Knowledge Regarding Coronavirus Disease-19 Related to Nutritional Practices in Residents of Medan City, Indonesia

Debora Natalia⁎, Dina Keumala Sarı⁎⁎, Rizky Adriansyah⁎⁎⁎, Wulan Fadinie⁎⁎

⁎Medical doctor Study Program, Faculty of Medicine, Universitas Sumatera Utara, Indonesia; ⁎⁎Tropical Medicine Program Study, Faculty of Medicine, Universitas Sumatera Utara, Indonesia; ⁎⁎⁎Department of Child Health, Faculty of Medicine, Universitas Sumatera Utara, H. Adam Malik General Hospital, Medan, Indonesia; ⁎⁎⁎Department of Anesthesiology and Intensive Care, Faculty of Medicine, Universitas Sumatera Utara, H. Adam Malik Central General Hospital, Medan, North Sumatera, Indonesia

Introduction

In early 2020, the world was shocked by the outbreak of a new type of pneumonia, which started in Wuhan, Hubei Province, and then spread rapidly to more than 190 countries and territories [1]. The World Health Organization (WHO) declared that the world entered a global emergency after the outbreak on January 31, 2020 [2].

This outbreak began in December 2019, when a mysterious pneumonia case was first reported in Wuhan, Hubei Province. The source of the transmission of this case is still uncertain, but the first case was linked to a fish market in Wuhan between December 18, 2019, and December 29, 2019 [3]. The first two cases of coronavirus disease-2019 (COVID-19) in Indonesia were reported on March 2, 2020, and the number of infections and deaths has continued to increase until now [1].

The samples studied showed the etiology of the new coronavirus. Initially, the disease was temporarily named the 2019 novel coronavirus (2019-nCoV). Then, the WHO announced a new name on February 11, 2020, that is, the COVID-19, based on the severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) (WHO, 2020). COVID-19 is a disease caused by a ribonucleic acid virus, namely, SARS-CoV-2, with a particle size of 120–160 nm [4]. The SARS-CoV-2 sequence has similarities with the coronavirus isolated in bats, so the hypothesis of Riedel et al. is that SARS-CoV-2 originated from bats, which then mutated and infected humans [5]. Common signs and symptoms of COVID-19 infection include acute respiratory symptoms, such as fever, cough, and shortness of breath. In severe cases of COVID-19, it can cause pneumonia, acute respiratory syndrome, kidney failure, and even death [6].

Many efforts had been made in the literature to determine how the body’s resistance to respiratory infections could be improved. Some of them were quitting smoking and alcohol consumption, improving sleep quality, and taking supplements [1]. Macro, micro, and phytonutrients in foods, especially colorful fruits
and vegetables, generally promote a healthy immune response [7]. Diet and nutrition always influence the competence of the immune system and determine the risk and severity of infection. There is a two-way relationship between diet, nutrition, infection, and immunity. A person’s nutritional status affects their risk of infection and the clinical course of COVID-19. Therefore, the maintenance of a healthy macro and micronutrient status is an important preventive measure for COVID-19. When a person’s nutritional status is improved, either through diet modification or nutritional supplementation, it is very important to determine the clinical course of COVID-19, especially in malnourished individuals [8]. Given the role nutritional status plays in a person’s immunity, the evaluation of individual nutrition may be important for preparing a person for the COVID-19 pandemic. Besides, knowledge about COVID-19 is very important. If knowledge about COVID-19 is inadequate, preventing the transmission of the disease will be difficult, and the probability that a person will experience COVID-19 infection will be increased. Based on those reasons, we decided to do this research, the aim of this study was to find relationship among all parameters that affecting nutritional practice. Thus, in this study, whether there is was a relationship between knowledge regarding COVID-19 and nutritional practices in residents of Medan city, Indonesia, which was investigated.

Materials and Methods

A cross-sectional study was conducted between June 2020 and July 2020. The data were collected online, because it was not feasible to do an offline survey. This research was conducted on residents of Medan City, which consists of 21 subdistricts that had been included in the COVID-19 red zone since June 5, 2020. The population of Medan City, based on a 2018 report, is 2,264,145 people. The data in the present study were collected from a total of 210 questionnaires. A total of 10 samples from outside the city of Medan were excluded, so the analysis consisted of 200 research samples from Medan City.

The data used in this study were primary data obtained directly by the researcher. The primary data were obtained from people by having them fill out the research questionnaire. A Google Forms was used to collect the data, and the questionnaire was distributed using WhatsApp, Line, and Direct Message Instagram. People who were living in Medan, were aged 18–35 years, understood the use of Google Forms, and were willing to fill out the questionnaire were directed to open the Google Forms link provided and fill out the questionnaire. Research samples outside Medan City would be excluded from this study.

The questionnaire used was taken from previous researches [9], [10] and COVID-19 guideline in Indonesia [11], but only the knowledge variable was used. The questionnaire was translated, and a validity test was conducted using product moment correlation techniques (significance<0.05). The reliability was also tested using Cronbach’s α (Cronbach α = 0.769). For the data analysis, each correct answer was given a value of 1, while an incorrect answer was given a value of 0. To assess nutritional behavior, the questionnaire used was taken from previous research on balanced nutrition. The questionnaire consisted of 13 questions, with 1 question excluded. The assessment of nutritional behavior consisted of a score of 4 = often, a score of 3 = sometimes, a score of 2 = rarely, and a score of 1 = never. From the data collection results, a 75% score was considered good, 56–74% was considered satisfactory, and <55% was considered poor.

We used the SPSS program (version 24; SPSS Inc., Chicago, IL, USA) to perform the analysis. The descriptive analysis was reported as the frequency, percentage, and mean scores. The knowledge scores and practices of different persons, according to the demographic characteristics, were compared using an independent samples t-test, one-way analysis of variance, Mann–Whitney U-test, and Kruskal–Wallis test.

To determine differences in the level of knowledge of COVID-19 and nutritional behavior based on demographic characteristics, the Chi-square test and Fisher's exact test were used. To show the relationship between knowledge and attitudes, the Chi-squared test was used. Linear regression analysis was applied with an odds ratio and 95% confidence interval (CI) to find possible determinants of good knowledge regarding COVID-19 and health practice. p < 0.05 was considered statistically significant in all tests.

Results

The data in the present study were collected from a total of 210 questionnaires. A total of 10 samples from outside the city of Medan were excluded, so the analysis consisted of 200 research samples from Medan City. In this final sample, there were 128 women (64%) and 172 people (86%) aged 18–25 years old, with an average age of 21.98 years. Most of the research samples were from residents of Medan Kota, and the highest education level was senior high school. The characteristics of the respondents are shown in Table 1.

More than 90% of the respondents had a good understanding of the following points relating to COVID-19: COVID-19 is a disease caused by a virus (97.5%); transmission of COVID-19 can occur through
close contact (95.5%) and respiratory droplets (99%); there are greater risk factors associated with elderly individuals (94%); fever, cough, sore throat, and shortness of breath are symptoms that can be found in COVID-19 (94.5%); infection can be prevented through washing hands and using face masks (98.5%); infection can be prevented by avoiding traveling to crowded places (98%); children and young adults need to be involved in the prevention of COVID-19 (91%); and infection can be effectively prevented through isolation (96.5%) and the isolation of COVID-19 contacts (97.5%) (Table 2).

In terms of nutritional practices, some Medan residents often pay attention to body weight (21.5%); eat a variety of foods (30.5%); eat 3 times a day (52.5%); eat fruit (13%, 5%) and vegetables (24%) properly; consume animal protein (29%); consume protein properly (33.5%); reduce their consumption of sweet, salty, and fatty foods (19.5%); drink eight glasses of water a day (58.5%); read food packaging labels (45.5%); wash hands before eating (74.5%); and do physical activities (18.5%). These results can be found in Table 3.

There was no significant difference between the respondents in the mean score for knowledge of COVID-19 and nutritional practices based on certain demographic characteristics (Table 4).

In addition, there was no significant difference between the respondents based on other demographic characteristics in the level of knowledge and behavior, except for education, with a knowledge score of p = 0.033 (Table 5). An analysis was conducted using the Spearman’s rho test. A relationship between education and knowledge toward COVID-19 was shown, with a significance value of 0.016 (p < 0.05) with a correlation value of 0.171.

The relationship between knowledge of COVID-19 and nutritional practices has p = 0.022. Because p < 0.05, the hypothesis that there is a relationship between the level of knowledge about COVID-19 and nutritional practices in the general public in Medan City is accepted. Furthermore, the results of the linear regression test showed that an increase of 1% in knowledge increases the value for behavior associated with balanced nutrition by 0.244 (Table 6). An analysis was conducted using the Spearman’s rho test. A relationship between knowledge towards COVID-19 and nutrition practices was shown, with a significance value of 0.022 (p < 0.05) with a correlation value of 0.161.

**Discussion**

As of September 2020, COVID-19 cases are still increasing and continue to be a significant concern in public health. Knowledge regarding COVID-19 is an important factor for the formation of individual nutritional practices. When nutritional status is improved, it is very important to determine the clinical course of COVID-19.

Female respondents participated more readily in the research, with as many as 128 women volunteering for the questionnaire and only 72 male
Table 3: Nutritional practices results

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Frequently, n (%)</th>
<th>Sometimes, n (%)</th>
<th>Rarely, n (%)</th>
<th>Never, n (%)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>In order to maintain a normal weight, I regularly pay attention to weight gain</td>
<td>43 (21.5)</td>
<td>86 (43)</td>
<td>46 (23)</td>
<td>25 (12.5)</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>In order to achieve my ideal nutritional status, I consume a wide variety of foods</td>
<td>61 (30.5)</td>
<td>93 (46.5)</td>
<td>38 (19)</td>
<td>8 (4)</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>To meet the nutritional needs for a day, I regularly eat 3 times a day</td>
<td>105 (52.5)</td>
<td>93 (46.5)</td>
<td>33 (16.5)</td>
<td>9 (4.5)</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I consume fruit at least 2 times a day</td>
<td>27 (13.5)</td>
<td>58 (29)</td>
<td>93 (46.5)</td>
<td>22 (11)</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>I consume vegetables at least 3 times a day</td>
<td>48 (24)</td>
<td>71 (35.5)</td>
<td>54 (27)</td>
<td>21 (10.5)</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I consume animal protein and plant protein at least 2 times a day</td>
<td>67 (33.5)</td>
<td>84 (42)</td>
<td>41 (20.5)</td>
<td>8 (4)</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>In order not to suffer from anemia, I consume animal protein</td>
<td>58 (29)</td>
<td>87 (43.5)</td>
<td>38 (19)</td>
<td>17 (8.5)</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I reduce the consumption of sweet, salty, and fatty foods</td>
<td>39 (19.5)</td>
<td>71 (35.5)</td>
<td>71 (35.5)</td>
<td>19 (9.5)</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I drink eight glasses of water a day</td>
<td>117 (58.5)</td>
<td>55 (27.5)</td>
<td>25 (12.5)</td>
<td>3 (1.5)</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I read the labels on food packaging before buying products</td>
<td>91 (45.5)</td>
<td>56 (28)</td>
<td>37 (18.5)</td>
<td>16 (8)</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Before eating and drinking, I wash my hands</td>
<td>149 (74.5)</td>
<td>91 (19.5)</td>
<td>12 (6)</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I do physical exercise or sports for at least 30 min a day</td>
<td>37 (18.5)</td>
<td>71 (35.5)</td>
<td>72 (36)</td>
<td>20 (10)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Differences in the mean scores for COVID-19 knowledge and nutritional practices based on demographic characteristics

<table>
<thead>
<tr>
<th>Variables</th>
<th>COVID-19 knowledge Mean (SD)</th>
<th>Nutritional practices Mean (SD)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male 10.97 (1.80) 0.488 36.25 (4.70) 0.623</td>
<td>Female 11.23 (1.26) 35.44 (5.78)</td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>18–25 11.10 (1.54) 0.572 35.62 (5.49) 0.557</td>
<td>26–35 11.32 (1.02) 35.43 (5.01)</td>
<td></td>
</tr>
<tr>
<td>Subdistricts</td>
<td>Medan Ampas–Medan Derai 10.96 (1.83) 0.609 36.01 (4.68) 0.057</td>
<td>Medan Hekilia–Medan Perjangian 11.29 (1.18) 35.42 (5.72)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Senior high school 11.23 (1.5) 0.124 35.49 (5.38) 0.243</td>
<td>College/university 10.90 (1.41) 36.33 (5.51)</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td>Unemployed 11.20 (1.17) 0.682 35.61 (5.28) 0.268</td>
<td>Entrepreneur 11.07 (1.07) 34.29 (5.33)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Public servant 11.31 (1.50) 39.00 (0.00)</td>
<td>Private employees 10.84 (1.92) 35.19 (5.16)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student 11.43 (1.14) 36.57 (5.44)</td>
<td>Teacher 11.39 (1.86) 34.55 (7.05)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Others 11.00 (1.48) 40.00 (8.72)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>Low 11.30 (1.17) 0.758 35.83 (5.48) 0.354</td>
<td>Middle 10.91 (2.28) 36.67 (5.48)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High 11.16 (1.17) 36.03 (4.96)</td>
<td>Very high 10.95 (1.51) 35.95 (5.57)</td>
<td></td>
</tr>
<tr>
<td>Source of COVID-19 information</td>
<td>Journal/articles and case report 12.67 (0.58) 0.073 37.67 (7.4) 0.434</td>
<td>Local government 11.67 (0.58) 38.00 (0.00)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mass media 11.24 (1.91) 36.22 (4.92)</td>
<td>Social media 11.07 (1.22) 35.58 (5.94)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parents/friends/relatives 10.78 (1.40) 33.83 (8.85)</td>
<td>Local health workers/expert visits 11.50 (1.48) 38.25 (2.06)</td>
<td></td>
</tr>
</tbody>
</table>

COVID: Coronavirus disease.

respondents. The same result was found in several other studies [9], [10], [12], [13].

The number of respondents who had a low income is in line with the occupation of respondents, who were students or unemployed. Social media has an important role, if used responsibly and appropriately, in the rapid and effective dissemination of important information. As for sources of information about COVID-19, most were from social media and mass media. Thus, social media and mass media have an important role to play in spreading information about COVID-19 [9], [14], [15]. However, some studies found that social media can have some drawbacks. Among the drawbacks are the possibility that the information submitted is out-of-date, has never been expertly reviewed, is invalid or incorrect, does not apply to a particular environment, or is even fake [16], [17]. Thus, questions regarding the myths and perceptions of COVID-19 need to be measured as well.

Research on COVID-19 knowledge has been carried out several times, especially in Indonesia [12], [13] and several other Asian countries, such as the Philippines, Saudi Arabia, China, Vietnam, and Pakistan [9], [10], [18], [19], [20]. Most respondents had a good level of knowledge. The results of this study are in line with those presented in the previous studies [9], [10]. Understanding of the treatment of COVID-19 is still lacking, even though the respondents had a good understanding of the transmission, symptoms, and prevention of COVID-19. There was a difference between this study and the research of Saefi et al. (2020). In that study, most of the respondents did not know that COVID-19 was caused by a coronavirus. However, in this study, the term used was "COVID-19 is caused by a virus." This shows that using different terms can produce different results. Good knowledge might be related to demographic characteristics, but there was no significant difference in the mean score of knowledge and good knowledge based on demographic characteristics.

Besides, one study showed that gender, age, educational background, professional background, health status, and living environment, as well as the level of knowledge and attitudes of the community, could influence nutritional practices. Along with the development of technology, people could access information regarding nutritional practices through social media and mass media [21]. However, the results of this study indicate that there is no significant difference between nutritional practices and demographic characteristics.

During the COVID-19 pandemic, people could also change their nutritional practices, for example, they might increase their consumption of vegetables, fruit, and water and reduce their consumption of sugary drinks and snacks [21]. However, other studies found that the quarantine period might cause depression, stress, and anxiety disorders, which could trigger the consumption of high-sugar foods and reduce physical activity [22]. The quarantine period in Medan City was still ongoing in June 2020, and a new normal period was effective on July 1, 2020. A statement by Mattioli et al. (2020) stating that at the end of the quarantine period, the economic crisis could prolong or worsen this poor lifestyle and lead to an increased risk of cardiovascular disease.

In this study, people tended to have good nutritional practices. This result was not consistent with a previous study, which found that most samples had satisfactory nutritional practices [23]. The respondents
The relationship between the level of knowledge about COVID-19 and nutritional practices was investigated in this study. In other words, people with proper knowledge about COVID-19 will do proper nutrition practices according to the knowledge they have. The existence of this relationship also indicates that improved nutritional practices may lead to a stronger immune system and a reduced risk of chronic disease and other infectious diseases. However, the infection rate and mortality of COVID-19 have so far continued to increase in Medan. Public awareness about efforts to prevent the transmission of COVID-19 is also needed in addition to implementing good nutritional practices.

Acknowledgments

We thank to the cooperation and support of all the respondents for the time and effort that they devoted to the study.

Conclusions

The relationship between the level of knowledge about COVID-19 and nutritional practices was investigated in this study. This study has some limitations which were this study conducted in local area and the samples dominated by female gender. Several variables that were not included in the study may affect nutritional practices, namely, attitudes, perceptions, and beliefs. In addition, to determine whether the changes in nutritional practices were due to the changing circumstances, data on nutritional practices before and after the COVID-19 pandemic are needed.

Authors’ Contributions

D.N.: Manuscript preparation, data analysis, and manuscript editing. D.K.S: Design, concepts,
clinical studies, and manuscript review. R.A.: Statistical analysis. W.A.: Literature search and manuscript editing.

Ethics Approval and Consent to Participate

This study was conducted according to the guidelines laid down in the Declaration of Helsinki and all procedures involving research study participants were approved by the Universitas Sumatera Utara Ethical Committee, No. 103/KEP/USU/2020. Written and verbal informed consent was obtained from all subjects for this study. Verbal consent was witnessed and formally recorded. All participants were aware of the whole process in this study.

References


PMid:32661860

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PMid:32571612

PMid:32842905