

# Knowledge, attitudes and practices of the Chinese public with respect to coronavirus disease (COVID-19): An online cross-sectional survey

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## Research article

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# Abstract

**Background:** Coronavirus disease (COVID-19) has become pandemic. The knowledge, attitudes, and practices (KAP) of the public play a major role in the prevention and control of infectious diseases. The objective of the present study was to evaluate the KAP of the Chinese public and to assess potential influencing factors related to practices.

**Methods:** A cross-sectional online survey was conducted in China in February 2020 via a self-designed questionnaire comprising 33 questions assessing knowledge, attitudes, and practices.

**Results:** For the 2,136 respondents from 30 provinces or municipalities in China, the accurate response rate for the knowledge section was 72.7–99.5%, and the average was 91.2%. In the attitude section, the percentage of positive attitudes (“strongly agree” and “agree”) ranged from 94.7–99.7%, and the average value was 98.0%. The good practices (“always” and “often”) results ranged from 76.1–99.5%, and the average value was 96.8%. The independent samples t-test revealed that gender and ethnic differences had no effect on knowledge, attitude or behaviour ( $P > 0.05$ ). However, knowledge was associated with age ( $t = 4.842, p < 0.001$ ), marital status ( $t = -5.323, p < 0.001$ ), education level ( $t = 8.441, p < 0.001$ ), occupation ( $t = -10.858, p < 0.001$ ), and place of residence ( $t = 7.929, p < 0.001$ ). Similarly, attitude was associated with marital status ( $t = -2.383, p = 0.017$ ), education level ( $t = 2.106, p = 0.035$ ), occupation ( $t = -4.834, p < 0.001$ ), and place of residence ( $t = 4.242, p < 0.001$ ). The results of multiple linear regression analysis showed that the factors influencing practices were knowledge ( $t = -3.281, p = 0.001$ ), attitude ( $t = 18.756, p < 0.001$ ), occupation ( $t = -3.860, p < 0.001$ ), education level ( $t = 3.136, p = 0.002$ ), and place of residence ( $t = 3.257, p = 0.001$ ).

**Conclusions:** The Chinese public exhibited a good level of knowledge of COVID-19, a positive attitude, and high adherence to good practices. COVID-19-related knowledge, attitudes and practices were affected by age, marital status, education level, occupation, and place of residence to varying degrees. In addition, practices were affected by knowledge and attitudes toward COVID-19.

## Introduction

In December 2019, coronavirus disease (COVID-19) first emerged in Wuhan, China, leading to a large outbreak in China and outbreaks worldwide. Confirmed patients and asymptomatic infected people are the main sources of infection[1]. The routes of transmission are diverse and include close contact, droplets from asymptomatic or oligosymptomatic patients and possibly aerosols in health care environments[1], and the population is generally susceptible to infection. According to WHO statistics, as of 23 March 2020, the number of confirmed COVID-19 cases had reached 332,930 worldwide[2]. Among these cases, 81,601 were in China, and the remaining 251,329 cases were from more than 180 different countries, including Italy, the United States of America, Spain, Germany, and Iran. The disease has resulted in 14,510 deaths so far, and the fatality rate is approximately 4.35% [2]. Obviously, COVID-19 has become a global public health issue.

Because the population is generally susceptible to COVID-19, it is extremely challenging to prevent and control the spread of this infectious disease. Currently, no vaccine has been developed for COVID-19, and no antiviral wonder drug is specifically recommended. Therefore, applying preventive measures, such as avoiding contact with confirmed or suspected cases, practicing good hand hygiene, observing respiratory etiquette, and cleaning and disinfecting surfaces, etc., to reduce the spread of the disease is of utmost importance[3, 4]. Many interventions are simple and inexpensive; however, a lack of knowledge often leads to poor application and unsafe behaviour [5]. In addition, misleading information and negative attitudes toward emerging infectious diseases may result in unnecessary concern, rumours, social chaos, and even excessive panic, which might aggravate the epidemic[6]. Previous experience with severe acute respiratory syndrome (SARS) has shown the importance of monitoring public perceptions of epidemic control, as these may affect the public's compliance with advocated precautionary behaviours. Recognition of factors that may affect precautionary behaviours, such as knowledge and risk perception of the disease, may also help to prevent the spread of infection. The existing literature has indicated that knowledge, attitude and risk perception with respect to infectious diseases are significantly correlated with protective behaviour[7–9], and the behaviour of the public or potential risk groups can play a major role in both the prevention and control of infectious diseases[10]. Therefore, it is important to assess the public's knowledge, attitudes, and practices (KAP) regarding COVID-19. However, there is little knowledge available about the Chinese public's KAP with respect to COVID-19. Specifically, the present study was performed to evaluate KAP among the Chinese public and to assess potential influencing factors related to preventive behaviours. The results of the study can provide information about the effectiveness of the health education efforts of China's health authorities and about how to design evidence-based interventions to reduce the risk of contracting COVID-19.

## Methods

### Study design and participants

This study was a cross-sectional online survey conducted on a special questionnaire survey platform (Wenjuanxing, <https://www.wjx.cn/>) in China. Convenience sampling was used to select potential respondents. The inclusion criteria were  $\geq 18$  years old; able to use a smartphone; and able to understand the content of the questionnaire. The exclusion criteria were unable to fill in the questionnaire due to illness or other reasons and unwilling to participate in the research. According to the Kendall sample estimation method for multivariate analysis, the minimum sample size should be 10 times of variables[11]. The questionnaire applied in the study included 33 variables. Therefore, the minimum sample size for this survey was 330.

### Instrument

Based on the research purpose, the researchers designed the questionnaire themselves. The survey consisted of four sections: demographic variables and knowledge, attitudes and practices with respect to

COVID-19. The demographic variables included sex, age, ethnicity, marital status, education level, occupation and place of residence. There were 13 items in the knowledge section, and each item contained 3 options, namely, "true", "false" and "don't know"; 1 point was given for a correct answer, and 0 for an incorrect answer or "don't know" response. The total score of this section ranged from 0 to 13, and the higher the score is, the better the degree of knowledge. In the attitude section, there were five items, and a Likert scale was used to assess the level of agreement with the statements; response options ranged from 1 (strongly disagree) to 5 (strongly agree). The total score in this section was 5–25, and a higher score indicates a more positive attitude. The practices section included 15 items, and a Likert scale was used to assess the level of agreement with the statements; the response options ranged from 1 (never) to 4 (always). The total score in this section was 15–60; the higher the score, the better the protective actions taken. The content validity index (CVI) of the questionnaire was confirmed by 9 experts in our research team. Before the formal survey, we conducted a pilot study including 50 people to evaluate the internal consistency reliability (Cronbach's  $\alpha$ ). Finally, the CVI was 0.94, and the Cronbach's  $\alpha$  values was 0.846.

## Data collection

The self-designed questionnaire was input into an online questionnaire survey platform (Wenjuanxing, <https://www.wjx.cn/>), and the questionnaires were sent to potential respondents through WeChat by convenience sampling during February 2020. Online informed consent was presented to the respondents before they completed the questionnaire.

## Statistical analysis

SPSS version 22.0 (IBM Corp., Armonk, NY, USA) was used for all statistical analyses. The categorical data are described by the frequency and composition ratio. The continuous data are described as the means and standard deviations. The t-test was used to analyse whether there were differences in the knowledge, attitudes, and practices related to COVID-19 among groups with different demographic characteristics. Multiple linear regression analysis was used to explore the factors influencing the public's COVID-19 prevention practices. All statistical tests were two-sided, with  $p \leq 0.05$  considered statistically significant.

## Results

### Socio-demographic information of the participants

A total of 2,136 survey responses from 30 provinces or municipalities in China were received. The top five participating provinces and municipalities were, in order, Guizhou (1,701, 79.6%), Chongqing (165, 7.7%), Sichuan (130, 6.1%), Hubei (30, 1.4%), and Henan (25, 1.2%). The socio-demographic details of the 2,136 participants are summarized in Table 1.

Table 1  
Socio-demographic information of the participants (N = 2136)

<b>Variable</b>	<b>n (%) or Mean <math>\pm</math> SD</b>
<b>Sex</b>	
Male	467 (21.9)
Female	1669 (78.1)
<b>Age (year)</b>	33.1 $\pm$ 8.8
<b>Ethnicity</b>	
Han	1830 (85.7)
Other	306 (14.3)
<b>Marital status</b>	
Married	1473 (69.0)
Unmarried	593 (27.8)
Divorced	65 (3.0)
Widowed	5 (0.2)
<b>Education level</b>	
Middle school and below	94 (4.4)
High school/technical secondary school	113 (5.3)
Junior college	333 (15.6)
Bachelor's degree	1259 (58.9)
Master's degree and above	337 (15.8)
<b>Occupation</b>	
Medical staff	1228 (57.5)
Worker	34 (1.6)
Farmer	23 (1.1)
Self-employed	120 (5.6)
Student	176 (8.2)
Employee of an enterprise or institution	393 (18.4)
Unemployed or retired	33 (1.5)
Other	129 (6.0)

Variable	n (%) or Mean $\pm$ SD
Place of residence	
City	1740 (81.5)
Countryside or town	396 (18.5)
SD: standard deviation	

## Knowledge of the public regarding COVID-19

The accurate response rate for the knowledge section ranged from 72.7% (*Family gatherings may spread infection*) to 99.5% (*Most people infected present with fever, fatigue, and dry cough as the main symptoms*), and the average accuracy rate was 91.2%. Except for the two items "Family gatherings may spread infection" and "A suspected case can only be ruled out after two consecutive negative tests of respiratory pathogenic nucleic acid (at least one day apart)", the accurate response rate for the other 11 items was greater than 80%, as shown in Table 2.

Table 2  
Knowledge level of respondents regarding COVID-19 (N = 2136)

Items	Accuracy n (%)
1. The source of infection is primarily confirmed and asymptomatic patients	1919 (89.8)
2. Transmission mainly occurs through respiratory droplets and close contact	2108 (98.7)
3. The population is generally susceptible to infection	2001 (93.7)
4. It is highly infectious and spreads quickly	2121 (99.3)
5. Washing hands frequently, wearing masks and other measures can effectively prevent infection	2115 (99.0)
6. Family gatherings may spread infection	1553 (72.7)
7. The incubation time of the disease is 1–14 days, typically 3–7 days	2056 (96.3)
8. Most people infected present with fever, fatigue, and dry cough as the main symptoms	2125 (99.5)
9. Most patients have a good prognosis, while a few are in critical condition	1875 (87.8)
10. A suspected case can only be ruled out after two consecutive negative tests of respiratory pathogenic nucleic acid (at least one day apart)	1659 (77.7)
11. Suspected and confirmed patients should be isolated and treated in designated hospitals with effective isolation and protective conditions	2111 (98.8)
12. If you develop a fever during the outbreak, you can take your own medicine	1779 (83.3)
13. Medical alcohol at a concentration of 75% can effectively inactivate the virus	1911 (89.5)
Average accuracy	91.2

## Attitude of the public towards COVID-19

The proportion of positive attitudes (strongly agree and agree) ranged from 94.7% (*It is believed that the outbreak will soon be contained*) to 99.7% (*I am willing to cooperate with the relevant departments to take prevention and control measures*), and the average value was 98.0%, as shown in Table 3.

Table 3  
The public's attitude towards COVID-19 (N = 2136)

Items	Strongly Agree n(%)	Agree n(%)	Not sure n(%)	Disagree n(%)	Strongly disagree n (%)
1. I pay close attention to the development of the epidemic situation	1995 (93.4)	134 (6.3)	4 (0.2)	0 (0)	3 (0.1)
2. I think I am playing an important role in controlling the epidemic	1754 (82.1)	340 (15.9)	38 (1.8)	2 (0.1)	2 (0.1)
3. I fear infection for myself and my family	1809 (84.7)	273 (12.8)	41 (1.9)	7 (0.3)	6 (0.3)
4. It is believed that the outbreak will soon be contained	1699 (79.5)	325 (15.2)	96 (4.5)	11 (0.5)	5 (0.2)
5. I am willing to cooperate with the relevant departments to take prevention and control measures	1956 (91.6)	172 (8.1)	5 (0.2)	0 (0)	2 (0.1)
Average rate	86.3	11.7	1.7	0.2	0.2

## Practices of the public with respect to COVID-19

The proportion of good practices (always and often) ranged from 76.1% (*Home environment disinfection*) to 99.5% (*Wash hands*), and the average value was 96.8%. Except for the three items, "Monitor body temperature", " Appropriate exercise", and "Home environment disinfection", the good practice adherence rate of the remaining 12 items was more than 80%, as shown in Table 4.

Table 4  
The public's COVID-19 prevention practices (N = 2136)

Items	Always	Often	Sometimes	Never
	N (%)	n (%)	N (%)	N (%)
1. After the outbreak, stay at home to prevent infection	1752 (82.0)	301 (14.1)	63 (2.9)	20 (0.9)
2. Wear a mask when going out	2072 (97.0)	51 (2.4)	9 (0.4)	4 (0.2)
3. Wash hands	1970 (92.2)	155 (7.3)	10 (0.5)	0 (0)
4. Seek medical advice when symptoms such as fever and cough appear	1870 (87.5)	161 (7.5)	90 (4.2)	15 (0.7)
5. Monitor body temperature	1273 (59.6)	406 (19.0)	353 (16.5)	104 (4.9)
6. Open windows to keep the air fresh	1823 (85.3)	280 (13.1)	32 (1.5)	0 (0)
7. Rest properly and don't stay up late	1498 (70.1)	385 (18.0)	229 (10.7)	24 (1.1)
8. Appropriate exercise	1287 (60.3)	406 (19.0)	407 (19.1)	36 (1.7)
9. Home environment disinfection	1104 (51.7)	522 (24.4)	448 (21.0)	62 (2.9)
10. Reduce time in airtight, airless environments	1780 (83.3)	244 (11.4)	54 (2.5)	58 (2.7)
11. Reduce visits to crowded places	1831 (85.7)	218 (10.2)	43 (2.0)	44 (2.1)
12. Avoid direct contact with public facilities that may be infected, such as elevator buttons and stair railings	1673 (78.3)	323 (15.1)	107 (5.0)	33 (1.5)
13. Active quarantine after contact with high-risk groups	1923 (90.0)	143 (6.7)	44 (2.1)	26 (1.2)
14. Cover mouth and nose when coughing or sneezing	1944 (91.0)	162 (7.6)	20 (0.9)	10 (0.5)
15. Keep warm and avoid catching cold	1965 (92.0)	161 (7.5)	6 (0.3)	4 (0.2)
Average rate	87.4	9.4	2.1	1.1

## Single-factor analysis of the influencing factors of knowledge, attitudes and practices

The independent samples t-test analysis indicated that gender and ethnic differences had no effect on knowledge, attitudes and practices. The knowledge score of the < 32-year-old group was lower than that of the  $\geq$  32-year-old group, and the difference was statistically significant. Marital status, education level, occupation and place of residence all had an impact on the scores of knowledge, attitudes and practices, and the differences were statistically significant, as shown in Table 5.

Table 5  
Univariate analysis of the factors influencing knowledge, attitudes and practices (N = 2136)

Items	Number	Statistical value	Knowledge (Mean ± SD)	Attitudes (Mean ± SD)	Practices (Mean ± SD)
<b>Sex</b>					
Male	467		11.78 ± 1.30	24.16 ± 1.61	55.37 ± 5.24
Female	1669		11.88 ± 1.15	24.19 ± 1.54	55.86 ± 4.93
		t	-1.593	-0.406	-1.782
		P	0.112	0.685	0.075
<b>Age (year)*</b>					
< 32	999		11.73 ± 1.22	24.21 ± 1.70	55.87 ± 5.23
≥ 32	1137		11.98 ± 1.34	24.16 ± 1.41	55.65 ± 4.80
		t	4.842	-0.700	-0.999
		P	< 0.001	0.484	0.318
<b>Ethnicity</b>					
Han	1830		11.87 ± 1.16	24.17 ± 1.53	55.75 ± 4.94
Other	306		11.77 ± 1.30	24.28 ± 1.70	55.76 ± 5.40
		t	1.365	-1.164	-0.036
		P	0.173	0.245	0.971
<b>Marital status</b>					
Married	1473		11.96 ± 1.10	24.23 ± 1.43	55.93 ± 4.75
Unmarried or divorced or widowed	663		11.64 ± 1.32	24.07 ± 1.79	55.35 ± 5.52
		t	-5.323	-2.383	-2.101
		P	< 0.001	0.017	0.036
<b>Education level</b>					

Items	Number	Statistical value	Knowledge (Mean ± SD)	Attitudes (Mean ± SD)	Practices (Mean ± SD)
Below junior college	207		11.01 ± 1.56	23.97 ± 1.71	53.53 ± 6.32
Junior college and above	1929		11.95 ± 1.10	24.21 ± 1.53	55.99 ± 4.78
		t	8.441	2.106	6.803
		P	< 0.001	0.035	< 0.001
<b>Occupation</b>					
Medical staff	1228		12.11 ± 0.93	24.33 ± 1.32	56.53 ± 4.27
Other	908		11.53 ± 1.39	23.99 ± 1.80	54.70 ± 5.69
		t	-10.858	-4.834	-8.497
		P	< 0.001	< 0.001	< 0.001
<b>Place of residence</b>					
City	1740		11.98 ± 1.05	24.27 ± 1.38	56.14 ± 4.56
Countryside or town	396		11.34 ± 1.54	23.80 ± 2.13	54.03 ± 6.33
		t	7.929	4.242	6.272
		P	< 0.001	< 0.001	< 0.001
*The median age of the subjects was 32 years.					

## Multiple linear regression analysis of the factors influencing practice (N = 2136)

The statistically significant indicators of knowledge and attitude from the results of the single-factor analysis were incorporated into the multifactor model. With the practices score as the dependent variable, marital status (married = 1, single/widowed/divorced = 2), education (below junior college = 1, college degree and above = 2), occupation (medical staff = 1, other professions = 2), place of residence (city = 1, countryside/town = 2), knowledge (continuous variable), and total attitude score (continuous variable) were the six independent variables. Multiple linear regression was conducted by the stepwise entry method with a selection level of 0.05 and elimination level of 0.10. The results showed that the regression

model was statistically significant ( $F = 104.141$ ,  $P < 0.001$ , adjusted  $R^2 = 0.195$ ). The five independent variables included in the model had statistically significant effects on practice ( $P < 0.05$ ), as shown in Table 6.

Table 6  
Multiple linear regression analysis of the factors influencing practice

Variable	Partial regression coefficient (B)	Standard error (SE)	Standardized partial regression coefficient (Beta)	t	P
Constant	23.537	2.009	—	11.716	< 0.001
Attitude score	1.195	0.064	0.371	18.756	< 0.001
Occupation	-0.838	0.217	-0.083	-3.860	< 0.001
Knowledge score	0.286	0.087	0.068	3.281	0.001
Place of residence	-0.867	0.266	-0.067	-3.257	0.001
Education level	1.130	0.360	0.067	3.136	0.002

## Discussion

The current study was conducted to assess and compare the knowledge, attitudes and practices of different population groups with respect to COVID-10 in China. This evaluation was essential to improve protective practices for preventing COVID-19 infection among the public because there is no vaccine available and no specific treatment being offered against the disease at present. In our study, 2,136 people participated, and the response efficiency was 100%.

The results of this study showed that the Chinese public has good knowledge of COVID-19, with an overall correct response rate of 91.2%, which is coincident with other similar studies published earlier[12–16]. This result was expected because governmental offices at all levels have released relevant education materials in a timely manner and have delivered COVID-19-related content through various channels, including television, the Internet, WeChat, and publicity boards, since the outbreak began. Except for the two items "Family gatherings may spread infection" and "A suspected case can only be ruled out after two consecutive negative tests of respiratory pathogenic nucleic acid (at least one day apart)", the accuracy rate of the remaining 11 items was between 83.3% and 99.5%. On the one hand, this implies that the public has incomplete knowledge of COVID-19, especially regarding some professional knowledge, and still needs further education. On the other hand, this infectious disease has caused infection within family groups[17, 18]. Hence, health authorities should further increase publicity to raise public awareness of the disease.

In the present study, participants showed extremely positive attitudes towards COVID-19. A total of 99.7% of the public paid close attention to the development of the epidemic situation, 98.0% thought they played an important role in controlling the epidemic, 94.7% believed that the outbreak would soon be contained, and 99.7% expressed willingness to cooperate with the relevant departments to take prevention and control measures. The results are similar to those of other published studies[12–15], likely because the Chinese government at different levels has attached great importance to the epidemic and adopted strict prevention and control measures in a timely manner against the disease after the outbreak[19]. In addition, with the COVID-19 pandemic and media reports, the Chinese public understands the severity of the epidemic. Therefore, they desire to actively participate in epidemic prevention and control. In addition, 97.5% of the public expressed fear of infection for themselves and their families, indicating that health authorities should continue to organize corresponding health education and publicity in a timely manner to prevent fear from spreading.

The majority of the public adhered to good practices with respect to COVID-19 infection. This may be because the public has good COVID-19 knowledge and a positive attitude, which ultimately translates into good practice. However, the least common practice among participants was “Home environment disinfection”. It may be that during the outbreak, the shortage of protective equipment, such as medical alcohol and chlorine-containing disinfectants, made it difficult to disinfect the home environment. This result suggests that during the outbreak of infectious diseases, government departments should try their best to provide sufficient supplies of protective equipment so that the public can take protective actions.

Further analysis found that age was an influencing factor of the public's grasp of COVID-19. The population younger than 32 years old (the median age of the study subjects) had poorer knowledge than their counterparts. This may be due to the increase in social experience and knowledge reserves with age. Marital status, education, occupation, and place of residence all had an impact on knowledge, attitudes, and practices. Married people had a better grasp of knowledge, more active protective attitudes, and higher adherence rates to protective behaviours than unmarried, divorced, or widowed individuals. This may be because married people have the responsibility of caring for their families in addition to self-protection. Therefore, they tend to learn more about protection, take a more positive attitude, and engage in proactive protective actions. People with a college degree or above had better knowledge, attitudes and practices than their counterparts. It may be that the higher the degree one has, the broader one's knowledge and the stronger one's learning ability, making it easier to grasp the relevant knowledge regarding COVID-19, adopt a protective attitude and be more positive. It has been suggested that health education should be targeted to people with different educational levels and with different needs for health education. For the less educated population, easy-to-understand publicity materials may be more effective[20]. Medical personnel had higher knowledge, attitude, and behaviour scores than non-medical respondents, because medical personnel generally have a college degree or higher and have received more professional medical training. Hence, in the process of the prevention and control of COVID-19, the average person needs more education on COVID-19-related knowledge than medical staff. Compared with rural or urban residents, those living in cities had higher scores for knowledge, attitudes, and practices. The possible reasons are as follows. (a) Information sources are more available and spread

faster in cities, and people can obtain first-hand information quickly[21]. (b) The cultural literacy of city residents is generally higher than that of people living in rural or urban areas[22]. (c) The composition of people in the city is more complex, and there is high population density, which increases the likelihood of COVID-19 dissemination. As a result, citizens are more proactive in epidemic prevention. (4) Medical and protective supplies in cities are more abundant than in rural areas, so citizens have more opportunities to obtain relevant protective supplies and take active protective action.

In mastering the basic knowledge on COVID-19 prevention and control, the ultimate goal is to be able to apply it in practice, that is, to be able to properly take protective measures, control the roots of infection, cut off the transmission route, and protect vulnerable groups. The results of multiple linear regression analysis showed that knowledge, attitude, occupation, education level, and place of residence were the main factors affecting the public's protective behaviour. According to the KAP model, knowledge is the basis and attitude is the driving force of behaviour change[23]. Therefore, improving people's knowledge and fostering positive attitudes toward epidemic prevention are indispensable for improving protective behaviour. Moreover, this result indicates that it is necessary to take targeted measures to improve people's protective behaviour effectively based on their profession, education level and area of residence.

This study has two limitations. First, while we conducted this non-random sampling online survey involving 30 provinces or municipalities by convenience sampling, nearly 80% of the respondents came from Guizhou Province, and the composition of the sample was uneven, mainly including medical staff (who have a high education level), city residents and young people. Therefore, the generalizability of the research results has certain limitations. In addition, this study was based on self-reported information about knowledge, attitudes and practices with respect to COVID-19. It is possible that participants looked up the answers before answering some of the questions, which may exaggerate the accuracy rate of COVID-19 knowledge. To alleviate this bias, we made the questionnaire anonymous and emphasized anonymity during the survey, and we stressed the importance of answering questions honestly before completing the questionnaire.

## **Conclusion**

In summary, the public in China has a good grasp of the relevant knowledge on COVID-19, positive attitudes, and high adherence rates with respect to protective behaviours. Practices are affected by knowledge, attitudes, occupation, education, and place of residence.

## **Abbreviations**

COVID-19: Coronavirus Disease; KAP: Knowledge, Attitudes, and Practices; WHO: World Health Organization; SARS: Severe Acute Respiratory Syndrome; CVI: Content Validity Index; SD: Standard Deviation.

## **Declarations**

## Availability of data and materials

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

## Ethics approval and consent to participate

The study was reviewed and approved by the Biomedical Research Ethics Committee of the Affiliated Hospital of Zunyi Medical University (KLL-2020-010). Online informed consent was presented to the respondents before they completed the questionnaire.

## Consent for publication

All authors consented for the publication.

## Competing interests

The authors declare that they have no competing interests.

## Funding

Not applicable.

## Authors' contributions

RJH, HMG, LY, HT, LL, MC, DH and YW were responsible for conceiving and designing the experiments, collecting and analysing the data, and writing and revising the manuscript. RJH, XLY and ZXJ were responsible for the data interpretation. ZXJ and AYY made important intellectual contributions to the research design, provided technical guidance and revised the manuscript. HMG and RJH contributed equally to this paper. All the authors read and approved the final version of the manuscript.

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## References

1. China National Health Commission: Diagnosis and treatment of COVID-19 in China (Version 7); 2020.
2. WHO: Coronavirus disease (COVID-2019) situation reports-63; 2020.
3. Chinese Center For Disease Prevention: *Guidelines for public protection against COVID-19*. Version 1 edition. Beijing: People's Medical Publishing House; 2020.
4. Al-Hazmi A, Gosadi I, Somily A, Alsubaie S, Bin SA: Knowledge, attitude and practice of secondary schools and university students toward Middle East Respiratory Syndrome epidemic in Saudi Arabia: A cross-sectional study. *SAUDI J BIOL SCI* 2018, 25(3):572-577.
5. Lei X, Jing S, Zeng X, Lin Y, Li X, Xing Q, Zhong X, Ostbye T: Knowledge, attitudes and practices towards avian influenza among live poultry market workers in Chongqing, China. *PREV VET MED* 2019, 162:151-159.
6. Blendon RJ, Benson JM, DesRoches CM, Raleigh E, Taylor-Clark K: The public's response to severe acute respiratory syndrome in Toronto and the United States. *CLIN INFECT DIS* 2004, 38(7):925-931.
7. Goodwin R, Haque S, Neto F, Myers LB: Initial psychological responses to Influenza A, H1N1 ("Swine flu"). *BMC INFECT DIS* 2009, 9:166.
8. Ma XW, Liu YF, Yuan J, Liu JP, Xie CJ, Liu YH, Chen JD, Feng J, Di B: An analysis of the knowledge, attitudes and behaviors among live poultry traders during the early wave outbreak of human infected Avian influenza A(H7N9) in Guangzhou City, China. *Chinese Journal of Disease Control & Prevention* 2015, 19(6):593-596.
9. Seale H, Heywood AE, McLaws ML, Ward KF, Lowbridge CP, Van D, MacIntyre CR: Why do I need it? I am not at risk! Public perceptions towards the pandemic (H1N1) 2009 vaccine. *BMC INFECT DIS* 2010, 10:99.
10. de Zwart O, Veldhuijzen IK, Elam G, Aro AR, Abraham T, Bishop GD, Voeten HA, Richardus JH, Brug J: Perceived threat, risk perception, and efficacy beliefs related to SARS and other (emerging) infectious diseases: results of an international survey. *INT J BEHAV MED* 2009, 16(1):30-40.
11. Wang JL: *Clinical Epidemiology-Design, Measurement and Evaluation of clinical scientific research (Version 3)*. Shanghai: Shanghai Scientific and Technical Publishers; 2009.
12. Luo L, Zeng XJ, Liao X, Yang YQ: Disease cognition, coping style and exercise behavior among the public during novel coronavirus epidemic: an online survey. *Chin J Public Health* 2020:1-4.
13. Zhu YC, Feng HW, Luo YZ, He TF, Lou WW: Knowledge, attitude and practice of coronavirus disease 2019 in Ningbo residents. *PREV MED* 2020, 32(03):230-234.
14. Cai HL, Zhu YX, Lei LB, Pan CH, Zhu LW, Li JH, Gu J, Hao YT: Novel coronavirus pneumonia epidemic-related knowledge, behaviors and psychology status among college students and their family members and friends: an internet-based cross-sectional survey. *Chin J Public Health* 2020:1-4.
15. Li WH, Liu B, Liu M, Zhao XH, Chen QS: Investigation and analysis of public cognition and prevention awareness of Corona Virus Disease 2019 inside and outside Hubei Province. *Journal of Jinan University( Natural Science & Medicine Edition)* 2020:1-8.

16. Geldsetzer P: Knowledge and Perceptions of COVID-19 Among the General Public in the United States and the United Kingdom: A Cross-sectional Online Survey. *ANN INTERN MED* 2020.
17. Chan JF, Yuan S, Kok KH, To KK, Chu H, Yang J, Xing F, Liu J, Yip CC, Poon RW *et al*: A familial cluster of pneumonia associated with the 2019 novel coronavirus indicating person-to-person transmission: a study of a family cluster. *LANCET* 2020, 395(10223):514-523.
18. Qian G, Yang N, Ma A, Wang L, Li G, Chen X, Chen X: A COVID-19 Transmission within a family cluster by presymptomatic infectors in China. *CLIN INFECT DIS* 2020.
19. Cheng V, Wong SC, To K, Ho PL, Yuen KY: Preparedness and proactive infection control measures against the emerging novel coronavirus in China. *J HOSP INFECT* 2020, 104(3):254-255.
20. Shi R, Cai Y, Zeng W, Wang Y: A KAP survey to the severe acute respiratory syndrome in Shanghai residents. *Chinese General Practice* 2003, 06(06):481-482.
21. Xu YF, Li P, Zhou J, Guo LF: Investigation on cognitive behavior and psychological status of SARS in residents of Nanning city. *Practical Preventive Medicine* 2005, 12(01):134-135.
22. Feng J, Li TG, Qin PZ, Lu JY, Chen C, Chen ZQ, Yang ZC: Telephone survey and analysis of flu among citizens in Guangzhou. *South China Journal of Preventive Medicine* 2013, 39(04):35-37.
23. Li WY, L J, Yu GL, Xu JH: Application of the knowledge-belief-practice model in nursing practice: current status and prospects. *Journal of Nursing Science* 2015, 30(06):107-110.