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Assessment of Attitudes and Individual Practices Regarding Barrier Measures During the COVID-19 Crisis in Communes V and VI of Bamako District

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Abstract

Introduction: COVID-19 is an acute respiratory syndrome caused by the novel coronavirus, SARS-CoV2. This infectious disease is a zoonosis, the origin of which is still debated, which emerged in December 2019 in Wuhan, in the province of Hubei in China. The spread of SARS-CoV-2 in China led to a pandemic, declared on March 11, 2020 by the WHO. From March 25, 2020, Mali recorded its first two epidemics with two (2) confirmed cases. The objective of our study was to assess individual attitudes and practices in the face of barrier measures during the Covid-19 crisis in Commune V and VI of the District of Bamako.

Method: A cross-sectional study with prospective collection was carried out from December 1, 2021 to February 1, 2022. The target population of our study was people aged at least 18 years or older. Data were processed and analyzed using SPSS version 20.0 software.

Result: A total of 200 people were surveyed. The most represented age group was people aged 18 to 28 with 54%. The male sex predominated in 69% of cases. 68% of our respondents believed in the existence of coronavirus disease. Hand washing, the use of hydro-alcoholic gel and the wearing of masks were respected respectively at 69.5%; 60.5% and 54.5%.

Conclusion: For better prevention against this epidemic, it is important to raise public awareness to respect the barrier measures recommended by the WHO.

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Keywords: Covid-19 crisis; attitudes; Practices; Barrier measures; Commune V and VI; Bamako.

Introduction

COVID-19 was first documented in December 2019 in Wuhan, China. The disease quickly spread worldwide and was recognized by the World Health Organization (WHO) as a Public Health Emergency of International Concern (PHEIC) on January 30, 2020, and as a pandemic on March 11, 2020 (1).

According to the WHO, as of November 28, 2022, the total number of coronavirus cases worldwide was 641,883,161, with 6,626,970 deaths, corresponding to a mortality rate of 1.03% (2).
Africa reported its first case in February 2020; by November 28, 2022, Africa had 9,419,642 confirmed COVID-19 cases with 174,972 deaths (2).

In Mali, the first two COVID-19 cases were recorded on March 25, 2020. As of November 28, 2022, Mali had reported 32,760 cases with 742 deaths, representing a case fatality rate of 2.26% (2).

The spread of this disease has led to unprecedented social consequences over the past ten years: quarantine of suspected or asymptomatic individuals, enforcement of physical distancing, closure of daycare centers, schools, and universities, prohibition of gatherings, cancellation of cultural or religious events, closure of shops and borders, suspension of international flights, and even the imposition of lockdowns in major cities or entire countries (3).

In many countries, quarantine and lockdowns successfully slowed the spread of the COVID-19 pandemic. Mandatory restrictions, however, may affect individuals' coping capacities, emotional, behavioral, and psychological well-being. Moreover, in countries without strict lockdowns, looming health and economic threats have impacted individuals and their families (4).

The uncertainty associated with this unprecedented health crisis, anxiety about being confined at home, and the realities of many individuals working from home while educating their children and managing household needs have exerted considerable pressure on everyone.
To mitigate the emotional and psychological impacts of the COVID-19 crisis, including lockdowns, it is necessary to understand the coping capacities of affected individuals. Analyzing the population's knowledge and behaviors is crucial to better guide the public health response.
The objective of this study was to assess individual attitudes and practices regarding barrier measures during the COVID-19 crisis in Communes V and VI of Bamako District.

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Methods

Study setting and location

As part of a multi-country research protocol, initially planned online and titled "Family and Individual Adaptation during COVID-19 Management in Southern Countries", we conducted a prospective survey in Communes V and VI of Bamako District, Mali.

Description of Commune V

Commune V covers an area of 41 km² and consists of eight neighborhoods: Badalabougou, Sema I, Quartier Mali, Torokorobougou, Baco-Djicoroni, Sabalibougou, Daoudabougou, and Kalaban-Coura, with a population of 249,727 inhabitants (5).

Description of Commune VI

Commune VI, with an area of 8,882 hectares, is the largest commune in Bamako District, with a population of approximately 600,000 inhabitants. It comprises ten neighborhoods: Banankabougou, Djanekela, Faladie, Magnambougou, Missabougou, Niamakoro, Sénou, Sogoniko, Sokorodji, and Yrimadio (5).

Study design and period

We conducted a cross-sectional study with prospective data collection from December 1, 2021, to February 1, 2022.

Study population

The study population consisted of individuals aged 18 years and above residing in Communes V and VI of Bamako District.

Inclusion criteria

All individuals aged 18 years or older residing in Communes V and VI who consented to participate in the study.
Exclusion criteria

Individuals younger than 18 years, non-residents of Communes V and VI, or those who refused to participate.

Sampling

We assumed that barrier measures would be poorly respected in Mali due to limited resources, and based on this assumption, we estimated that 30% of the population would adhere to them. The sample size was calculated using Daniel Schwartz's formula:

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$$n = \frac{(z)^2 \cdot p(1-p)}{d^2}$$

Where:

- n= sample size
- z= standard normal deviation for α = 5%, $z = 1.96$
- p= estimated proportion of adherence in the population (p = 0.30)
- d= tolerated margin of error (d = 7%)

$$n = \frac{(1.96)^2 \cdot 0.3(1-0.3)}{(0.07)^2} = 164.6$$

Thus, the minimum sample size was set at 165 participants.

Study variables

The variables studied included:

- Sociodemographic characteristics: age, sex, marital status, residence.
- Belief in the existence of COVID-19 in Mali.
- Attitudes and practices: hygiene and confinement measures recommended by authorities, preventive measures used, and self-reported levels of anxiety, boredom, insomnia, nervousness, and family relationships.

Data collection

Collection tools

Data were collected using a pre-established questionnaire.

Procedure

Participants were administered the questionnaire with their consent. Responses were recorded on a data collection sheet. Questions were optional, except for sociodemographic characteristics.

Data entry and analysis

Data were entered and analyzed using SPSS version 20. The Chi-square test was applied as appropriate for statistical comparisons. A p-value < 0.05 was considered statistically significant.

Operational definitions

Attitudes of participants

To determine participants' attitudes, we asked questions regarding their levels of anxiety, boredom, insomnia, and nervousness:

- **Anxiety:** A distressing state caused by anticipating an event or suffering that one fears, or by uncertainty.
- **Boredom:** Temporary displeasure or annoyance caused by difficulty, obstacle, or impediment.

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- **Insomnia:** Lack or poor quality of sleep affecting physical, psychological, and social daytime activities.
- **Nervousness:** A state of irritability or temporary excitability of the nerves.

Ethical considerations

The study protocol was approved by the scientific committee, the national COVID-19 coordination unit, and the ethics committee of the Faculty of Medicine and Pharmacy. Participation was voluntary, and informed consent was obtained. Questionnaires were anonymous to ensure confidentiality.

Results

A total of 200 individuals were surveyed. The majority were young adults aged 18–28 years, with a male predominance of 69%.

Sociodemographic characteristics of participants

Among the respondents, the age group 18–28 years accounted for 54%, with a male predominance of 69%; 56% were single, and 59.5% resided in Commune V compared to 40.5% from Commune VI (Table 1).

Belief in the disease

The participants believed in the existence of the disease in 68% of cases (Figure 1).

Acceptability of hygiene measures

According to the results, more than half (71.5%) of our participants agreed with the hygiene measures recommended by the authorities (Table 2).

Practice of preventive measures

Among the various preventive measures practiced by the participants, regular handwashing was the most commonly applied, with 69.5% (Table 3).

Relation of respondents according to compliance with preventive measures and belief in the existence of the disease

According to the results obtained, there was a statistically significant association between all the variables studied and the belief in the existence of the disease (Table 4).

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Discussion

Sociodemographic characteristics of participants

In our study, the 18–28-year age group was the most represented, accounting for 54%. This finding is similar to that reported by Sangho O et al in the Timbuktu region of Mali, who found that nearly half of confirmed COVID-19 cases were aged 15–34 years (6). These results are consistent with Mali's age pyramid, characterized by a particularly young population.

Males were more represented, with a proportion of 69% (138/200). The sex distribution in our study population is comparable to that of a study conducted by Aminata Diarra et al in Bamako, which reported a male predominance of 57% (7). This high representation of males may be explained by data from the Demographic and Health Survey of Mali (DHS/EDSM), which indicates that men are generally more numerous in Mali. Similar findings were reported by Cécile Longchamps et al (8) in France and Mamadou Makhtar Mbacké Leye et al (9) in Dakar, who found male proportions of 75.3% and 66.5%, respectively. However, our results differ from those of Mohammed Majam et al (10) in South Africa, who reported a predominance of females (70.7%).

Single participants were the majority in our study, representing 56%. This proportion is lower than that reported in a KAP study on the COVID-19 pandemic conducted in a university setting in Kinshasa in 2020, where singles accounted for 82% (11). This difference may be explained by variations in study settings and sample size.

Regarding participants' residence, 59.5% (119/200) lived in Commune V, while 40.5% (81/200) resided in Commune VI.

Belief in the existence of Coronavirus disease

In our study, 68% of participants believed in the existence of Coronavirus disease, whereas 32% did not. This result is lower than that reported by Mamadou Makhtar Mbacké Leye et al (9) in Dakar, where almost all respondents (94.8%) believed in the existence of the disease.

The proportion observed in our study (68%) may be explained by the intensification of awareness-raising campaigns conducted by Malian health authorities, using several local languages through mass media such as television and radio. Belief in the existence of the disease is essential for encouraging population engagement in efforts to combat this pandemic.

Acceptability of hygiene measures

Among the various preventive measures practiced by the participants, regular handwashing was the most commonly adopted, reported by 69.5% of respondents. Comparable findings, for instance, studies carried out during the COVID-19 pandemic in sub-Saharan Africa reported handwashing adherence rates ranging from 60% to 80%, reflecting increased public sensitivity to

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hygiene behaviors in response to perceived health threats (12-13). The 69.5% prevalence observed in the present study falls within this range, suggesting consistency with regional and international trends. This finding highlights a relatively good level of awareness and adherence to basic hygiene practices, which are widely recognized as one of the most effective and accessible means of preventing the transmission of infectious diseases, particularly those spread through contact and respiratory droplets.

Hand hygiene has long been identified as a cornerstone of infection prevention and control (IPC). The World Health Organization (WHO) emphasizes that regular handwashing with soap and water can significantly reduce the transmission of pathogens responsible for respiratory infections, diarrheal diseases, and emerging infectious diseases such as COVID-19 (WHO, 2009; WHO, 2020). The relatively high proportion observed in this study suggests that public health messaging regarding hand hygiene may have been effectively disseminated among the study population.

Practice of preventive measures

In our study, handwashing and mask-wearing were observed in 69.5% and 54.5% of participants, respectively. These findings should encourage health authorities to strengthen awareness campaigns among this population, particularly regarding the consistent use of masks and, above all, proper handwashing. Beyond COVID-19 prevention, regular handwashing with soap and water is deeply ingrained in our society, as it remains a critical measure for preventing diseases such as amebic dysentery, cholera, and Ebola.

The use of alcohol-based hand sanitizer was observed in 60.5% of participants in our study.
This low usage rate may be linked to financial constraints associated with implementing this measure, as the price of sanitizers increased significantly at the beginning of the pandemic. Sanitizers were not accessible to certain disadvantaged segments of the population.

In our study, 77% of volunteers attended events. This result is higher than that reported by Mohammed Majam et al. in South Africa (8), where only 10.4% of participants attended gatherings with more than ten people. Only 20% of our volunteers adhered to social distancing measures.

This finding reflects the social, political, economic, and cultural context of West African countries in general, and Mali in particular, where maintaining social distancing is somewhat difficult due to overcrowding.

Relation of respondents according to compliance with preventive measures and belief in the existence of the disease

The present study highlights a statistically significant association between belief in the existence of the disease and adherence to all preventive measures assessed, including handwashing, use of

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alcohol-based hand sanitizer, avoidance of handshakes, participation in events, mask-wearing, and respect for social distancing measures ($p < 0.05$ for all variables). These findings underline the central role of risk perception and belief in disease existence in shaping individual preventive behaviors during infectious disease outbreaks.

Handwashing was significantly associated with belief in the existence of the disease ($p = 0.001$). Participants who believed in the disease were more likely to report regular handwashing compared with those who did not believe or only partially believed in its existence. This result is consistent with previous studies showing that individuals who perceive a disease as real and threatening are more inclined to adopt basic hygiene practices recommended by public health authorities (14-15). Handwashing with soap and water remains one of the most effective and affordable measures for preventing the transmission of infectious diseases, including COVID-19, cholera, and Ebola, particularly in low-resource settings (16).

A significant association was also observed between belief in the disease and the use of alcohol-based hand sanitizer ($p = 0.02$). Participants who believed in the existence of the disease showed higher compliance with sanitizer use. Similar findings have been reported in other African and Asian settings, where belief in disease severity strongly influenced compliance with recommended preventive measures (17-18). However, despite this association, overall use of hand sanitizer remained suboptimal, possibly due to economic constraints and limited accessibility, especially during the early phase of the pandemic when prices increased sharply.
Avoiding handshakes was significantly associated with belief in the disease ($p = 0.001$). Participants who believed in the disease were more likely to adopt alternative greeting practices. This behavior change reflects the influence of perceived susceptibility and perceived severity, as described in the Health Belief Model (19). In many African societies, physical contact during greetings is deeply rooted culturally, making behavioral change particularly challenging in the absence of strong belief in the disease (20).

Participation in social events was also significantly associated with belief in the disease ($p = 0.001$). Individuals who did not believe in the disease or believed in it only partially were more likely to attend gatherings. This finding aligns with studies reporting that disbelief or misinformation about COVID-19 reduced compliance with restrictions on mass gatherings (21). In contrast, individuals who acknowledged the existence of the disease were more likely to limit their participation in events, reflecting higher risk awareness.

Mask-wearing showed a strong association with belief in the disease ($p = 0.001$). Participants who believed in the disease were significantly more likely to wear masks compared with those who did not. This result corroborates findings from multiple studies indicating that belief in disease existence and trust in public health information are key determinants of mask adherence (22-23). Masks are recognized as an effective barrier to respiratory virus transmission, particularly in settings where physical distancing is difficult to maintain.

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Respect for social distancing measures was also significantly associated with belief in the disease ($p = 0.002$). Participants who believed in the disease demonstrated higher compliance with distancing recommendations. Nevertheless, adherence remained generally low, reflecting the social, economic, and cultural realities of West African countries, including Mali, where overcrowding, extended family living arrangements, and informal economic activities make physical distancing difficult to implement (24-25).

Conclusion

This study shows that, despite a relatively encouraging adoption of certain preventive measures, additional efforts are still needed to improve risk perception, strengthen trust in health information, and overcome the economic and sociocultural barriers to compliance with recommendations. Strengthening awareness campaigns tailored to the local context, involving community and religious leaders, and improving access to preventive tools appear to be essential. Such an integrated approach could not only improve the response to COVID-19 but also sustainably strengthen the prevention of other major infectious diseases in resource-limited settings.

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Conflicts of interest
The authors declare no conflicts of interest.

Authors' contributions
All authors contributed to the data analysis, interpretation of the results, and the preparation of the manuscript.

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Table 1: Distribution of respondents according to sociodemographic characteristics

Variables	Frequency (N = 200)	Percentage (%)
Age group		
18–28 years	108	54.0
29–39 years	69	34.5
40–50 years	13	6.5
51–61 years	7	3.5
62 years and above	3	1.5
Sex		
Male	138	69.0
Female	62	31.0
Marital status		
Single	112	56.0
Married	82	41.0
Divorced	3	1.5
Widowed	3	1.5
Residence		
Commune V	119	59.5
Commune VI	81	40.5

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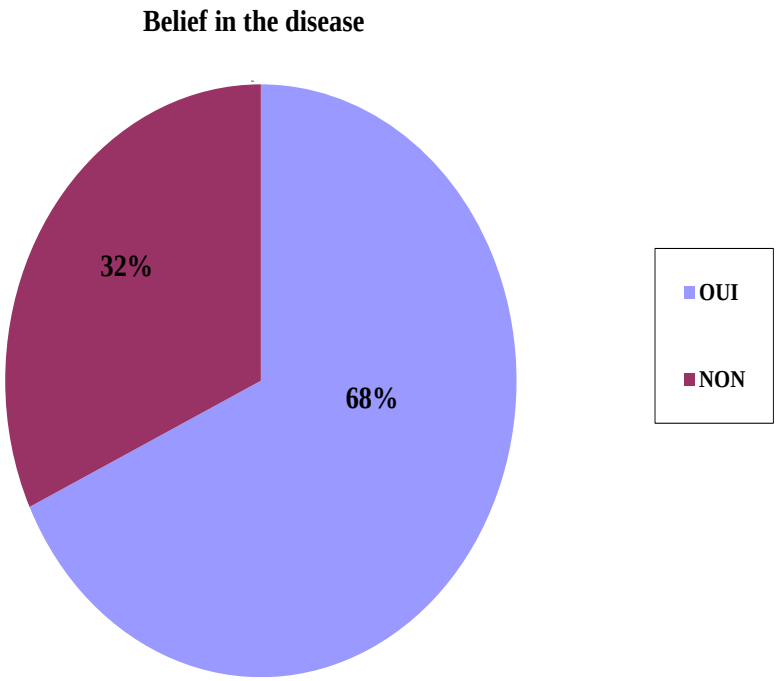

Figure 1: Distribution of respondents according to belief in the existence of this disease

Table 2: Distribution of respondents according to the acceptability of hygiene measures (handwashing, use of hydroalcoholic gel, etc.) and containment measures (closure of schools and ports, curfews, etc.) recommended by the public authorities

Variables	Frequency (N = 200)	Percentage (%)
Hygiene measures		
Yes	143	71.5
No	57	28.5
Containment measures		
Yes	94	47.0
No	106	53.0

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Table 3: Distribution of respondents according to the practice of preventive measures

Variables	Frequency (N = 200)	Percentage (%)
Regular handwashing		
Yes	139	69.5
No	13	6.5
Not really	48	24.0
Use of hydroalcoholic gel		
Yes	121	60.5
No	79	39.5
Greeting without handshakes		
Yes	101	50.5
No	99	49.5
Participation in events		
Yes	154	77.0
No	10	5.0
Not really	36	18.0
Wearing masks		
Yes	109	54.5
No	40	20.0
Not really	51	25.5
Respect for physical distancing measures		
Yes	40	20.0
No	89	44.5
Not really	71	35.5

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Table 4: relation of respondents according to compliance with preventive measures and belief in the existence of the disease

Preventive measures			Belief in the existence of the disease		p-value
	Total N (%)	Response	Yes N (%)	No N (%)	
Handwashing	139 (100)	Yes	106 (76.3)	33 (23.7)	0.000
	13 (100)	No	3 (23.1)	10 (76.9)	
	48 (100)	Not really	27 (56.2)	21 (43.8)	
Use of hydroalcoholic gel	121 (100)	Yes	102 (84.3)	19 (15.7)	0.000
	79 (100)	No	34 (43.0)	45 (57.0)	
Greeting without handshakes	101 (100)	Yes	85 (84.2)	16 (15.8)	0.000
	99 (100)	No	51 (51.5)	48 (48.5)	
Participation in events	154 (100)	Yes	101 (65.6)	53 (34.4)	0.001
	10 (100)	No	3 (30.0)	7 (70.0)	
	36 (100)	Not really	32 (88.9)	4 (11.1)	
Wearing masks	109 (100)	Yes	91 (83.5)	18 (16.5)	0.000
	40 (100)	No	17 (42.5)	23 (57.5)	
	51 (100)	Not really	28 (54.9)	23 (45.1)	
Physical distancing measures	40 (100)	Yes	36 (90.0)	4 (10.0)	0.002
	89 (100)	No	52 (58.4)	37 (41.6)	
	71 (100)	Not really	48 (67.6)	23 (32.4)	