for surveys of large size populations to make the sample as representative as possible of the country's population [12]. The precision of estimates of surveys only increases very slightly beyond a sample size of 1000 and costs of inviting more than 1000 participants may exceed the statistical benefits [13].

The study was conducted 8–10 weeks, into the pandemic during the first wave of the COVID-19 in SL. By the time SL has been ranked 9th best country in the world for its successful immediate response on managing the virus [14]. With the medical and academic background of the authors it was expected more HCW, particularly the medical undergraduates and doctors to take the questionnaire and such a bias was one of the major concerns' authors had initially. However, the sample had more non HCW with the non HCW: HCW ratio being 1.86:1. Colombo, Gampaha, Kurunegala and Kandy were represented more and it could be because they are highly populated districts [15] and also the research team has a higher contact base in them.

The majority of the participants perceived them (80.63%) and their immediate environment (76.53%) were free of the risk of the infection. That may be a reflection of the safer outbreak status of the country at the time or blissful unawareness or psychological denial in at least a few. It could also be that the study group possibly came from a higher socio-economic background with less congestion and more people compliant with preventive measures which lead to feel safe. However, it is noteworthy that 19.08% and 16.28% of participants were not sure whether they themselves were infected or anybody else in their immediate environment was infected, respectively. This response can be a result of the knowledge about the higher possibility of asymptomatic/less symptomatic cases and they probably lived with some uncertainty and related anxiety. Such anxiety can be alleviated if they are informed that kind-of disease patterns, which is the presentation of the majority are less harmful.

A percentage as high as 83.3% was having good confidence in their overall knowledge on prevention irrespective of their differences in socio-demographic characteristics. This positive response could be due to a certain degree of social desirability bias too. A high majority have shown a good knowledge about the common symptoms of the infection (Fig. 4) and this may reflect the success of the health messages disseminated in the country and or the knowledgeability of the study population; They could have educated themselves from online sources. It was expected to find HCW and the more educated to have fared better on knowledge on preventive measures but there were no demographic boundaries. HCW, however, identified individual symptoms of COVID-19 which were given less publicity on media better than non-HCW probably because they have more exposure to actual patients as only designated health institutions were accepting COVID patients. They also possibly learnt on the job and / or by consulting scientific literature on details of the COVID-19 as a necessity of the job. It was notable that a small percentage seem to believe there is a drug and /or a vaccine available against the COVID-19 infection. There were some media reports on the effectiveness of chloroquine against the virus and how some local as well as world leaders promoted the drug during the period of data collection. The hydroxychloroquine arm of the "Solidarity trial" was removed by health authorities since there was no significant difference of mortality and morbidity compared to the standard care on 17th of June [16]. The confusion must have sprung from such intermittent reports on various treatment trials. There was some debate and unclarity regarding the exact incubation period with some research having shown it as 21 days. For example, the incubation period was found to be longer in older adults [17]. Although there were slight differences in evidence, the accepted incubation period by WHO was up to 14 days at the time of the study. [18],[19].

About half of our study population was thinking there is some self-susceptibility to the COVID-19 infection. It is understandable that the relatively more mature participants and HCW found the probability of them getting infected is significantly higher. There was no significant association between the probability of self susceptibility perception and the presence of a chronic illness. Probability of infection is found to have association with chronic kidney disease and Diabetes mellitus only [20] (Table 3).

There was an alarming media hype where Chinese patients seemingly dropped dead in the streets at the initial stages of the COVID-19. The media was blamed for fuelling panic and anxiety about the disease [21]. Yet it is interesting to see close to half of our population is inconclusive about the severity (Fig. 7). The fact that there is a significant association between the severity perception and having a chronic disease indicates, that particular health message was delivered to them quite successfully (Table 4) [22]. Despite substantial variability across cultures, individualistic worldviews, personal experience, prosocial values, and social amplification through friends and family are significant determinants of risk perception in a multi country study and risk perception correlated significantly with reported adoption of preventative health behaviours [23].

Our population, in general, was highly confident in the ability to protect themselves and highly compliant with health recommendations. The recommendations were followed irrespective of the differences in their basic demographics. The scientifically unproven methods such as sprinkling of turmeric water and use of "perumkayan" (Asafoetida) which is practiced by some in-Sri Lankan culture were not popular among the study group (Table 5). The younger (< 30 years) participants used more herbal supplements compared to the above 30 group as a preventive measure. It is possible their elders offered traditionally popular herbal supplements such as coriander to youngsters during the lockdown periods which could have influenced the response of younger participants or this may be a result of the developing nationalist ideas mainly among the youth, globally [24]. Non HCW also used herbal supplements significantly more than their HCW counterparts. The HCW participants are probably employed in the western medicine fields rather than the non-western health care fields such as Ayurveda. The participants who are younger, more educated and belonging to the HCW category disinfected the mobile phones more compared to older, less educated and non HCW respectively. Mobile phone use may be higher in the first group with resultant higher risk perception of phones being contaminated and the behaviour of disinfecting them.

We inquired about coping with, not seeing family and friends. Sri Lanka being a collectivistic society, individual members often perceive themselves to be members of their ethnic, religious or linguistic group rather than individual and autonomous beings [25]. Claimed it can be done by understanding the need and respecting the recommendation to limit traveling. The authors have first-hand experience where the HCW not visiting their elderly parents and children but living separately to protect them from the infection.

The majority of the participants came up with understandable responses on exploring the effect of COVID-19 on the individuals' affect. However, it is interesting to see some, after all the wide spread knowledge to the contrary, believed the virus is spreading slowly. This shows the importance of reiterating the health messages in health education. The majority did not feel helpless and that may be due to the fact that SL has managed to contain the spread of the virus in the country successfully during the time of the study. One participant, a specialist colleague in public health, has criticized the response "close to me" in the questionnaire via personal communication (Fig. 11). The response came from the original mother study in Germany. We acknowledge that the use of the phrase in relation to a "deadly" virus is difficult to fathom in our culture. Sri Lankans use the phrase "close to me" to denote something dear to heart, not to an entity such as COVID-19 virus. Therefore, we wonder how the participants saw and processed the question. HCW category however, have a significant association with the feeling of the "virus being close to them", it could be they took the question in a more western context.

Only a 22.3% of the population had a good trust towards social media (e.g., Facebook, Twitter, YouTube, WhatsApp, Viber) despite the widespread use of them in the country with Facebook topping the list with 80.16% of Sri Lankans using the platform [26]. Maybe people use social media for pleasure and socio -

political reasons and not as a trustworthy source of information. The newspapers and radio stations were not popular, either. This may be a reflection of an important shift in information seeking patterns in SL, with wider spread internet access, increasing electronic platforms disseminating information. The participants less than 30 years had a significantly higher trust in the private television channels compared to older group. It will be fascinating to explore in a qualitative approach whether they are ignorant, gullible or having some other driving force in order to have trusted private channels more compared to the older participants. It is common knowledge that the main private television channels are run by the owners from the two main political camps in the country and it is possible the trust on them was influenced by the political views of the participants.

The information stated as most needed were those concerned with the disease itself; its severity, treatment and prevention at country's level as well as personal level. This concern in our population may reflect how the Sri Lankan public was made to attune with the pandemic. It is a little surprising to see the participants did not have the need to know about the children's education as one of the highest needs. Education plays a major part in Sri Lankan culture and most of the Sri Lankan parents live to educate their children to their best. Relatively lower concern could be due to several reasons. The data collection was done fairly early into the outbreak and the worries probably have not started mounting and there were ongoing discussions to reopen the country too, which gave a sense of hope [27]. The teachers, in both the private and government sector, attempted to keep the education process continuing using their personal data and mobile apps in some settings and it must have helped the parents in our study not to worry too much. The population, finding the COVID-19 virus new and dangerous may have concerns over the safety of the children than their education. It is also quite noteworthy our population did not bother much about the personal grooming needs compared to some, for example some US citizens who rebelled against stay-at-home requests highlighting their grooming needs. Some communities apparently used demands on haircuts as a symbol of protest to win their "freedom". ("operation haircut" at Michigan, USA) [28]. Many Sri Lankans resorted to having haircuts at home by family members and considered it as the norm and the need of the era according to the expressions in social media and that compliance and understanding were represented by our study population too.

We did not explore the behaviour of checking individual data sources, but the overall checking. Majority looked for COVID-19 information more often than not. In the face of stress and anxiety, individuals are often prone to use strategies that are designed to help but proven counterproductive. For example, checking social media frequently for COVID-19 related information can induce stress [29]. While COVID-19 fact checking is a necessity, ensuring there is some checking on checking and engaging in behaviours which help destress are important [30].

We modified the questionnaire to match the local COVID-19 response when assessing the trust in institutions/ personnel in their ability to manage the outbreak. Participants having more or less equal overall trust placed on HCW plus professional associations and Police plus military in the battle against COVID-19 in SL, could imply many aspects. Despite many criticisms of authorities for "militarizing" the COVID-19 operation, utilizing the armed forces to control spread by tracking contacts, building quarantine and other health care centres and running quarantine centres paid well to control the first wave of the country. Health sector alone does not have the infrastructure, man power, skills or the means to manage the COVID-19 demands placed on the country. Some operations were technically supervised by content specialist consultants (e.g., epidemiologists) in armed forces. The carefully and strategically planned operations of rescuing the Sri Lankan students in Wuhan, China and Sri Lankan chef from a cruise ship are some extraordinary examples that gained the love as well as trust of the public in the authorities [31],[32].

The affluent Sri Lankan general public will rely on the private sector for ease, comfort and better care yet maybe it is worth exploring why the majority would not trust them in a condition where life and death infection happens.

It is noteworthy that most knew about the two professional colleges, the SL college of community physicians [33] and SL college of psychiatrists [34] (Table 13) with only a small minority such as 12.8 % and 15.4% not knowing the two colleges respectively. We believe the active Facebook pages maintained by the both professional bodies and its members sharing college newsfeeds in their personal social media contributed to the raised awareness of the colleges [35]-[37]. Though the author characteristics may also have contributed to the finding, the knowledge of the two professional bodies among our participants who comprised a non HCW majority shows the potential of practical and convenient platforms such as Facebook for professional bodies to reach out to lay public in health education.

The majority of our population has trusted the newly elected President in his ability to manage the pandemic effectively [38]. Despite the accusations levelled at him by the local and international critiques about employing the military for the outbreak control, the first wave of COVID-19 was successfully managed in the country. The government was also trusted by participants probably because of the trust they had in the president and at the time of the study the parliament was dissolved and the president was managing the situation with his trusted officials, both civil and army. A notable percentage of our population have placed their trust on the ayurvedic council, though not to the extent they trusted the allopathic medical bodies. This insight is important and demands us to utilize the rich ayurvedic heritage and traditional ayurvedic practices in treatment following proper research either singly or in collaboration with western medicine.

SL has four main religions and Theravada Buddhism is the state religion with 70.2% of people being Buddhists. Many religious activities were continuing in mass gatherings and later regulations were brought in prohibiting them [39]. Our study population had comparatively less trust in religious institutes in the ability in managing the outbreak. Those who were educated only up to school level trusted the mosque in its ability to manage COVID-19 more than those who were educated above school level. Although there is a statistically significant association found between lower education levels and believing the mosque as a reliable source of information, stratified analysis was impossible (since we did not collect the race and the religion) to control the confounding effects of the religion and the race.

Our population believes the government university and school system can manage the infection better than the private education institutes. This may be reflecting the trust in the free education providing institutions in the country as opposed to the private educational institutes. The government institutes are under strict regulations and rules and the authorities are responsible and accountable which may be giving the public some sense of security. The private institution probably has the reputation for aiming at more profits gaining than maintaining the quality. Particularly the medical education in SL lies almost

solely in the purview of the government university system and the government sector doctors are trusted and respected in general, in any health emergency. Sri Lanka has proved it possessed considerable but unheralded expertise in managing deadly diseases, having eliminated malaria and polio, grappled successfully with AIDS, SARS, H1N1, Chikungunya and MERS and was substantially containing Dengue. In 2005, the health system avoided the much-anticipated epidemics following the Indian Ocean tsunami. The participants indicated their unwavering trust in the government healthcare system and its products.

Close to 2 / 3 of people in the study have no confidence in the media in their ability to deal with the virus. This information presents an important take home message for the media authorities in the country. Our population has only 9.5 % who are school educated, all others having some post - AL education of varying degree. If the media authorities want to uplift the media conduct to a believable level by the educated public is a question, we researchers pose. We also believe they can contribute to increase the taste and expectations of the not so educated and / or questioning fractions in the community too. The media is a very important stakeholder in disasters to give correct health messages and information without making the public panic. Poor trust in mainstream media can influence people to seek information from unconfirmed sources and then get misled. Lower trust in the media is alarming for both media authorities and health professionals involved in health promotion.

The younger participants have placed trust in some institutions and personnel more than their older counterparts. The professional colleges, medical associations and unarguably the most powerful trade union of the country, GMA were trusted more significantly by them [40]. It is raising questions whether individuals are more cautious before trusting when they grow older. The difference in occupation health care Vs non health care also exposed some interesting findings with HCW trusting the government allopathic health system while the Non HCW placed significant trust in private and ayurvedic hospitals. The HCW are probably from western medical disciplines and are biased towards the mainstream allopathic government medicine. Ayurveda may have much to offer in standalone or supplementary therapy yet the field needs backing by quality research in order to be recognized by all fractions in a population.

We explored opinions on policies and measures related to covid-19 in SL. The whole country in general was compliant with whatever the health instructions disseminated by the authorities. The general belief of the majority was "One has to live first, to safeguard human rights and respect traditions!". Whoever criticized and questioned the recommendations were scorned on social media and other media as such opposition was considered as an anti-government action, thus politicizing the issue. The concepts such as respecting autonomy and individual rights in relation to COVID-19 management were discussed among some fractions. We believe the highly positive and compliant approach of the study population on the policies and measures taken in the country reflects the country's majority's subservient opinion in general.

Sri Lanka ' s primary health care system is of high standards [41]. SL takes pride in prevention of communicable diseases by way of its very successful immunization program from birth [42]. The public is quite attuned to immunization programs run by the government health team which include the internationally renowned public health midwives who deliver the bulk of the service door to door [43]. Sri Lankans in general grow up listening to the importance of vaccination to prevent preventable infections and the anti-vaccination theme is almost not heard by an average Sri Lankan. Therefore, as opposed to some nations in the world SL is pro vaccination and the positive response of our study population is a reflection of that.

Avoiding certain people during COVID-19, based on their country of origin has many facets to it. SL has a reputation of being one of the best tourist friendly destinations in the world [44]. However, some fractions were panicking that the tourists would bring the virus to the country and closed the doors to foreigners [45]. The majority deciding it is appropriate to avoid foreigners probably thought prevention is better than cure. We believe that decision is based more on health risks rather than that of any discrimination. In self-preservation, people avoid the stimuli that cause danger and unpleasant sensation such as fear and pain. Thus, one naturally averts from dangerous situations and these responses are mostly instinctive with minimal deliberate control and overreacting is understandable [46].

We asked whether the government should restrict access to the internet and social media in order to stop misinformation and subsequent agitation of the public. It has been a practice to block Facebook for the same purpose following the easter attack in SL in April 2019 [47]. There is no proof that banning social media is a solution to dissemination of fake news. In fact, authorities can use social media to prevent adverse reactions as social media companies have information about user behaviour patterns that the governments do not have and the third-party researchers have additional information about how information moves across the ecosystem. Combating the spread of misinformation must be a joint effort between the social media companies, governments and individual users [48]. As a strategy, government institutions like health promotion bureau and department of government information entered to the world of social media and became popular among users with high level of post reach and engagement [49],[50]

The participants below 30 years of age agreed significantly for coercive practices employed by the government compared to their older counterparts. The HCW and participants who had more than school education and not the younger participants, have opposed restricting access to internet and social media Thus the questions whether the younger fraction was ready to forgo individual rights /wishes and the HCW and more educated fraction relied on social media and internet more, in the face of the pandemic, arise. These are important insights for delivering health messages and policy making by the authorities in disasters like the COVID-19.

Some showed paranoia and indecisiveness on certain concerns emerged in the world about the pandemic. The majority did not believe China was deliberately placing the world in danger. China is a very close ally of SL to a point of concern in some fractions in SL. Participants below 30 years showed significant paranoia in relation to surveillance of citizens, hidden agendas and secret organizations behind government decisions. Why the below 30 group is more inclined to believe in conspiracies about secret activities and governments spying on them for their social media data are a question worth exploring. This can be due to a personality trait and we have a selection bias since the sample is less representative. A qualitative study would tell whether they are insecure, more knowledgeable or on a lighter note, watch too many American movies!

There was no statistically significant association in relation to facing adversities against the age, living district, educational level and occupation; probably everybody had the same adverse experiences irrespective of their differences in demographics. It is noteworthy that the majority are willing to seek help in experiencing stress related to COVID-19 policies.

Non HCW were strongly of the opinion obligatory mass testing should be carried out upon re opening, compared to HCW. The different knowledge, attitudes and experience between two groups may be the reason for this difference in opinion. Either, even the non-health care fraction was in tune with scientific preventive measures or the HCW perhaps knew more about PCR testing (cost, ability to generate false negative and positive results) and hence the neutral or low opinion of the effectiveness of mass testing.

Exploration of stigma in relation to COVID-19 was one major motive of the study. Stigma is common in relation to race, religion, culture, gender and health. Before COVID-19, there were other illnesses (e.g., Tuberculosis, HIV/AIDS) that carried social stigma, discrimination, and exclusion.[51],[52]. Stigmatizing language (e.g., "tuberculosis suspect") that has been criticized by advocates in the past, has been used during the current pandemic too, unfortunately. (e.g., "COVID-19 suspect"). Such judgmental terms influence attitudes and behaviours not only preventing patients from seeking treatment but also influencing the way authorities approach the disease. Research in China shows that the psychological impact of fear of COVID-19 is more dangerous than the disease itself [53]. Fear accentuates social stigma and discrimination. The frontline health care workers worldwide have been discriminated because of fears of transmitting the virus. The breakdown of social support structures such as religious institutes and family and friends, anxiety caused by curfews, many uncertainties around COVID-19 and fear of being infected and also being forced to quarantine has given rise to huge issue of stigma in relation to COVID-19 SL too. The media reports and authority statements gave the impression they are holding the COVID-19 infected people responsible for contracting the virus and the outlook was that of total blame. The involvement of police and military in COVID-19 management in SL pluralized criminalizing the infected. In the early phase of COVID-19 in SL, Sri Lankan media showed an alarming level of breaching privacy of the patients and contacts. Later it was identified as an issue and rectified [54], [55]. Racial and religious minorities were discriminated against in media reporting and there was a huge issue of not allowing the burial of dead bodies of COVID-19 patients in SL which led to deep worries in Muslim community. Another fraction that was discriminated was patients with addictions to substances, they were double stigmatized when they were infected with COVID-19. Media should involve in combating stigma by joining hands with health authorities and more so by way of their conduct. The majority of our study population though reported not believing COVID-19 as stigmatizing, have indicated the basis of stigma. It is possible they were referring to others but not to themselves in the process. People with greater personal resources (income, education, social support) and good mental health have been shown to be less worried and less likely to stigmatize [56]. It is known that education, clear and honest communication and the use of non-discriminatory language have the power to significantly improve the knowledge, attitudes, and behaviours related to COVID-19 and reduce stigma [57]. The majority in our population did not think contracting COVID-19 is stigmatizing, probably they are a comparatively fortunate fraction that shows above protective qualities. Another possible reason could be that they did not feel the full impact of the disease as the pandemic was reasonably well contained in SL during the first wave [58].

Study explored the COVID-19 related behaviours. Epidemics, natural disasters and extraordinary events trigger panic buying in general and during COVID-19 too people resorted to buying excessive amounts of toilet paper, hand sanitizers, dry rations etc. Panic purchases during a public crisis negatively impact social stability, economic orders, company management, and consumer psychology [59]. The need and obligation to protect and care for the family influences the consumer's considerations, family being a social factor that influences consumer decisions related to panic buying behaviour. Anxiety around the uncertainty, personal factors like self-confidence and self-efficacy also contribute to panic behaviours [60],[61]. Consistency in government policies on events such as re opening, giving correct and transparent information, rules restricting buying in bulks and organizing a system to have essentials provided without a break would reduce panic buying. The older method of door to door selling of products like fish, vegetables, milk etc. were revitalized in the country and the social media groups were formed and supported each other in local communities. The authorities promoted the mobile vendors by issuing curfew passes and recommended strict health guidelines to prevent the spread of the virus. Our population's majority (75.4%) that claimed they did not panic buy goods, probably have managed due to some of the personal and societal strengths such as economic stability and supportive environment. Drinking alcohol was marked as a least engaged behaviour in our sample. According to a national survey only 2.4% of females consume alcohol in SL [62] and 57.04% of our sample was females. SL, in general, looks down upon drinking alcoholic beverages and social desirability bias must have come in the marking of the response.

Worries and fears in relation to the pandemic were explored to find more than the personal worries our population was worried about the country's capacity to handle the possible case load. This shows the population we studied were either more farsighted and knowledgeable about the depth of the pandemic or had basic needs of their personal life such as food, lodging and medicine etc. fulfilled during the pandemic or both. Maslow postulated one has to have the basic needs met in order to concentrate on higher order issues [63]. Participants below 30 years of age were significantly worried about the government not disclosing some information to the public. This finding again throws the queries whether the younger population in our study is more mistrusting and questioning and why. The above 30 age group's significant worry about limited freedom of movement and missing out on vacations is probably because they had more responsibilities of employment and providing for the family and they have got used to a life style of taking break from employments respectively. The younger participants were understandably more significantly worried about the closure of universities and higher educational centres. The low-risk district dwelling participants are more concerned about higher education, maybe participants from high-risk districts had more pressing health and basic survival related concerns comparatively. Less than 30, non HCW categories had significant worries about paying their bills. HCW most probably had stable government jobs compared to non HCW. Worries about bill payments may reflect the financial hardships of younger participants and threat to job security in non-healthcare participants. Worries could lead to mental health challenges at the time and in many years to come [64]. Our population worries least about maintaining social life in vivo. Yet the younger participants showed some significant worry about defending a decision not to take part in a social event. The younger the age more the need for social conformity [65]. It is important to consider these behavioural patterns in formulating regulations and punishing rule breakers in the pandemic response in the country.

Majority (above 61%) of our population have no confusion in the tested areas in the study. Health messages in SL were seemingly better grasped by them. Local COVID-19 authorities made sure the masks were mandated when the infection started creating an impact in SL [66]. We could not identify any

statistically significant association between various confusions and selected socio-demographic factors.

We compared probability and severity perceptions on cough, cold and fever (the culturally relatable term for seasonal flu, used in the mother study) and probability and severity perceptions on COVID-19. Our population perceived COVID-19 infection to be more severe than cough, cold and fever infection. However, probability wise they perceived that they are more susceptible to common cold than to COVID-19. Both of these differences are statistically significant. To our population “catching common cold is easier than catching COVID-19!” This perception was probably because SL did not have to face the full impact of COVID-19 as it was circumscribed to the few clusters and well controlled during the first wave. The risk perception differs between different places, individuals, cultures and subcultures and it is potentially a strong modifier of the epidemic evolution, since it can influence the community spread [67].

The population linked having chronic illnesses to a higher susceptibility to and severity of cough cold and fever (Table 28, Table 29). However, they associated chronic illness to higher severity of COVID-19 but not to higher probability of getting infected with COVID-19 (Table 3, Table 4). It is interesting to find our study population thinking chronic illnesses do not increase the probability of getting COVID-19 but they do increase the probability of getting cough cold and fever. They found HCW to be more susceptible to both conditions than non HCW (Table 3, Table 28). It is an understandable response. The symptom characteristics of the influenza /common cold and COVID-19 are compared in a few studies but there is no work comparing severity and probability perceptions on the two conditions [68].

Conclusion

The study presents a girth of information on the perceptions, behaviours and concerns in relation to the COVID-19 pandemic of a considerably large community sample spread across the country. The majority study population is highly educated and young (less than 40 years), probably had internet access enabling them to seek information from many sources both national and international, did not have to rely on local media for information, and had important and very relevant perceptions and behaviours in relation to the pandemic over all, such as the country's economy and overloading of the health resources etc. for example. The participants below 30 years of age agreed significantly for coercive practices and believed in conspiracy theories more than the older counterparts. The total population in general was compliant with health recommendations and the majority did not worry about autonomy rights and individual freedom. The knowledge about various aspects of the COVID-19 infection was good in the majority. According to our study the effective risk communication, clear/ transparent policy decisions and responsible/ non stigmatizing and believable media conduct are major areas warranting improvement in COVID-19 management in SL. Thus, the findings offer important messages for the authorities to shape their response to future pandemics as well as the current pandemic and future waves of the same pandemic. Researchers hope to provide local data for international comparisons informing WHO policies and interventions for current and future reactions for the pandemic/s.

Limitations Of The Study

The study using online platform limited the participation of certain important population groups; the elderly, a recognized risk group for COVID-19 and disadvantaged population groups such as ethnic minorities, financially disadvantaged with no internet facilities, individuals who are not used to electronic devices/ internet, young people below 18 years, and other vulnerable groups such as medically ill etc. Phone interviews either alone or as a supplement were suggested by the mother study to be used to mitigate this limitation. However, the lock down, travel restrictions, financial restraints (the study was unfunded) did not allow phone or face to face data collection. Therefore, representativeness of our population of the general population is reduced which in turn affects the generalizability of the study findings. The social benefit of the study may consequently be reduced. The findings of the survey need to be interpreted in this context. Conducting, more tailored and targeted surveys with those specific population groups will be supplementary to the study.

The people who do not have the habit of using the internet for seeking or verifying factual information resort to mainstream media, mainly the television news. While they can have a commendable role to help combat the pandemic [69] the television channels may represent politically biased viewpoints and reporting may not be independent at times [70]. The perceptions, attitudes and behaviours of the viewers could be greatly influenced by those of the TV channels [71]. On one hand our population may not represent the general population because of the specifics of the demography such as 64.7 % having qualifications of a basic degree or above, yet on the other hand that very same specifics offer a tremendous opportunity for the authorities to shape COVID-19 response based on study results as the majority of our participants does not seem to base their thinking and behaviours on what is shown on TV!

In addition, the complexity of the pandemic and crisis and the public response is considerable, and an online survey can only serve to monitor a few key issues - not explore them in-depth. Another limitation of the study is that, while validated for other scales and well-grounded in robust behavioural research, the items in the study tool have not been validated through a rigorous process for COVID-19 specifically. This is due only to the fact that we have never experienced this virus before. Self-reported behaviours are known to differ from actual behaviour, due to the social desirability effect. Finally, as each country needs to adapt the questionnaire, not all data collected with this tool can be compared across countries for future evaluation purposes. The hope is that each country will collect and analyse at least several variables in common that may provide useful insights for cross-country comparisons. Potential risks identified included only the inconvenience of the time taken to respond to the survey. However, given the prevailing restrictions of locomotion people faced, many individuals had more available time for a task like this. The cross-sectional design will not allow the assessment of actual causal relations and will only be snapshots of a current state of the public perceptions and behaviours. To explore the causal relations and also to see the pattern changes in behaviours and perceptions the survey is best conducted repeatedly. For such an intervention, financial and manpower issues need to be resolved via national or international level collaboration.

List Of Abbreviations

WHO - World Health Organization

HCW - Health care workers

SL - Sri Lanka

MOH - Medical Officer of Health

PHI - Public Health Instructor

SLMC - Sri Lanka Medical Council

SLMA- Sri Lanka Medical Association

GMOA - Government Medical Officers Association

AMC - Ayurvedic Medical Council

SLCP - Sri Lanka College of Psychiatrists

CCPS - College of Community Physicians Sri Lanka

Declarations

Ethics approval

Approved by Ethics review committee, Faculty of Medicine, University of Peradeniya.

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Consent for publication

Not applicable as our manuscript contains any individual person's data in any form.

Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests

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Authors' contributions

PG developed the protocol and the questionnaire to suit the local setting with SS and TP. SS and TP prepared the google forms in consultations with PG and all three authors published the questionnaire online for data collection. Initial data acquisition and analysis were done by SS and TP under the guidance of PW. The final analysis was done by PW and DT. The manuscript was written mainly by PG with PW and DT contributing. All authors read and approved the final manuscript.

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Authors' information

CV of the principle and the corresponding author is attached with the manuscript

References

1. Uscher-Pines L, Omer SB, Barnett DJ, Burke TA, Balicer RD. Priority Setting for Pandemic Influenza: An Analysis of National Preparedness Plans. *PLoS Med*. 2006;3(10):e436. doi:10.1371/journal.pmed.0030436
2. WHO. *Vaccination and Trust -How Concerns Arise and the Role of Communication in Mitigating Crises*. World Health Organization; 2017. <https://www.euro.who.int/en/health-topics/disease-prevention/vaccines-and-immunization/publications/2017/vaccination-and-trust-2017>. Accessed November 3, 2020.
3. Glik DC. Risk communication for public health emergencies. *Annu Rev Public Health*. 2007;28:33-54. doi:10.1146/annurev.publhealth.28.021406.144123

4. WHO. *WHO | Communicating Risk in Public Health Emergencies*. World Health Organization; 2020. <http://www.who.int/risk-communication/guidance/download/en/>. Accessed November 3, 2020.
5. REYNOLDS B, W. SEEGER M. Crisis and Emergency Risk Communication as an Integrative Model. *J Health Commun*. 2005;10(1):43-55. doi:10.1080/10810730590904571
6. Sonja A. Rasmussen, Richard A. Goodman, eds. *The CDC Field Epidemiology Manual*. Oxford University Press; 2018. doi:10.1093/oso/9780190933692.001.0001
7. Reintjes R, Das E, Klemm C, Richardus JH, Keßler V, Ahmad A. "Pandemic public health paradox": Time series analysis of the 2009/10 influenza A/H1N1 epidemiology, media attention, risk perception and public reactions in 5 European countries. *PLoS One*. 2016;11(3). doi:10.1371/journal.pone.0151258
8. Rubin GJ, Amlôt R, Page L, Wessely S. Public perceptions, anxiety, and behaviour change in relation to the swine flu outbreak: Cross sectional telephone survey. *BMJ*. 2009;339(7713). doi:10.1136/bmj.b2651
9. Carpenter CJ. A meta-analysis of the effectiveness of health belief model variables in predicting behavior. *Health Commun*. 2010;25(8):661-669. doi:10.1080/10410236.2010.521906
10. WHO/Europe | Coronavirus disease (COVID-19) outbreak - Survey tool and guidance: behavioural insights on COVID-19, 29 July 2020. <https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/publications-and-technical-guidance/risk-communication-and-community-engagement/who-tool-for-behavioural-insights-on-covid-19/survey-tool-and-guidance-behavioural-insights-on-covid-19-produced-by-the-who-european-region>. Accessed November 3, 2020.
11. Media statement for COVID 19 CCPSL. <https://ccpsl.org/wp-content/uploads/2020/03/Media-statement-for-COVID-19-CCPSL-EnglishV2.0-1.pdf>. Accessed December 16, 2020.
12. Taherdoost H. Determining Sample Size; How to Calculate Survey Sample Size. *Int J Econ Manag Syst*. 2017;2. <https://papers.ssrn.com/abstract=3224205>. Accessed November 13, 2020.
13. Chiang I-CA, Jhangiani RS, Price PC. Conducting Surveys . In: *Research Methods in Psychology – Simple Book Production*. 2nd ed. BCcampus; 2015.
14. Daily Mirror - SL performs well in fighting Coronavirus & ranked 9 in GRID Index. http://www.dailymirror.lk/breaking_news/SL-performs-well-in-fighting-Coronavirus-ranked-9-in-GRID-Index/108-186696. Accessed November 13, 2020.
15. POPULATION CHARACTERISTICS - CENSUS OF POPULATION AND HOUSING 2001. Department of Census and Statistics. http://www.statistics.gov.lk/Population/PopHouStat_Population. Accessed November 3, 2020.
16. WHO. Coronavirus disease (COVID-19): Hydroxychloroquine. <https://www.who.int/news-room/q-a-detail/q-a-hydroxychloroquine-and-covid-19>. Published June 19, 2020. Accessed November 3, 2020.
17. Kong T. Longer incubation period of coronavirus disease 2019 (COVID-19) in older adults. *AGING Med*. 2020;3(2):102-109. doi:10.1002/agm2.12114
18. Centers for Disease Control and Prevention. Management of Patients with Confirmed 2019-nCoV | CDC. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>. Published 2020. Accessed November 3, 2020.
19. WHO. Q&As on COVID-19 and related health topics. <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub>. Accessed November 3, 2020.
20. Rozenfeld Y, Beam J, Maier H, et al. A model of disparities: Risk factors associated with COVID-19 infection. *Int J Equity Health*. 2020;19(1). doi:10.1186/s12939-020-01242-z
21. Gabrielle Pickard Whitehead. Are coronavirus fears being over-hyped by the media? Chinadaily. <https://global.chinadaily.com.cn/a/202003/09/WS5e65b96aa31012821727d6e4.html>. Published 2020. Accessed November 3, 2020.
22. WHO. United Nations Inter-Agency Task Force on NCDs (UNIATF). <https://www.who.int/groups/un-inter-agency-task-force-on-NCDs>. Accessed December 14, 2020.
23. Dryhurst S, Schneider CR, Kerr J, et al. Risk perceptions of COVID-19 around the world. *J Risk Res*. 2020;23(7-8):994-1006. doi:10.1080/13669877.2020.1758193
24. Bieber F. Global Nationalism in Times of the COVID-19 Pandemic. *Natl Pap*. April 2020:1-13. doi:10.1017/nps.2020.35
25. Cultural Atlas – Sri Lankan Culture - Core Concepts. <https://culturalatlas.sbs.com.au/sri-lankan-culture/sri-lankan-culture-core-concepts>. Accessed November 3, 2020.
26. Social Media Stats Sri Lanka | StatCounter Global Stats. Statcounter. <https://gs.statcounter.com/social-media-stats/all/sri-lanka>. Accessed November 4, 2020.
27. Schools to be re-opened for second terms on May 11. <https://www.newsfirst.lk/2020/04/11/schools-to-be-re-opened-for-second-terms-on-may-11/>. Accessed November 4, 2020.
28. Michigan protest: Pictures, videos from Operation Haircut. <https://www.lansingstatejournal.com/story/news/2020/05/20/michigan-protest-pictures-operation-haircut-lansing-capitol/5229182002/>. Accessed November 4, 2020.
29. Salkovskis PM. The Importance of Behaviour in the Maintenance of Anxiety and Panic: A Cognitive Account. *Behav Psychother*. 1991;19(1):6-19. doi:10.1017/S0141347300011472
30. Ahmad AR, Murad HR. The impact of social media on panic during the COVID-19 pandemic in iraqi kurdistan: Online questionnaire study. *J Med Internet Res*. 2020;22(5). doi:10.2196/19556
31. Ministry of Defence - Sri Lanka | Defence News Fight against COVID-19: Chef Anura speaks out. http://www.defence.lk/Article/view_article/1161. Accessed November 13, 2020.

32. Ministry of Defence Sri Lanka. Ministry of Defence - Sri Lanka | Defence News. http://www.defence.lk/Article/view_article/876. Accessed November 4, 2020.
33. Home Page · College of Community Physicians of Sri Lanka. <https://ccpsl.org/>. Accessed November 16, 2020.
34. SL College of Psychiatrists. <https://slcpsych.lk/>. Accessed November 16, 2020.
35. Sri Lanka College of Psychiatrists. SLCOPsych hotline for frontline workers. - Sri Lanka College of Psychiatrists | Facebook. <https://www.facebook.com/SLCOP/posts/2960208190736876>. Published 2020. Accessed November 4, 2020.
36. Health Promotion Bureau. HPB | New Coronavirus (COVID-19) outbreak. <https://hpb.health.gov.lk/en/news-single/7>. Published 2020. Accessed November 4, 2020.
37. සමස්ත සෞඛ්‍ය සේවක සංගමය | Facebook. <https://www.facebook.com/groups/1877864755854282>. Accessed November 13, 2020.
38. Gotabaya Rajapaksa. Profile of His Excellency Gotabaya Rajapaksa. <https://www.president.gov.lk/president/>. Published 2020. Accessed November 4, 2020.
39. Wijayaratne S. Request to halt Sri Pada pilgrimage . Daily News. <https://www.dailynews.lk/2020/03/17/local/214635/request-halt-sri-pada-pilgrimage>. Published March 17, 2020. Accessed November 4, 2020.
40. GMOA. GMOA – Government Medical Officers’ Association. <https://www.gmoa.lk/>. Published 2020. Accessed November 4, 2020.
41. The World Bank. Sri Lanka Overview. <https://www.worldbank.org/en/country/srilanka/overview>. Published 2020. Accessed November 4, 2020.
42. Epidemiology Unit M of H. Sustaining Vaccination Coverage Continued national commitment to primary health care with a strong focus on community engagement. *Unicef*. 2014. https://www.unicef.org/rosa/media/5191/file/UNICEF_Sustaining_Vaccination_Coverage_SriLanka.pdf. Accessed November 4, 2020.
43. WHO. Primary Health Care Systems (PRIMASYS) . *WHO*. 2020. <http://www.who.int/alliance-hpsr/projects/primasys/en/>. Accessed November 4, 2020.
44. Wilson A. Sri Lanka ranked top country for travel in 2019 by Lonely Planet | Travel | The Guardian. *The guardian*. <https://www.theguardian.com/travel/2018/oct/23/sri-lanka-ranked-top-country-for-travel-in-2019-by-lonely-planet>. Published October 23, 2018. Accessed November 4, 2020.
45. BBC NEWS. Coronavirus: US and Australia close borders to Chinese arrivals - BBC News. *BBC*. <https://www.bbc.com/news/world-51338899>. Published February 1, 2020. Accessed November 4, 2020.
46. The fear of coronavirus is changing our psychology - BBC Future. <https://www.bbc.com/future/article/20200401-covid-19-how-fear-of-coronavirus-is-changing-our-psychology>. Accessed December 15, 2020.
47. Committee to Protect Journalists. Social media still blocked in Sri Lanka following terror attack - Committee to Protect Journalists. <https://cpj.org/2019/04/social-media-still-blocked-in-sri-lanka-following/>. Published April 29, 2019. Accessed November 4, 2020.
48. Renee DiResta | Aspen Ideas. <https://www.aspenideas.org/speakers/renee-diresta>. Accessed December 1, 2020.
49. Department of Government Information - Sri Lanka | Facebook. <https://www.facebook.com/DepartmentOfGovernmentInformation/>. Accessed December 14, 2020.
50. Health Promotion Bureau | Facebook. <https://www.facebook.com/hpbsrilanka/>. Accessed December 14, 2020.
51. Daftary A. HIV and tuberculosis: The construction and management of double stigma. *Soc Sci Med*. 2012;74(10):1512-1519. doi:10.1016/j.socscimed.2012.01.027
52. Daftary A, Frick M, Venkatesan N, Pai M. Fighting TB stigma: We need to apply lessons learnt from HIV activism. *BMJ Glob Heal*. 2017;2(4). doi:10.1136/bmjgh-2017-000515
53. Yu H, Li M, Xiang W, et al. Coping style, social support and psychological distress in the general Chinese population in the early stages of the COVID-2019 epidemic. *Res Sq*. 2020. doi:10.21203/RS.3.RS-20397/V2
54. Ministry of Defence Sri Lanka. Defence Ministry requests media to respect privacy of coronavirus infected patients. <http://www.defence.lk/Covid19/article/1345>. Published April 27, 2020. Accessed November 4, 2020.
55. Ministry of Defence Sri Lanka. Defence Secretary requests public not to stigmatise Tri-Forces personnel fighting against coronavirus. <http://www.defence.lk/Covid19/article/1368>. Published April 29, 2020. Accessed November 4, 2020.
56. Des Jarlais DC, Galea S, Tracy M, Tross S, Vlahov D. Stigmatization of newly emerging infectious diseases: AIDS and SARS. *Am J Public Health*. 2006;96(3):561-567. doi:10.2105/AJPH.2004.054742
57. Gollust SE, Nagler RH, Fowler EF. The Emergence of COVID-19 in the U.S.: A Public Health and Political Communication Crisis. *J Health Polit Policy Law*. May 2020. doi:10.1215/03616878-8641506
58. Sotgiu G, Dobler CC. Social stigma in the time of coronavirus disease 2019. *Eur Respir J*. 2020;56(2). doi:10.1183/13993003.02461-2020
59. Wijaya T. Factor Analysis of Panic Buying During the Covid-19 Period in Indonesia. *SSRN Electron J*. May 2020. doi:10.2139/ssrn.3603750
60. Engel J, Blackwell R, Miniard P. *Consumer Behavior*. 10th ed. Mason OH: Thomson/South-Western; 2006.
61. Kotler T, Keller. *Marketing Management*. 12th ed. Pearson; 2006. <https://www.pearson.com/us/higher-education/product/Kotler-Marketing-Management-12th-Edition/9780131457577.html>. Accessed November 4, 2020.
62. Somatunga L, Ratnayake L, Wijesinghe W, Yapa Y, Cooray M. National alcohol use prevalence survey in Sri Lanka. *J Postgrad Inst Med*. 2014;1(0). doi:10.4038/jpgim.7858
63. Poston B. *An Exercise in Personal Exploration: Maslow's Hierarchy of Needs*. Association of Surgical Technologists ; 2009. <http://www.ast.org/pdf/308.pdf>. Accessed November 4, 2020.

64. Kathirvel N. Post COVID-19 pandemic mental health challenges. *Asian J Psychiatr.* 2020;53. doi:10.1016/j.ajp.2020.102430
65. Klein RL. Age, sex, and task difficulty as predictors of social conformity. *J Gerontol.* 1972;27(2):229-236. doi:10.1093/geronj/27.2.229
66. Health Promotion Bureau. Rolling updates on Coronavirus disease (COVID-19). <https://hpb.health.gov.lk/en/covid-19>. Published 2020. Accessed November 4, 2020.
67. Cori L, Bianchi F, Cadum E, Anthonj C. Risk perception and covid-19. *Int J Environ Res Public Health.* 2020;17(9). doi:10.3390/ijerph17093114
68. Song X, Delaney M, Shah RK, Campos JM, Wessel DL, DeBiasi RL. Comparison of Clinical Features of COVID-19 vs Seasonal Influenza A and B in US Children. *JAMA Netw open.* 2020;3(9). doi:10.1001/jamanetworkopen.2020.20495
69. Broadcasters Serving Their Communities in Response to COVID-19 Pandemic | Federal Communications Commission. <https://www.fcc.gov/broadcasters-serving-their-communities-response-covid-19-pandemic>. Accessed November 16, 2020.
70. Sri Lanka election commission censors state TV in lead-up to vote | Sri Lanka | Al Jazeera. <https://www.aljazeera.com/news/2019/11/3/sri-lanka-election-commission-censors-state-tv-in-lead-up-to-vote>. Accessed November 16, 2020.
71. Denemark D. Television Effects and Voter Decision Making in Australia: A Re-examination of the Converse Model on JSTOR. *Br J Polit Sci.* 2002;32:668-690. https://www.jstor.org/stable/4092378?seq=1#metadata_info_tab_contents. Accessed November 16, 2020.

Figures

Figure 1

Distribution of the study population in the country

Figure 2
COVID 19 Infected status of the self and others in the immediate social environment

Figure 3
Perception of overall knowledge on prevention

Figure 4

Perception of knowledge about individual symptoms of COVID 19 N=1001, figures in bars are numbers of participants, percentages were calculated for analysis

Figure 5
Knowledge about incubation period

Figure 6

Perception on probability of getting infected with COVID 19 Unlikely = Extremely unlikely + Unlikely + Somewhat unlikely, Likely = Somewhat likely + Likely + Extremely likely

Figure 7

Perception of severity of infection with COVID 19 Severe = Less severe + severe + very severe, Not severe = Very mild disease + Not severe + Not severe at all

Figure 8

Confidence in the ability to protect self from COVID 19 Good confidence = I know + Very much so, Poor confidence =I know to some extent + I don't know at all+ I don't know much

Figure 9

Compliance with recommendations from authorities Compliant = Follow to a some extent + I follow+ Very much so, Not compliant = Not at all + I do not follow much

Figure 10

Coping with not seeing the family living outside home and not seeing friends Good coping = Can be done + Easy for me + very easy for me, Poor coping =Difficult for me +very difficult for me +impossible for me

Figure 11

Effect of COVID 19 on the individuals' affect N=1001, figures in bars are numbers of participants, percentages were calculated for analysis.

Figure 12

Frequency of seeking information High frequency = often + once a day + several times a day, Low frequency = sometimes + rarely +very rarely

Figure 13

Opinion on overall COVID 19 decisions taken in Sri Lanka Disagree= Strongly disagree + Disagree + Somewhat disagree, Agree = Strongly agree + Agree + Somewhat agree.

Figure 14
Opinion on the difficulty in managing stressful events due to COVID 19 policies

Figure 15
Opinions on help seeking behaviours in relation to stressful experiences due to COVID 19 policies.

Figure 16

Opinion on contracting COVID 19 as stigmatizing

Figure 17

Basis for stigma

Figure 18

Behaviours practiced in relation to COVID 19

Figure 19

Confusions about the information on COVID 19 information

Figure 20

Perception of the probability of contracting COVID 19 Vs. perception of the probability of contracting an episode of cough, cold and fever Unlikely = Extremely unlikely + Unlikely + Somewhat unlikely, Likely = Extremely likely + Likely + Somewhat likely.

Figure 21

Perception of the severity of COVID 19 Vs. perception of the severity of an episode of cough, cold and fever Severe = Very severe + Severe + Less severe, Not severe = Not severe at all + Not severe + Very mild disease.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [CoverletterforCovidstudyForBMCPublicHealth1.docx](#)