Indian Adults and Covid-19 Scenario

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ABSTRACT

In order to understand the knowledge and practices used by the selected respondents in adopting a new normal to resist the COVID-19 pandemic age, the current study, titled Knowledge and Practices towards COVID-19 of the People of Ahmedabad City of Gujarat State, was conducted. 200 respondents from Ahmedabad City, aged 21 to 58, were chosen using a convenient sampling method. An online questionnaire using Google Forms was designed and executed using different social platforms such as email, WhatsApp, and text messages. In the study, descriptive statistics such as mean and standard deviation for continuous variables and frequency and percentages for discrete variables were used. Results of this study showed that social media was the most commonly accessed source of information on COVID-19 and that a large majority of respondents had greater access to information about it. Further, the majority of the respondents had a higher level of knowledge and were well-informed on the signs and symptoms, the spread of the disease, and preventive measures, but they were only partially or incorrectly informed about the recommended hand hygiene practices and risk factors that could increase the virus's ability to spread. Nevertheless, more than half (54%) of the responders had inadequate COVID-19 practices. With regard to the variables of education and occupation, there were significant disparities in the respondents' practices. The results of this study could serve as a baseline for NGOs, government officials, and other stakeholders as they reform and rebuild risk communication programs for such highly contagious diseases.

Keywords: COVID-19, Knowledge, Practices, Citizens of Ahmedabad City, Gujarat, India

INTRODUCTION

The first case of the newly discovered global public health issue COVID-19 was reported in Wuhan, China, in December 2019. It quickly spread and reached every nation within a few months. It resulted in a significant number of fatalities in various nations, including India. Coronavirus (COVID-19) infections are newly developing respiratory viruses that have been linked to symptoms ranging from the common cold to severe acute respiratory syndrome (SARS) (Bhagavathula et al., 2020). The highly contagious coronavirus disease has rapidly spread to every continent, overwhelming even the most resilient healthcare systems with its explosive spread potential. Further, India confronts difficulty in controlling epidemics like COVID-19 because of its enormous population and issues with public hygiene, which can make it more difficult to prevent and control the spread of infectious diseases. Due to elements including the virus' unknowns, asymptomatic transmission, and whispers on social media, the pandemic is a major issue for countries like India, which is densely populated and has poor public cleanliness. The WHO established the acronym COVID-19 on February 19, 2020, and on March 11, that same year, it formally designated this unusual coronavirus disease as a pandemic. As of May 28, 2021, a total of 220 nations and territories worldwide had reported 169,710,788 confirmed cases of the coronavirus COVID-19 that originated in Wuhan, China, and

3,527,082 fatalities. India, which has a population of more than 1.34 billion and is the second-largest country in the world by population, came in second place, reporting a total of 27,555,457 confirmed cases with a death toll of 318,895 as of May 28, 2021.

Major measures were taken by the nation to address this crisis, including containment, which involved isolating cases, tracking down people who had contact with those infected, and putting the entire country on lockdown. Other measures included delaying the spread of the crisis through social isolation, mitigating it by providing the best care possible for those who needed hospitalization, and ensuring support for those who contracted the virus. The government and public health professionals were working extremely hard to stop the spread of COVID-19, but citizens of the country also played a critical role in the fight. Despite the execution of all the numerous steps listed above, the number of coronavirus-positive patients in India was increasing daily.

The public healthcare system concentrated on eight key areas: airport screening, information education and communication, contact tracing, the creation of COVID-19 hospitals and care centers, testing, manpower augmentation training, a district-level task force, and other non-COVID-19-related support. Ghosh R. et al. (2020) With a population of 7.8 lakh, Ahmedabad district, which is the most populous city in Gujarat state, reported 233,462 confirmed cases, making it the state's most active case- and death-reporting district. Ahmedabad has been ranked first with the greatest reporting of COVID-19 confirmed cases and deaths, despite leadership and governance responses since the beginning of the epidemic. This raised questions about Ahmedabad residents' community participation during the pandemic and risk communication. The article makes an effort to examine the attitudes and knowledge of COVID-19 among a group of Ahmedabad, Gujarat, residents.

REVIEW OF LITERATURE

To ascertain the public's knowledge, attitudes, and practices of COVID-19 in Malaysia, Azlan and Hamzah (2020) carried out a cross-sectional study. The study's results showed that knowledge ratings varied significantly between genders, age groups, locations, occupational groupings, and income brackets. Participants who were female, older than 50, and in the higher income bracket scored better on knowledge tests. The majority of participants (87.8%) used hand sanitizer and frequently washed their hands as part of good hand hygiene.

In their online cross-sectional study on attitudes, knowledge, and practices related to the COVID-19 epidemic in Bangladesh, Ferdous et al. (2020) emphasized that 48.3% of participants had more precise knowledge and 55.1% had more regular practices related to COVID-19 prevention.

Agarwal & Imtiyaz (2020) used an online web-based survey technology to perform a cross-sectional study on 1372 Indian population members' knowledge, attitudes, and practices regarding COVID-19. The results showed that most respondents had rudimentary awareness of the illness at the start of the pandemic. The perfect knowledge score and adherence to preventative measures were shown to be higher in females than in males, respectively.

In 2020, Dkharetal evaluated the knowledge, attitudes, and practices of social media users in Srinagar, Jammu, and Kashmir, India, on the COVID-19 pandemic. The study included a total of 1574 participants. The results showed that almost all of the respondents (98%) were familiar with the coronavirus. A large majority, or 87%, reported following recommendations and washing their hands with soap and water regularly.

The unique sociodemographic, cultural, and healthcare setting of India made the study on "COVID-19 knowledge and practices of Indian citizens" essential. Existing research from other nations might not

adequately describe India's particular difficulties and responses to the pandemic. Government regulations, healthcare disparities, and sociocultural variables all have a significant impact on how Indians see and treat COVID-19. For customized public health interventions, understanding these aspects is essential. India's demographic diversity, healthcare system, and government structure are very different from those of other countries, which could affect how things turn out. The knowledge and practices of Indian citizens must therefore be studied in order to properly adjust strategies. India's COVID-19 reaction is also relevant on a global scale due to its size and importance. By focusing on India, this study fills a vacuum in the literature by illuminating the ways in which social norms, healthcare inequalities, and governmental regulations affect people's knowledge of and adherence to COVID-19. Its results are essential for improving healthcare legislation, worldwide pandemic management plans, and public health initiatives.

Null Hypothesis: There will be no significant differences in the knowledge and practice level of the selected citizens of Ahmedabad city, Gujarat, towards COVID-19 with respect to the selected variables, viz., age, gender, education, occupation, monthly income, prevalence of chronic disease or disability in the family, and access to information for COVID-19.

METHODOLOGY

This research has a descriptive focus. Using personal connections via emails, web-based applications, and social media, responses from a sample of 200 residents chosen from Ahmedabad city, Gujarat state, using the snowball sampling technique were gathered. The inclusion criteria were that the participants should be between the ages of 21 and 58, who have digital skills and only those who live in Ahmedabad city. Online Google Forms were used to collect data, and the survey results were provided in Excel format for offline analysis of the raw data. In addition to demographic data, a knowledge test on the causes of COVID-19, its symptoms, transmission, incubation period, susceptible populations, preventive measures, and government actions was created to gauge the respondents' level of knowledge. This was done by consulting a variety of books, articles, and previous studies on pandemics and COVID-19.

The tool was validated by experts for judging the content validity, relevance, logical sequence, language used, and appropriateness of the response system. Minor changes were made to the tool as per the suggestions and comments received from the experts. The split-half reliability test method was used for measuring the reliability of the questionnaire. The tool was given to thirty citizens, including an equal number of males and females from Ahmedabad City. The result of the reliability test using the formula for the split-half reliability test was 0.80. A pre-test of the research tool was done to check the language and how much time the respondents needed to reply. The faculty IECHR Committee approved the study with the number IECHR/FCSC/2020/32.

Data from test results and practices was scored and categorized. Data analysis was done using descriptive statistics of mean and standard deviation for continuous variables, and for discrete variables, frequency and percentage were used through the SPSS package. To find significant differences, the t-test and ANOVA were used in the study.

RESULTS AND DISCUSSION

I) Demographics of the respondents

Among the 200 participants in the study, 53% were men, and the remaining women (47%) were between the ages of 21 and 24 years. Respondents who were educated made up 56%. Sixty percent of respondents claimed to have a healthy life with no major illnesses or diseases; however, in their family, nearly one-fourth of respondents (26%) said that chronic illnesses like diabetes mellitus and hypertension were

common. The study participants who were categorized as being in the unpaid labor category (students and homemakers) made up 50% of the sample.

II) Information sources used by respondents for COVID 19

More than half of those polled (56%) indicated that they had easy access to COVID-19 information. The vast majority of the chosen respondents (70.3%) primarily depended on social media, followed by national and regional television (65%) in that order, as their primary sources of knowledge regarding COVID-19.

III) Knowledge level of the respondents regarding COVID-19

Table 1: Frequency and Percentage Distribution of the Respondents According to Their Knowledge Level Regarding COVID-19 (n=200)

Sr. No.	Knowledge items	Correct		Partially Correct		Incorrect	
	Origin and growth of COVID-19	n	%	n	%	n	%
1	Regarding the first case of a novel coronavirus in the world	171	85.5	0	0	29	14.5
2	Causes of COVID-19	189	94.5	0	0	11	5.5
3	The coronavirus got its name from	81	40.5	0	0	119	59.5
	Signs and symptoms						
4	Major signs and symptoms of COVID-19	182	91	18	9	0	0
5	Regarding an asymptomatic person infected with COVID-19	129	64.5	0	0	71	35.5
Corona virus spread, transmission, and incubation period							
6	Spread of Coronavirus	142	71	53	26.5	5	2.5
7	Risk factors that can increase transmission of COVID-19 from one person to another	50	25	135	67.5	15	7.5
8	Incubation period of COVID-19	133	66.5	0	0	67	33.5
The most affected population by COVID-19							
9	People vulnerable to COVID-19	173	86.5	0	0	27	13.5
10	People comorbid to COVID-19	188	94	4	2	8	4
Protective measures for COVID-19							
11	Effective protective measure(s) against COVID-19	162	81	34	17	4	2
12	Regarding physical or social distancing	171	85.5	0	0	29	14.5
13	Regarding hand hygiene protocol during COVID-19	82	41	99	49.5	19	9.5
14	Duration of handwashing to combat COVID-19 as per the Government of India guidelines	101	50.5	0	0	99	49.5
15	Regarding face masks	152	76	46	23	2	1
Government measures							
16	The purpose of the lockdown and night curfew adopted by the government during COVID-19	5	2.5	189	94.5	6	3
17	Regarding the mobile app launched by the government of India for COVID-19	179	89.5	0	0	21	10.5

The vast majority of respondents knew only a little about the COVID-19 hotspots in the city, the AROGYA SETU app, risk factors that could increase disease transmission, and recommended hand-washing practices. About how long COVID-19 takes to develop symptoms and how it spreads asymptomatically, a substantial number of respondents were uninformed. When asked how long hands must be washed for the coronavirus to be killed, half of the respondents answered incorrectly.

Partially correct or inaccurate knowledge of such crucial elements can encourage the spread of false information and prevent the adoption of acceptable COVID-19 practices. Therefore, based on the aforementioned findings, it can be concluded that the execution of personal protective measures in the context of the present pandemic is only possible if the community is well-informed about COVID-19 and favorably responds to the government's preventative norms and instructions.

Further, the results of the respondents who had inaccurate knowledge indicated that those working on the COVID-19 outbreak, including the government, health professionals, and communication strategy planners, needed to include accurate information for COVID-19 infected people who were asymptomatic in their information, education, and communication (IEC) and mass campaign efforts.

Additionally, it is critical to educate the public about virus risk factors and super-spreaders, as well as the simplest and most important preventive measure of proper handwashing, when a higher percentage of respondents in the current study lack the proper knowledge of risk factors spreading coronavirus and handwash protocols. If a person is informed and educated about how to implement preventive measures, they are more likely to do so with confidence.

Table 2: Variable Wise Knowledge frequency and percentage of the Selected Citizens of Ahmedabad City Regarding COVID-19 (n=200)

Sr.No.	Variables	Categories	Knowledge			
			Low		High	
			f	%	f	%
1	Age	Young Adults	51	63.8	59	49.2
		Adults	21	26.2	46	38.3
		Older Adults	8	10	15	12.5
2	Gender	Male	39	48.8	67	55.8
		Female	41	51.2	53	44.2
3	Education	Intermediate	12	15	9	7.5
		Educated	48	60	63	52.5
		Highly Educated	20	25	48	40
4	Occupation	Business	16	20	10	8.3
		Job/Service	18	22.5	56	46.7
		Unpaid work	46	57.5	54	45
5	Monthly Income	Middle Income	31	38.8	46	38.3
		High Income	49	61.3	74	61.7
6	Prevalence of chronic disease in families	Present	9	11.3	32	26.7
		Absent	71	88.8	88	73.3
7	Access of Information regarding COVID-19	Low access information	44	55	44	36.7
		High access information	36	45	76	63.3

The characteristics in the above table make it evident that a higher proportion of Ahmedabad city residents fall into the following categories of variables with less awareness about COVID-19:

- Citizens whose families had no prevalence of any chronic disease (88.8%),
- young adults (63.8%),
- high-income group (61.3%) and educated (60%)
- citizens who fall under "unpaid work" (57.5%);
- had low access to information regarding COVID-19 (55%). and
- Females (51.2%)

Given the importance of citizen knowledge in fighting pandemics, the findings above on the lower level of awareness among various categories of variables suggest that it may have a significant impact on control efforts. It can be stated that a substantial portion of young adults in Ahmedabad were unaware of COVID-19 because six out of ten (63.8%) of the city's youth had a lower level of understanding of it. These young adults may believe—as the WHO has suggested—that they are less susceptible to COVID-19 than children and older people, or it may be that Ahmedabad residents are unwilling to adequately educate themselves about this infectious disease because COVID-19 cases and fatalities are so uncommon in that city.

Comparing the job/service and firm categories to the category of unpaid work, which included students and homemakers, 57.5% of respondents demonstrated a lower degree of expertise. The same conclusions were made by Azlan AA et al. in 2020, who noted that "the average knowledge score of students regarding COVID-19 was significantly lower than those of other occupation categories who were employees of the public or private sector, self-employed, and others."

The same table also shows that respondents with low monthly earnings ranked among the least knowledgeable about COVID-19, while respondents with middle and high incomes had the most knowledge about COVID-19.

Azlan AA et al., 2020, who studied "public knowledge, attitudes, and practices towards COVID-19: A cross-sectional study in Malaysia," highlighted this finding in their study and explained that it may indicate limited access to accurate and timely information about the virus for the public. This study demonstrates the urgent need to improve young people's COVID-19 practices by raising their awareness of the disease through health education. These results also suggest that the health education campaign would be more successful if it focused on specific demographic groups. For instance, COVID-19 knowledge might be greatly increased if health education initiatives were designed specifically for females and people with restricted access to information about the disease.

Differences in knowledge about COVID19 among the selected citizens of Ahmedabad city in relation to the selected variables.

Table 3: One way ANOVA test showing differences in knowledge of the selected citizens of Ahmedabad towards COVID-19 in relation to the selected variables. (n=200)

One-way ANOVA						
Age						
Source	Sum of Squares	df	Mean Square	F	p	
Between Groups	94	2	47	1.5	0.221	FALSE
Within Groups	6089.9	197	30.9			
Education						
Source	Sum of Squares	df	Mean Square	F	p	
Between Groups	55.2	2	27.6	0.9	0.413	FALSE

Within Groups	6128.7	197	31.1			
Occupation						
Source	Sum of Squares	df	Mean Square	F	p	
Between Groups	355.7	2	177.9	6	0.003*	Significant
Within Groups	5828.2	197	29.6			

*p-value significant at < 0.05

Table – 4: 't' test showing differences in Knowledge of the Selected Citizens of Ahmedabad Regarding COVID-19 in relation to the Selected Variables (n=200)

t-test							
Variable	Category	N	Mean	Std. Deviation	t-Value	p-Value	Remarks
Gender	Male	106	27.2	4.82	1.94	0.05*	Significant
	Female	94	25.7	6.25			
Monthly Income	Low income	77	26.1	6.39	0.94	0.349	NS
	High Income	123	26.8	5			
prevalence of disease	Yes	41	27.9	5.53	1.79	0.075	NS
	No	159	26.2	5.55			
Access to information for COVID-19	Low access to information	88	25.1	5.94	3.29	0.001*	Significant
	High access to information	112	27.6	5.02			

*p value significant at < 0.05

According to the data in tables 3 and 4 above, there were no significant differences in the respondents' knowledge of the characteristics related to age, education, monthly income, and the prevalence of chronic disease in the family. The null hypothesis, which states that there will be no discernible differences in the level of knowledge of the selected citizens of Ahmedabad city to combat COVID-19, is accepted for the variables chosen, including age, education, monthly income, and the prevalence of chronic disease in the family for COVID-19. However, age and education are significant determinants of respondents' understanding of COVID-19, according to data from other studies. Zhong et al., in their study in China (2020), also conveyed that knowledge has an association with factors like educational background, but the findings of the current investigation did not support their conclusions. There was no discernible correlation between respondents' knowledge and age or educational background in the current investigation.

The respondents' knowledge was significantly different depending on the respondents' gender, access to information, and occupation. Therefore, null hypotheses that claim there will not be any significant differences in the level of knowledge of the selected Ahmedabad city residents to combat COVID-19 in relation to selected variables, such as gender, access to information, and occupation, are rejected. According to a study carried out in Ghana by Serwaa D. et al. (2020), "knowledge of COVID-19 was found to be substantially linked with occupation." The possible reason for the significant difference between job/service and business could be that while both job/service workers and business owners face the risk of COVID-19 infection, their unique circumstances, workplace requirements, income stability, and risk perception can differ significantly. This may be the cause of the significant knowledge differences between these two categories. As per the "Global Workplace Study 2020," the Indian workforce is the most resilient in the world, with 32 percent of employees highly resilient as against the global average of 17 percent. Similarly,

India is second in terms of fully engaged employees. About 20 percent of workers in India are fully engaged, as against a global average of 14 percent (https://www.businesstoday.in/latest/economy-politics/story/indian-workforce-among-most-resilient-in-world-says-adp-study-288554-2021-02-17). Hence, they had no option to work remotely on their own except with the organizational head's approval, and hence might be more exposed to the outside environment for their job or service and meet a greater number of people. However, people who are doing business can discretely make the decision to limit the number of people they meet virtually. They would have encouraged those who work or provide services to learn more about how to protect themselves, as they are more likely to have an infection. This implies that when the COVID-19 pandemic's impact on workplace safety is an issue and lockdown is not an option for a long time to prevent this COVID-19 outbreak, it is imperative that in such situations, keeping in mind workplace factors of different work settings and their perceived severity and environmental threats towards the epidemic, the plans and strategies to continue or reopen the workplaces should be decided keeping in mind government protocols and safety guidelines to combat COVID-19.

IV) Practices followed by the respondents towards COVID-19

Table 5: Frequency and percentage distribution of the selected citizens of Ahmedabad city according to the practices followed by them towards COVID-19 with respect to aspects within and outside their homes. (n = 200)

Sr. No.	Aspects	Poor Practices		Good Practices	
		f	%	f	%
1	Practices followed within the home	106	**53.0**	94	47.0
2	Practices followed outside the home	112	**56.0**	88	44.0

Table 5 data reveals that, regarding COVID-19 appropriate practices, nearly the majority of the respondents followed overall poor practices within as well as outside the home. The probable reason for such a finding can be attributed to poor knowledge regarding important facts and basic preventive measures for COVID-19.

Table 6: Frequency and Percentage Distribution of the Respondents According to Variable Wise Overall Practices of the Selected Citizens of Ahmedabad City to Combat COVID-19. (n = 200)

Sr. No.	Variables	Categories	Overall Practice			
			Poor practice		Good practice	
			f	%	f	%
1	Age	Young Adults	61	56.5	49	53.3
		Adults	36	33.3	31	33.7
		Older Adults	11	10.2	12	13.0
2	Gender	Male	61	56.5	45	48.9
		Female	47	43.5	47	51.1
3	Education	Intermediates	14	13.0	7	7.6
		Educated	64	59.3	47	51.1
		Highly Educated	30	27.8	38	41.3
4	Occupation	Business	17	15.7	9	9.8
		Job/Service	33	30.6	41	44.6
		No Income Group	58	53.7	42	45.7

5	Monthly Income	Middle Income	41	38.0	36	39.1
		High Income	67	62.0	56	60.9
6	Prevalence of Chronic Disease in family	Present	23	21.3	18	19.6
		Absent	85	78.7	74	80.4
7	Access of Information for COVID-19	Low access to information	46	42.6	42	45.7
		High access to information	62	57.4	50	54.3

As per Table 6, nearly half of the young adults, male gender, and educated respondents had poor practices compared to their counterparts. Also, respondents who were doing any job or service had good practices, while those who were doing business and unpaid work, i.e., students and homemakers, had comparatively poor practices.

Regarding practices followed at home, it was found that respondents followed government protocols regarding COVID-19 and maintained hand hygiene to a very high extent. However, the findings also revealed that practices such as sanitizing frequently touched surfaces were found to be followed to a very low extent, which can be seen as a great cause for concern. Respondents reported allowing domestic helpers, caretakers, and service providers even when they are sick or without checking their health status, which was also a cause of concern during such a pandemic. It was also found that a substantial number of the respondents either do not wear a mask when they are following social distancing or did not follow social distancing if they wore a mask. During such a pandemic, it is important to follow all the preventive measures together, and following only one or two is not adequate to combat COVID-19.

Regarding practices followed outside the home, it was found that outside the home, a very high percentage of people adhered to COVID-19's recommended behaviors, including wearing a mask that was properly fitted, practicing hand hygiene, keeping hand sanitizer on hand, covering one's mouth when coughing or sneezing, and maintaining social distance.

Differences in practices towards COVID-19 among the selected citizens of Ahmedabad city in relation to the selected variables

Table 7: t-test demonstrating differences in overall practices used by Ahmedabad City residents to combat COVID-19 in relation to the selected variables (n = 200)

Variables	Category	N	Mean	Standard Deviation	t-Value	p-Value	Remarks
Gender	Male	106	180.4	26.42	0.39	0.70	NS
	Female	94	181.8	26.00			
Monthly Income	Middle Income	77	181.8	27.65	0.31	0.756	NS
	High Income	123	180.6	25.30			
Prevalence of chronic disease	Yes	41	183.5	23.06	0.66	0.509	NS
	No	159	180.4	26.94			
Access to information	Low access to information	88	179.7	23.68	0.66	0.510	NS
	High access to information	112	182.1	28.03			

*p-value significant at < 0.05

Table 8: One-way ANOVA test demonstrating differences in Overall Practices of Selected Ahmedabad Citizens Regarding COVID-19 in Relation to Selected Variables. (n=200)

One-way ANOVA						
Age						
Source	Sum of Squares	df	Mean Square	F	*p*	
Between Groups	829.8	2	414.9	0.6	0.548	FALSE
Within Groups	135445.7	197	687.5			
Education						
Source	Sum of Squares	df	Mean Square	F	*p*	
Between Groups	5857.920	2	2928.960	4.424	.013 *	Significant
Within Groups	130417.580	197	662.018			
Occupation						
Source	Sum of Squares	df	Mean Square	F	*p*	
Between Groups	4352.2	2	2176.1	3.2	0.041*	Significant
Within Groups	131923.3	197	669.7			

*p-value significant at < 0.05

Tables 7 and 8 above clearly show that there were no significant differences between the respondents' habits with regard to age, gender, education, income, or the frequency of chronic disease in the household. Since age, gender, education, income, and the frequency of chronic disease in the family varied, the null hypothesis that there would be no observable variation in the practices of the chosen citizens of Ahmedabad, Gujarat, to combat COVID-19 was accepted. It is most likely that everyone knew that everyone is susceptible to the disease and that anyone can contract it if they do not adhere to the necessary COVID-19 appropriate practices, which would explain why there was no discernible difference in respondents' practices across age groups.

As seen in tables 7 and 8 above, there are considerable differences between the responses' methods for combating COVID-19 depending on the respondents' level of education and line of work. The null hypothesis, which asserted that there would not be any observable changes in the behaviors of the chosen residents of Ahmedabad city in the Gujarat state with relation to their responses to combat COVID-19, was therefore rejected.

CONCLUSION AND RECOMMENDATIONS

According to the study's findings, even though the majority of respondents had a decent understanding of COVID-19, there is still a need to increase public awareness, particularly with respect to correct information about important preventive measures. Further, in any situation, it's vital to make sure that the information is presented in a way that is accessible, intelligible, and sensitive to cultural differences. To effectively implement these strategies and reach a large audience, work with local organizations, educators, community leaders, and healthcare experts can be expanded. Also, to evaluate these initiatives' results frequently in order to alter and improve knowledge dissemination strategies as needed, In order to stop the COVID-19 pandemic, there is a critical need to raise awareness among the populace about the gravity of the coronavirus disease and personal accountability. All relevant information about COVID-19 should be made available to the public in a proper and reliable manner. To encourage more COVID-19-suitable practices among these groups, specific strategies can be developed that target the male gender, young adults and students, and homemakers.

In a similar vein, it was found that a concerning percentage of the respondents were too insensitive to implement effective preventive measures. Despite the government's strong attempts to stop the virus's spread, more has to be done to assist the populations that have been hit the hardest. Therefore, to increase public knowledge, aid in the development of a more positive mindset, and uphold the proper preventative behaviours, effective COVID-19 health education initiatives are extremely essential.

The results of the current study further emphasize the necessity for efficient health education initiatives that are concentrated on enhancing comprehension of COVID-19 and encouraging the adoption and maintenance of safe practices. In order to safeguard public safety, state authorities should be open enough to share accurate information on COVID-19 statistics, containment zones, and the availability of other helpful tools to combat this lethal disease. Additionally, all COVID-19 protocols should be carefully enforced by the ruling authorities because followers tend to observe what their leaders do and emulate it. Therefore, it is necessary for everyone to take responsibility for their actions, whether they are citizens, administrative officials, or other stakeholders, and to work together to combat COVID-19.

FUTURE RECOMMENDATIONS FOR RESEARCH

- A cross-sectional survey examining the knowledge and practices of the public can be conducted in other Indian megacities.
- Similar studies can be conducted to find out the general public's perceptions and attitudes about the risk of the COVID-19 pandemic.
- A comparative study of rural and urban people regarding their knowledge and practices towards COVID 19 in the different states of India can be conducted.
- A study can be conducted on exploration to enhance the population's understanding of basic public health matters in non-pandemic contexts, thereby promoting greater adherence to pandemic advisories when they are issued.

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