

Role of Social Capital in COVID-19 Recovery among Coronavirus Survivors during the First Wave of the Pandemic in South-West, Nigeria

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This study examines the role of social capital in recovery from COVID-19 among survivors of the first wave of the pandemic in South West Nigeria. Drawing on the Functional Specificity Hypothesis and the Social Network Theory, the study examines how interpersonal ties, workplace networks, and religious organisations influenced coping strategies and post-illness resilience. A qualitative design was employed, with twenty participants purposively selected and interviewed across Lagos, Ekiti, Ondo, and Osun States. Data were collected through in-depth interviews and were analysed thematically using Atlas.ti Software. Findings revealed that family networks constituted the strongest source of support, providing financial, emotional, and psychological assistance during illness and recovery. Social networks from the workplace also played a pivotal role, particularly in funding treatment and safeguarding employment, while religious institutions offered significant spiritual and moral support. Peer groups and neighbours provided supplementary aid, though their involvement was less consistent. However, stigma led some survivors to conceal their diagnosis, resulting in experiences of isolation and limited support. Continued assistance after recovery was largely confined to close family members and trusted friends, as institutional and wider social support networks often receded once patients tested negative. The study underscores that recovery from COVID-19 extended beyond biomedical treatment, relying heavily on broader social environments that facilitated access to resources and reduced distress. It concludes that integrating family, workplace, and faith-based structures into public health practices is critical to improving outcomes in future health emergencies.

Keywords: Social capital, COVID-19 recovery, social networks, Coronavirus survivors, family networks

Introduction

Several studies highlight the value of social capital in crisis management, showing that it is applicable in situations ranging from major natural disasters to pandemics (Chuang et al., 2015; Ronnerstrand, 2013; Uzobo & Moroyei, 2022). Networks of strong and weak relationships help people and communities by encouraging collaboration and resilience during the immediate response phase and during long-term rehabilitation. According to several studies, communities with high levels of social capital typically handle crises better than those with low levels (Aldrich, 2012; Chuang et al., 2015; Pitas & Ehmer, 2020; Uzobo et al., 2017). Evidence from outbreaks such as Ebola in 2014,

Severe Acute Respiratory Syndrome - SARS in 2003, and Zika in 2015–2016 illustrates that areas with higher levels of social capital demonstrated stronger coordination, teamwork, and composure in managing public health crises (Blair et al., 2017; Brayne, 2017; Kruk et al., 2015; Makridis & Wu, 2021; Trapido et al., 2019; Vinck et al., 2019; Wilkinson et al., 2017).

Although social capital is not a tangible resource, it arises from social interactions and manifests in various forms. Putnam (2000, p. 19) defines it as “connections among individuals, social networks and the norms of reciprocity and trustworthiness that arise from them”. Makridis and Wu (2021) highlight three interrelated elements:

trust, norms, and networks. Trust encompasses interpersonal reliability and confidence in political institutions; norms represent collective expectations of mutual support and cooperation; and networks refer to the ties and associations that generate individual and communal benefits. Similarly, Coleman (1988) views social capital as resources embedded in social networks that have productive value. He identifies three dimensions: obligations and trustworthiness, the transfer of information, and the establishment of agreed norms and sanctions.

Building on these conceptualisations, Szreter and Woolcock (2004) categorise social capital into bonding, bridging, and linking forms. Bonding capital refers to cooperative relations among similar individuals, while bridging capital captures ties across diverse groups. Linking capital describes relationships of trust and respect that span formal or institutional hierarchies. Although interrelated, these dimensions represent distinct facets of the social environment (Poortinga, 2012). Such networks and interpersonal ties provide a strong foundation for health-promoting and health-supportive communities (Eriksson, 2011). The greater a community's stock of social capital, the stronger its capacity to withstand and adapt to challenges (Amornsiriphong *et al.*, 2012).

Extensive evidence confirms that social capital improves both physical and mental health, mitigates the impact of socio-economic inequalities, and reduces mortality risks (Ehsan *et al.*, 2019; Luo *et al.*, 2021). It also empowers communities, fostering mobilisation and collective action in the face of adversity (Hikichi *et al.*, 2017; Wang *et al.*, 2019; Yagi *et al.*, 2016).

In the context of COVID-19, social capital played multiple roles. Social connections helped individuals regulate emotions, cope with stress, and remain resilient (Holmes *et al.*, 2020; Van Bavel *et al.*, 2020; Xiao *et al.*, 2020). However, its effect was reduced during lockdowns, as restrictions minimised differences in mobility across areas with varying levels of social capital (Bartscher *et al.*, 2020). Importantly, social capital influenced compliance with regulations and guidelines. In Singapore, for example, community-based organisations facilitated collaboration between the government and citizens, enabling communities with higher social capital to self-organise and comply with health directives (Rawat & Wu, 2020).

During the early stages of the pandemic before government-imposed restrictions-communities characterised by higher trust and reciprocity were more willing to adopt precautionary measures and follow informal containment rules (Imperial College COVID-19 Response Team, 2020; Borgonovi & Andrieu, 2020). Cities with strong social capital responded more quickly and recovered more effectively (Bartscher *et al.*, 2020; Pitas & Ehmer, 2020). Indeed, Bartscher *et al.* (2020) found that a one standard deviation increase in social capital was associated with a 12%–32% reduction in COVID-19 cases per capita across seven European countries, including Austria, Germany, Italy, the Netherlands, Sweden, Switzerland, and the United Kingdom. All things considered, these results confirm that social capital is an important tool in times of disaster, helping people locate vital assistance, building resilience, and speeding up recovery (Aldrich *et al.*, 2019; Parks, 2020; Ritchie & Duane, 2007).

Theoretical Framework

The functional specificity hypothesis is mostly linked to the works of Sidney Cobb, whose pioneering studies in the 1970s on social support and health highlighted the nonuniform functioning of social relationships. Cobb claimed that different forms of support, i.e., emotional, informational, and instrumental, play a specific role and are only effective when they are aligned with specific stressors or life problems (Cobb, 1976). This view was later extended by Sheldon Cohen and Thomas A. Wills, who empirically proved that the salutary effects of social support are conditional on the fit between the kind of support provided and the needs of the individual, thus making functional specificity a key explanatory paradigm in health sociology and social epidemiology (Cohen & Wills, 1985).

The theoretical roots of a social network theory can be traced back to classical sociology, especially to the work of Ferdinand Tönnies, who made a distinction between *Gemeinschaft* and *Gesellschaft*. In this differentiation, Tönnies enlightened the contrast between social relationships of intimacy and value and relationships of impersonality, formality and instrumental relationships, and this early conceptual framework formed the basis of the structural and functional analysis of social networks (Tönnies, 2001). These concepts were further

strengthened by Georg Simmel, who concentrated on patterns of interaction like dyads and triads, with the stress that social structure arises out of the relationship patterns of people and not out of individuals. Together, these classical works form the basis of the modern social network theory by predicting the dominance of relational relationships in the formation of social behaviour and outcomes (Simmel, 1950).

According to Bernardi and Klarner (2014), Social Network Theory in sociology has developed to include two important viewpoints on human behaviour. First of all, the theory acknowledges that people behave in structural contexts, including organisations, societies, and interpersonal networks. By influencing the opportunities and limitations that people work within, these structures have an impact on behaviour. Second, although social institutions have an impact, they do not completely dictate human behaviour; rather, they offer a framework that permits both agency and free will. According to Bernardi and Klarner (2014), people are viewed as being a part of networks of interactions that both allow and restrict their ability to act, influencing not only their interests but also how they perceive and pursue their options. Building on this, certain Social Network Theory subfields emphasise the significance of interpersonal impact. According to the social pressure perspective, friends and family have a big influence on a person's tastes and actions. For instance, during the COVID-19 epidemic, patients might have felt pressured to follow the health-seeking behaviours of others in their network or might have been affected by colleagues or family when choosing where to receive treatment (Scommegna, 2014). These kinds of interactions show how social expectations and conventions can apply subtle yet potent pressures to fit in.

The social support viewpoint, which emphasises the material and psychological resources that people can access through their networks, is another important factor. These resources, which can affect decisions regarding health and well-being, could include financial aid, childcare support, or emotional support. For example, because these options are seen as advantageous for both themselves and their larger family group, parents may favour medical facilities that have been suggested by reliable family

members. In Bulgaria, a striking example of such support is observed when young couples, following childbirth, reside with grandparents until they are financially secure enough to establish their own households (Scommegna, 2014).

Method

Research Design and Study Setting

This study employed a phenomenological qualitative design to examine the lived social experiences of individuals who survived COVID-19 in Southwestern Nigeria. A phenomenological approach was considered appropriate because it focuses on exploring and understanding human experiences within a social group. The research was carried out across four states in the region—Lagos, Ekiti, Ondo, and Osun—selected on the basis that they had recorded the highest number of COVID-19 cases and recoveries at the time of the investigation.

Sampling Strategy and Data Collection

Twenty participants who had fully recovered from COVID-19 participated in this study. To be eligible, participants had to meet the following criteria: (i) awareness of their COVID-19 status; (ii) recovery from the disease for a minimum of three months; and (iii) residence or employment in any of the four selected states. Participation was strictly voluntary, and only those who provided informed consent were included in the study.

A snowball sampling technique was employed, enabling one recovered patient to refer the researchers to another survivor. This approach was feasible because most participants had met one another during isolation and treatment. Initial contact with prospective participants was usually made by phone, during which the objectives of the study were explained. Each individual was then allowed to decide the most convenient interview location. Some chose neutral locations like relaxation centres, while others chose to have their interviews conducted at home.

Participants received comprehensive information about the study's goals and eligibility requirements before the start of each session. Before conducting interviews, written consent was obtained. Interviews were conducted in either Yoruba or English, based on the participant's preference. While Yoruba is widely used in the

Southwest, English is the official language of Nigeria. Giving participants this option allowed them to talk more openly about their experiences.

Data Collection Instrument

Data were gathered through unstructured in-depth interviews (IDIs), guided by an interview schedule designed around the study objectives. This tool allowed for open-ended discussions and in-depth probing of emerging themes. Questions explored various dimensions of social support during and after illness, including: *Who were your strongest sources of support during the crisis? Which members of your social network were aware of your illness? In what ways did your social capital assist you before and after diagnosis? Do you still receive support, and if so, what kind?*

Probes and follow-up questions were used where necessary to encourage detailed responses. Care was taken to avoid leading questions, thereby ensuring that participants narrated their experiences authentically. Each interview lasted between 20 and 30 minutes. Although Adler and Adler (2012) recommend interviewing up to 30 participants, data saturation was reached after the 20th interview, when no new insights emerged. All IDIs were audio-recorded, transcribed verbatim, and translated into English where necessary. Translations of Yoruba transcripts were verified by two language experts to preserve accuracy and meaning. Although, these experts had no academic qualifications in Yoruba, they had previously worked on several projects to translate instruments written in Yoruba language.

Validity and Reliability

To enhance validity, the instrument was first evaluated by two Professors of Sociology from the Niger Delta University and Obafemi Awolowo University. Their feedback informed revisions that improved both clarity and consistency. This was followed by a pre-test with two COVID-19 survivors who were not included in the final sample. Adjustments to the instrument was made based on this pilot exercise. The same interview guide was used for all participants to ensure reliability across sessions.

Ethical Considerations

This research adhered strictly to the ethical principles outlined in Nigeria's National Code of

Research, consistent with the Helsinki Declaration (1964) and its subsequent amendments. Ethical clearance was received from the College of Health, Afe Babalola University, Ado-Ekiti, Ekiti State, under approval number AB/EC/020/09/370.

Data Analysis

The interview data were analysed using thematic content analysis, as recommended by Braun and Clarke (2006). This process consisted of six systematic steps: familiarising oneself with the data, coding, creating preliminary categories, examining themes, identifying and labelling themes, and conducting the final analysis. The use of Atlas.ti software facilitated data management and organisation throughout this process.

To ensure a comprehensive understanding of the participants' narratives, the transcripts were reviewed multiple times. Each participant was assigned a code (P1–P20), and these codes were categorised into subthemes, which were then developed into overarching themes. Prior to the final analysis and presentation, the research team thoroughly reviewed and discussed each emerging topic.

Results

Socio-Demographic Profile of the Participants

The study involved a total of 20 participants, and their socio-demographic characteristics were analysed based on several factors: gender, income, marital status, age, employment status, religion, family type, and ethnic group. In terms of gender distribution, the study comprised 65% male participants and 35% female participants, indicating a higher representation of males in the sample. Participants' average monthly income ranged from 80,000 to 200,000, with the most frequently reported income bracket being between 100,000 and 180,000 per month, accounting for 70% of the participants.

The marital status data revealed that 90% of the participants were married, while 10% were widowed. There were no participants who were single or divorced. The age distribution of the participants ranged from 36 to 62 years, with the majority (60%) being between 45 and 54 years old. Additionally, 20% were above 54 years, and 20% were below 45 years. Regarding employment status, 40% of participants were civil servants, 20% worked in healthcare-related professions (including

nurses and health workers), 15% were engaged in business, 15% were self-employed, and 10% were retired.

In terms of religious affiliation, 60% of the participants identified as Muslims, while 40% identified as Christians, indicating a majority Muslim representation in the study. The family structure also varied; 55% reported having a monogamous family structure, while 45% indicated they were in polygamous family settings. Finally, regarding ethnic group representation, 75% of the participants were Yoruba, while 25% belonged to other ethnic groups, including Delta and Igbo.

Strongest Social Support

1. Family as a Primary Source of Support

For most participants, family members served as the strongest and most reliable support system. Family members did not only provide emotional and psychological comfort but also extended financial and logistical assistance.

"I will forever be grateful to my family. They have always been my pillar, especially in challenging situations. When I tested positive for COVID-19, I knew that with their support alone, I would be fine." – (32-year-old male, government employee)

"Both my immediate and extended family came to my aid financially while I was in the isolation centre. The people I least expected to help surprised me at my time of distress." – (28-year-old female, school teacher)

However, not all family responses were positive. One participant reported experiencing abandonment and social stigma from family members:

"Just when I tested positive for COVID-19, my family abandoned me. In fact, they were the ones spreading rumours about my health condition. Thankfully, my good friends like Tinuade, Alatisé, and Omisore (not real names) provided unwavering support." – (35-year-old male, business owner)

2. Workplace and Organisational Support

For some participants, their place of employment was a crucial support system, offering both financial assistance and job security during their illness. Employers and colleagues played an active role in ensuring that affected individuals received medical care and continued to earn a livelihood.

"My boss and colleagues were there for me throughout my illness. They ensured my financial needs were met and were eager for my return to work, valuing my contributions to the company." – (40-year-old male, IT professional)

3. Support from Religious Organisations

Faith-based institutions provided strong emotional and spiritual support to some participants. Some churches played an active role in offering prayers, checking on members, and sometimes offering material assistance.

"I got strong support from my religious body, especially my church. They checked up on me regularly and encouraged me through prayers." – (36-year-old female, banker)

4. Support from Peers and Social Networks

Close friends and club members were another vital source of support for some individuals. They provided financial assistance, emotional support, and helped reduce the sense of isolation caused by the illness.

"My best friend, Mr. Alatisé, and my close friends, Tinuade and Omisore, were my strongest support system. Their contributions went beyond money – they gave me hope and companionship." – (30-year-old male, engineer)

"My club members showed solidarity by calling and even providing financial support for some of my medical expenses." – (45-year-old male, entrepreneur)

5. Absence of Support and Social Isolation

While most participants received some form of support, a few reported feelings of isolation due to stigma or personal choice. Some did not disclose their illness to their social networks due to fear of discrimination or privacy concerns.

"None of my social capital or network was aware of my ailment, as I did not disclose it to them. I simply took a leave of absence to focus on my recovery." – (38-year-old female, lecturer)

This qualitative study underscores the diverse nature of social support during a health crisis. Family members were the most significant source of support, although responses varied from unwavering assistance to outright rejection. Workplace organisations and religious institutions also played a crucial role, while friends and club members stepped in where family support was lacking. However, social stigma led some individuals to experience isolation, highlighting the need for increased public awareness and supportive policies to help those dealing with health crises.

Disclosure of Illness and Initial Reactions

Participants had varied experiences regarding who was aware of their illness and how their social networks reacted. Some chose to keep their condition private, while others disclosed it to family, co-workers, or religious leaders.

- **Non-Disclosure of Illness** Some participants opted not to disclose their health status due to fear of stigma or personal reasons. A 30-year-old office worker shared:

"None of my social capital or network was aware of my ailment as I did not disclose it to them. All I did was to take a leave of absence for some time just to treat myself properly."

- **Disclosure to Employers and Workplace Reactions** Several participants informed their workplace about their illness to access leave or financial support. A 29-year-old state hospital worker said:

"The hospital management board that I work with was aware of my testing positive to COVID-19. I disclosed it to

them since I needed to be excused from work in order to take care of myself. They were sympathetic and shocked at the pronouncement."

- **Family and Friends as the First Point of Call.** Family and close friends were often the first to know about the illness. A 36-year-old male participant emphasised the importance of family support:

"The first point of call immediately I tested positive was my family members because they have always been my pillar in all situations of life."

A 40-year-old participant also credited his friends for unwavering support:

"My first point of call was my best friends, Mr. Alatise, Tinuade, and Omisore. We have been friends for life. They really stood by me, and I can't quantify their support in monetary value."

- **Religious Leaders and Pastors Providing Support.** Religious leaders were also mentioned as key figures in offering emotional and spiritual support. A 42-year-old female participant stated:

"My pastor, Mr. Lanre, was my first point of call; he was always praying for me. My family and friends were also aware of my plight."

The findings from this study highlighted that the level of disclosure varied among participants, with some choosing to keep their condition private while others sought support from their social networks. The reactions of those who were informed ranged from shock and sympathy to proactive assistance. These insights underscore the importance of strong social networks in enhancing coping mechanisms during health crises.

Social Capital and Support before COVID-19 Confirmation

This section examined the role of social capital in assisting individuals before they confirmed their COVID-19 status. The study explores various forms of support received from family members,

colleagues, religious organisations, and other networks. Based on the narratives of 20 participants, key themes were identified regarding the specific assistance provided before testing positive. Below are some direct accounts from respondents highlighting their experiences.

(a) Accompaniment to the Testing Centre: Several participants indicated that their family members accompanied them to the testing centre, demonstrating the importance of familial support during moments of uncertainty.

"My family members accompanied me for the testing. They were the ones who encouraged me to go, and their presence made the whole process less overwhelming." (32-year-old female teacher)

"You know, basically, I call them friends-turned-brothers and-sisters Alatisé, Tinuade, and Omisore. They were the ones that set the ball rolling for all the movement, such as making enquiries about the testing centre, going to the testing centre with me, and suggesting isolation." (29-year-old businessman)

While family members played a significant role, some individuals also relied on their workplace for logistic support.

"The office I worked for was of immeasurable support in all spheres, such as locating the testing unit, conveying me to the testing centre, and providing the needed support to ensure that I was fine." (35-year-old bank employee)

(b) Direction to the Testing Centre: For many participants, obtaining information about where to get tested was crucial. Several respondents credited their social network for helping them locate the testing centres.

"My family members were the ones who made inquiries as to where I could carry out the necessary test." (40-year-old civil servant)

"The coordinator of the Full Gospel Fellowship, who happens to be my pastor, was of great support to me. He made inquiries about the centre for testing, accompanied me to the testing centre, provided some funds, and most importantly, was always praying for me to get well and back on my feet." (45-year-old female trader)

Some also noted that their colleagues played an essential role in directing them to the right facilities.

"My colleagues directed me to the testing centre. I initially had no idea where to go, but they provided clear guidance." (30-year-old health worker)

(c) Suggestion to Go for Testing Based on Symptoms: The decision to go for testing was often influenced by family members, close friends, and even workplace policies.

"My husband supported the idea that I go for testing since I was having similar symptoms." (28-year-old housewife)

"The board suggested I go for testing just to know the state of my health. It was part of the organisation's policy to ensure that anyone showing symptoms got tested immediately." (33-year-old corporate employee)

(d) Suggestion to Self-Isolate: Upon noticing symptoms or after undergoing testing, many individuals were advised to self-isolate, either by health officials, family, or colleagues.

"The Hospital Management Board recommended that I isolate myself for two weeks, just to avoid the risk of spreading the virus." (36-year-old nurse)

"The COVID-19 management team suggested that I isolate myself. It was a challenging period, but their guidance helped me avoid unnecessary contact with others." (31-year-old engineer)

Friends also played an active role in reinforcing the need for isolation:

"My friends kept calling and checking in to ensure that I was isolating myself properly. They constantly reminded me to stay away from crowded places and take all necessary precautions." (27-year-old entrepreneur)

(e) Other Forms of Support: In addition to moral and logistical support, some respondents received financial assistance from their social networks.

"My club members assisted with some funds, which helped me manage expenses during the period I was unwell." (34-year-old civil servant)

"Both my immediate and extended family came to my aid financially while I was in isolation. In fact, the people I least expected to help surprised me during my distress." (38-year-old male trader)

The third objective which highlights the crucial role of social capital in providing support before individuals confirmed their COVID-19 status, again demonstrated that family members emerged as the strongest source of support, offering accompaniment, financial aid, and emotional encouragement. Workplace colleagues and religious organisations also played significant roles in directing individuals to testing centres and providing moral and financial support. While some participants faced their ordeal alone, the majority benefited from strong social networks that eased their journey through uncertainty.

Social Capital and Support during Illness

This qualitative study explores the role of social capital in providing support to individuals during illness. Based on the narratives of 20 participants, including health workers, traders, and civil servants, this study highlights the economic, spiritual, social, health, and psychological support offered by various social networks such as family, religious organisations, neighbours, co-workers, peers, and community members.

1. Support from Religious Organisations

Religious organisations played a vital role in offering spiritual and emotional support. Many participants expressed that prayers from religious leaders and faith-based communities provided them with strength and hope during their illness.

"The Chief Imam was praying for me daily, even over the phone during our conversations." (34-year-old trader)

A Christian participant recounted how their pastor provided both spiritual and financial support:

"The coordinator of the Full Gospel Fellowship, who happens to be my pastor, was of great support to me. He made enquiries about the testing centre, accompanied me there, provided some funds, and most importantly, prayed for me every day." (40-year-old civil servant)

2. Support from Family Members

Family members emerged as the strongest support system, providing financial, social, and emotional care. Participants highlighted how family members ensured they had the necessary resources for their treatment and well-being.

"My family members provided all the money I spent in the hospital. They also visited me daily, even though they were not allowed to see me. They would drop off food and other items with the nurses before leaving." (25-year-old health worker)

Apart from economic support, family members also provided psychological and logistic assistance.

"My family members were the ones who made inquiries about where I could carry out the necessary tests. They accompanied me to the test centre and ensured that all materials needed for the tests were available." (30-year-old teacher)

3. Support from Neighbours

Neighbours provided various forms of support, though their role was less significant compared to family and religious groups. Some participants

mentioned that neighbours expressed sympathy and concern, while others provided minor financial or logistical support.

“My neighbours were very sympathetic; they checked on me and sometimes sent food through the nurses.” (29-year-old trader)

4. Support from Co-workers

Colleagues and workplace organisations offered financial, psychological, and logistic assistance.

“My co-workers were calling to check on me and also encouraging me. Some even contributed money to help with my hospital bills.” (35-year-old civil servant)

In cases where participants worked in health-related organisations, their workplace played an even bigger role:

“Since we are all health-inclined, my office expertise assisted me and gave their maximum support.” (27-year-old nurse)

A participant who worked in a state government institution acknowledged the official support received:

“The State Hospital Management Board provided all the money I spent in the hospital.” (42-year-old government worker)

5. Support from Peers

Peers offered both emotional and financial support. However, visits were often limited due to hospital restrictions.

“Few of my peers also tried calling a couple of times just to know how I was faring, but they never visited the isolation centre.” (30-year-old business owner)

In some cases, friends contributed financially:

“A few friends assisted with some dollars just to make sure I got the best treatment and care.” (38-year-old banker)

This study underscores the importance of social capital in managing illness. Support from family, religious institutions, workplaces, and communities played an integral role in aiding recovery. The findings suggest that fostering strong social networks is crucial in health crises, as they provide holistic support that encompasses economic, emotional, and psychological well-being.

Social Capital and Continued Support among Participants after the Illness

This qualitative study explores the extent to which individuals continue to receive support from their social capital after recovering from an illness. Twenty individuals' comments were gathered, and they represented a range of post-recovery social support experiences. Professionals, family members, and community members who had previously received support during their sickness were among the participants. A range of perspectives emerged from the investigation, including continued emotional and financial support as well as a complete cessation of aid.

Nature of Continued Support

The data show that different social networks, such as friends, family, coworkers, religious organisations, and workplace associations, provide differing degrees of continuous support. Some participants stated that support ceased after they recovered, while others reported a relationship that was ongoing and marked by care and assistance.

Support Ceased After Recovery

Several participants noted that the support they received during their illness ended once they regained their health. A 30-year-old office worker expressed, “After testing negative, I stopped receiving support from my social network.” Similarly, a 35-year-old entrepreneur shared, “Now that I feel better, I no longer receive any form of support.” These responses suggest that social support may be closely tied to the perceived need for assistance. Once individuals are considered fully recovered, their support networks may withdraw their help.

Continued Support from Family and Close Friends

For some participants, family members and close friends continued to provide financial and emotional support even after recovery. A 28-year-old teacher expressed gratitude for ongoing family assistance:

“My family provided all the funds and necessary care needed for my quick recovery. My family still cares and supports me even though I am alright.”

Similarly, a 33-year-old businesswoman emphasised the enduring support from close friends:

“I will always be grateful to my three friends (Alatise, Tinuade, and Omisore). They provided all the care, support, and finance I needed for treatment. Though I am fine now, because we are friends for life, they still assist me in their usual manner.”

This highlights the role of close-knit relationships in sustaining long-term social support beyond periods of illness.

Workplace and Religious Support

Workplace and religious institutions also played significant roles in supporting individuals during illness, though this support did not always persist after recovery. A 40-year-old civil servant noted:

“A few of my colleagues in the office gave their financial support personally outside of what the organisation spent.”

A 45-year-old church member reflected on the impact of religious institutions:

“The religious organisation was a strong support for me during my illness. My pastor was always in touch, provided money for me, and constantly prayed for my healing. Although I am not receiving any support currently since I am healed, the moral support was invaluable.”

However, in some cases, religious institutions continued to provide emotional and spiritual support. A 38-year-old administrator noted:

“The church, my colleagues, friends, and family members all contributed immensely to my recovery during my illness. The church is still supportive with prayers and concern.”

This suggests that while financial support may diminish, spiritual and emotional support from religious groups often remains.

The findings from the last objective illustrate that social support networks play a crucial role in individuals' recovery processes, but the extent of continued assistance varies. Many participants experienced a cessation of support after their recovery, particularly from the workplace and extended networks. However, family members, close friends, and religious groups often maintained some form of ongoing support, either financially or emotionally. This highlights the need for stronger institutional structures that ensure sustained support beyond the period of immediate health crises.

Discussion of Findings

The findings of this study highlight the central role of family as a source of social support for individuals infected with COVID-19. Families provided emotional, psychological, and practical care that served as a strong buffer against the distress of illness. In African societies, family ties are often regarded as a crucial bond that nurtures solidarity and resilience, especially during times of difficulty. This reflects the Ubuntu philosophy, which emphasises interconnectedness and the idea that the well-being of one person is inseparable from that of others. In this sense, the care extended to sick relatives is not merely an obligation but a cultural expression of shared humanity. Thus, a close family relationship can have a great impact on well-being and health. These results are consistent with Hank and Steinbach's (2018) contention that, depending on the standard of care given, family support can either improve or worsen a person's health. Furthermore, it has been demonstrated that family involvement—such as discussions between family members and hospital administration—helps critically sick patients, particularly those with COVID-19, have better treatment outcomes (Widera et al., 2020).

According to the study, people's disclosure of disease differs based on their own circumstances

and how they expect other people to react. In spite of this, most people finally disclose their health status when asked. According to the participants, the first people they usually told after being diagnosed with COVID-19 were their close friends and relatives. The Ubuntu values of compassion, solidarity, and support for one another are reflected in this finding. Similar trends have also been shown in earlier research, such as people with HIV/AIDS telling family members about their illness to get emotional and financial support (Ssali et al., 2010). Disclosure, though, is not always simple, Lee et al. (2015) note that fear of rejection or stigma can lead patients to disclose first to friends while withholding information from family members, leaving relatives unaware of their health struggles.

The results showed that, in addition to disclosure, friends, family, and acquaintances often offered practical support by accompanying patients to testing centres before treatment or quarantine. These acts of support highlighted the commitment and resilience of loved ones during difficult times. However, not everyone experienced this. According to Naylor et al. (2021), to reduce the risk of infection, many hospitals have limited family presence, leaving patients to handle the process alone in some cases. The absence of support during testing and treatment might increase feelings of loneliness and sadness for those lacking close family ties.

Furthermore, the wider community was vital in supporting COVID-19 survivors. Beyond immediate family, assistance came from religious organisations, peers, and acquaintances, who offered emotional and practical help aimed at alleviating suffering. This aligns with Haugan and Eriksson (2021), who stress that social support—in the form of belonging, being valued, emotional encouragement, and practical assistance—is an essential factor in restoring health. Social support functions as a salutogenic resource, fostering resilience and improved mental health (Drageset, 2021; Uzobo et al., 2019).

Importantly, the study noted that social support did not end once recovery began. Some survivors continued to receive assistance from families, friends, and religious organisations even after overcoming the illness. Such continuity of care reinforces recovery and reduces the likelihood of post-illness complications. Orlas et al. (2021) argue

that ongoing social support contributes significantly to recovery following injury, while Aksoy et al. (2024) further emphasise that it can mediate the relationship between mental health challenges and subsequent health outcomes. Thus, sustained support networks are vital not only during illness but also in post-recovery adaptation.

Conclusion

Illness is an inevitable aspect of human existence; at one point or another, every individual will encounter it. While it may not be possible to completely prevent illness, certain factors can significantly influence how we feel when we are sick and how quickly we recover. Financial assistance, family involvement, spiritual support, and the care provided by friends and acquaintances all play vital roles in social support. These layers of support not only help alleviate the burden of illness but also provide patients with a sense of hope, belonging, and comfort—elements that are essential for the healing process.

The importance of support networks highlights that medical care alone does not determine an individual's ability to recover from illness. Recovery is influenced not only by the quality of medical care but also by a patient's broader social environment. When these elements work together positively, patients are more likely to experience better outcomes. Conversely, a lack of strong support networks can hinder healing, increase mental distress, and potentially worsen medical conditions.

Recommendations

It is recommended that a more structured framework is necessary to actively involve families in the treatment of patients, which will enhance recovery success. In addition to receiving education, families should have the authority to determine the services and forms of care that patients receive. Strengthening the relationships between patients, families, and healthcare providers through this collaborative approach will improve the quality of recovery.

Effective and meaningful communication with family members should be a top priority for healthcare professionals. Families often have crucial information about a patient's medical history, preferences, and lifestyle that can assist in

making treatment decisions when the patient is unable to communicate. By fostering open lines of communication, healthcare providers can enhance the accuracy of medical care and ensure that treatment is more personalised and responsive to the patient's needs.

Healthcare organisations and policymakers should consider creating platforms that connect patients and their families with resources for spiritual, psychological, and financial support. By addressing both physical and mental health needs, these platforms would ensure that patients receive comprehensive care that extends beyond the hospital environment. This shift would transform healthcare delivery from being solely focused on biomedical aspect to one that acknowledges and leverages the broader social determinants of health through the establishment of such systems.

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