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Original Research Article

Pattern of animal bite and health care seeking behavior of victims attending a specialized hospital

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ABSTRACT

Background: Animal bites constitute a significant yet preventable public health burden worldwide, particularly in rabies-endemic countries like Bangladesh. Despite the availability of effective post-exposure prophylaxis (PEP), gaps in awareness and timely healthcare-seeking behavior persist. The aim of the study is to assess the pattern of animal bites and the healthcare-seeking behavior of bite victims attending a specialized infectious disease hospital in Dhaka, Bangladesh.
Methods: This cross-sectional study was conducted at the Infectious Diseases Hospital (IDH), Mohakhali, Dhaka, from January to December 2022. A total of 115 animal bite victims were selected through convenience sampling.
Results: The mean age of participants was 33.6±15.3 years, with males constituting 72.2%. Most victims (80%) were urban residents, and 60% were married. Dogs were responsible for 73.0% of bites, followed by cats (25.2%), with stray animals accounting for 62.6% of cases. Knowledge about rabies was reported by 61.7% of participants, significantly associated with higher education level (p=0.007) and urban residence (p=0.001). Most participants (90.6%) washed wounds immediately, while economic (10.4%) and transportation (4.3%) barriers were minimal.
Conclusions: Animal bites remain a substantial public health concern in Bangladesh, predominantly caused by stray dogs in urban areas. Although most victims sought timely medical care and exhibited good preventive practices, knowledge gaps and inconsistent health-seeking behaviors persist among rural and less-educated populations. Strengthening community awareness, promoting responsible pet ownership, and ensuring equitable access to rabies vaccination services are vital for achieving Bangladesh's goal of dog-mediated rabies elimination by 2030.

Keywords: Animal bite, Rabies, Post-exposure prophylaxis, Health-seeking behavior, Epidemiology

INTRODUCTION

Children's and adults' health are increasingly being affected by animal injuries. Animal attacks result in numerous injuries and fatalities, as well as serious medical and societal repercussions, all over the world.[1] About 50% of all individuals experience at least one animal bite in their lifetime, especially during childhood.[2] Animal injuries account for more than 55,000 fatalities globally, with dogs, cats, and monkeys being the most frequently to

blame.[3] The threat of rabies to more than 3.3 billion people globally from animal bites is a worry for public health. These exposures mostly affect underserved people and have been known for more than 4,000 years, both in rural and urban regions.[4] In Bangladesh, there are between 200,000 and 300,000 dog bites every year, and 95% of rabies-related deaths are caused by rabid dog bites.[5] Approximately 90% injuries are from domestic animals and 70% of those are from pets and most importantly children under 15 from underprivileged rural communities in Bangladesh have the third highest fatality rate among rabies-endemic countries, and they are particularly affected.[6] Even though the zoonotic disease rabies is almost always lethal, it is simply preventable by promptly and effectively administering the vaccine to a dog bite victim.[7] Despite being a fatal illness, rabies can be prevented with prompt and effective post-exposure prophylaxis, which is almost always successful in avoiding rabies mortality.[8] Early availability, quality, and cost of services, as well as social group, health beliefs, locations, and personal characteristics of the users, all have an impact on how people seek healthcare.[9] Due to its mortality, the rise in the number of human bite incidents from animals, the harm it causes to livestock, and the resulting financial losses, rabies is very important.[10] Over the recent years, urbanization and deforestation have an impact on habitants, there are more chances of man being exposed to mammals and in turn leading to increase in animal bite cases.[11] High vaccine costs, ignorance and inadequate availability of primary health services limit the use of PEP in low-income countries and other factors such as lack of transport, more transportation cost referral to other health centers time have to be spent before receiving PEP for people living in longer distance from the health center also delay the initiation of treatment.[12,13] Increasing awareness of rabies prevention and control in communities includes awareness on responsible pet ownership regarding how to prevent dog bites, and immediate care after a bite.[13] In rabies endemic countries, where every animal bite is potentially a suspected rabid exposure, the exposed individuals should seek early and proper health care. It is also essential to complete the full course of post-exposure vaccination to protect against rabies. Community-awareness regarding rabies and health seeking behavior are critical both for the prevention and control of the disease in humans and animals. The study aims to assess the pattern of animal bite and health care seeking behavior of bite victims attending a specialized hospital.

METHODS

This cross-sectional study was conducted at the Infectious Diseases Hospital (IDH), Mohakhali, Dhaka, a 100-bed specialized hospital that serves as the primary referral center for rabies cases and animal bite victims from across Bangladesh. The study was carried out over one year, from January to December 2022 with 115 sample sizes. The protocol was developed in February and March, followed by ethical approval, instrument development, pretesting, and field preparation. Data collection occurred in July and August, with data processing, analysis, and report writing completed by the end of the year. The study aimed to assess the sociodemographic characteristics, pattern of animal bites, and health-seeking behavior among animal bite victims attending IDH. Participants were selected using a convenient sampling technique based on predefined inclusion and exclusion criteria.

Inclusion criteria

Victims of animal bites, including bites by dogs, cats, rats, or foxes. Both male and female participants. Individuals who provided informed written consent to participate.

Exclusion criteria

Severely ill patients unable to participate in interviews.

Ethical considerations

Ethical approval for the study was obtained from the Institutional Review Board (IRB) of the National Institute of Preventive and Social Medicine (NIPSOM). Permission was also secured from the hospital authority. Written informed consent was obtained from each participant prior to data collection. Participants were informed about the study's purpose, confidentiality, voluntary nature, and their right to withdraw at any time without consequence. No invasive procedures were performed, ensuring no harm to participants. Privacy and confidentiality were strictly maintained throughout the study.

Data collection

Data were collected using a semi-structured questionnaire and a checklist developed according to the study objectives. The questionnaire consisted of six parts covering: General information on animal bite victims, Sociodemographic characteristics, Pattern of animal bites, Health care–seeking behaviors following animal bites The checklist was used to record additional information from hospital records. Prior to data collection, the instruments were translated into Bangla, back-translated, and validated. Pretesting was conducted on 30 animal bite victims at the same hospital to ensure clarity and consistency, after which necessary modifications were made. Data were collected through face-to-face interviews conducted by trained researchers following written consent, taking approximately 25–30 minutes per participant. Data consistency, accuracy, and completeness were verified daily.

Statistical analysis

Data were coded, cleaned, and analyzed using SPSS latest version software. Descriptive statistics including frequency, percentage, mean, and standard deviation were used to summarize sociodemographic variables and bite patterns. Inferential statistics were performed using the Chi-square test to assess associations between variables.

The results were presented in tables and graphs. Reliability and validity of the instruments were ensured through pretesting, expert review, and adherence to standard data handling procedures.

RESULTS

Table 1 shows that the mean age of participants was 33.61±15.305 years, with most aged 21–35 years (37.40%). Males were 72.20%, and females 27.80%. Married individuals were 60.00%, and 95.00% were Muslim. Urban residents comprised 80.00%. Mean family income was 1.78±0.685, and 59.10% lived in nuclear families. Among respondents the students constituted the largest group at 31.30%, followed by businesspersons at 26.96% and service holders at 19.13%. Homemakers made up 15.65%, while day-laborers, farmers, and retired participants accounted for 3.48%, 1.74%, and 1.74%, respectively (Figure 1). Similarly, most participants had primary education at 39.13%, followed by secondary and HSC levels, each at 21.74%. Graduation and above were observed in 13.91%, while only 3.48% of participants were illiterate (Figure 2). Table 2 illustrates that dogs were responsible for 73.00% of bites, followed by cats at 25.20%. Stray animals accounted for 62.60% of cases. Legs were bitten most frequently at 53.90% and bites occurred mainly in the morning or evening at 67.00%, with 53.00% being unprovoked. About 73.90% took post-bite measures, and 65.20% visited clinics within 24 hours. Knowledge about rabies was 61.70%. Economic problems affected 10.40%, and transport issues 4.30%. Among 115 victims, 73.90% took measures after the bite. Males reported 73.50% and females 75.00%. Married participants took 63.80% measures, while unmarried 89.10%. By age, 5–20 years 88.20% was maximum and measures increased with education where secondary 80.00%, graduation 100%. Nuclear families reported 75.00% and urban residents 76.10% highest. Dog 73.80% and cat 75.90% bites were common, with measures taken more often for stray 75.00% and pet 73.20% animals, while unknown ownership accounted for 50.00% (Table 3). Knowledge about rabies was highest among graduates 100% and HSC 68.00%, lowest among illiterates 50.00%. Urban residents showed 69.60% awareness, rural 30.40%. Those bitten previously had 80.80% knowledge. Males 65.10%, females 53.10%. Category 3 exposure showed 70.70% awareness (Table 4). Table 5 represents among 115 participants, 72.80% of urban residents had knowledge about rabies compared to 34.80% of rural residents, while 65.20% of rural and 27.20% of urban residents lacked knowledge.

Table 1: Demographic characteristics of the respondents.

Variables	Frequency (N)	Percentage (%)
Age (years)		
5-20	34	29.60
21-35	43	37.40
36-50	27	23.50
51-60	11	9.60
Mean±SD	33.61±15.305	
Monthly family income		
15000-30000	42	36.50
31000-50000	56	48.70
51000-80000	17	14.80
Mean±SD	1.78±0.685	
Gender		
Male	83	72.20
Female	32	27.80
Marital status		
Married	69	60.00
Unmarried	46	40.00
Religion		
Muslim	109	95.00
Hindu	4	3.30
Christian	2	1.70
Family type		
Nuclear	68	59.10
Joint	47	40.00
Family member		
3-4	46	40.00
5-6	45	39.10
7-8	24	20.90

Continued.

Variables	Frequency (N)	Percentage (%)
Mean±SD	1.81±0.760	
Residence		
Urban	92	80.00
Rural	23	20.00

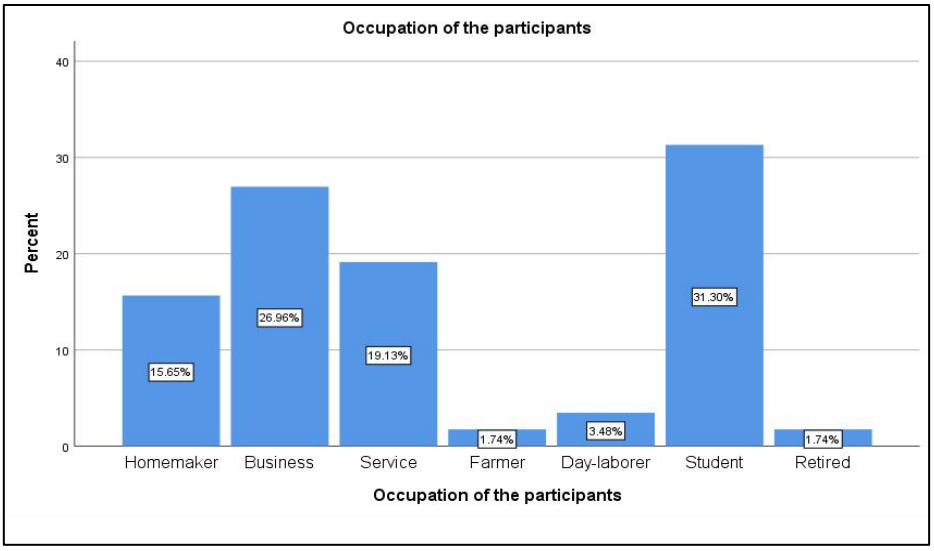

Figure 1: Occupation of the respondents.

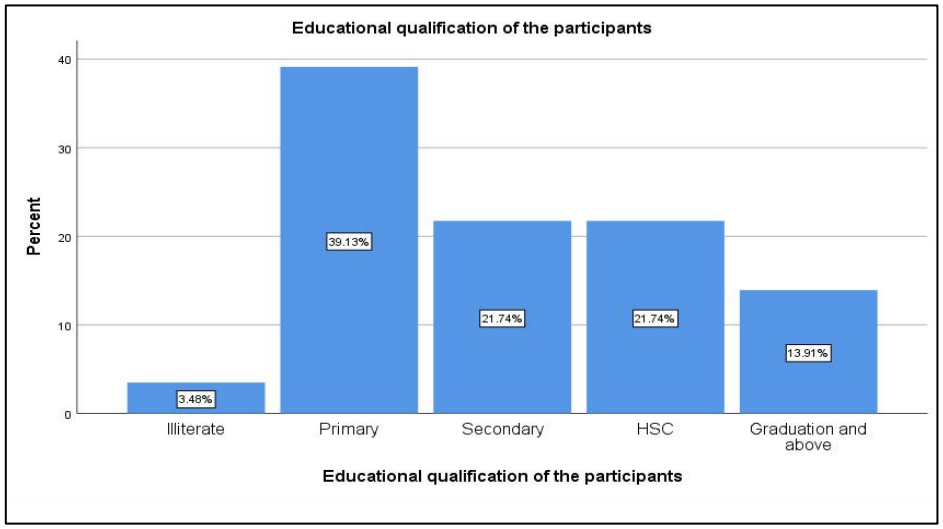

Figure 2: Educational status of the respondents.

Table 2: Distribution of animal bite victims according to bite characteristics, treatment-seeking behavior, and related factors (n=115).

Attribute	Frequency (N)	Percentage (%)
Type of animal that bitten		
Dog	84	73.00
Cat	29	25.20
Rat	2	1.70
Ownership status of the biting animal		
Stray	72	62.60
Pet	41	35.70
Unknown	2	1.70

Continued.

Attribute	Frequency (N)	Percentage (%)
Part of body bitten		
Leg	62	53.90
Hand	41	35.70
Body	7	6.10
Head and face	5	4.30
Type of exposure		
Bite	77	67.00
Scratch	37	32.20
Non-bite	1	0.90
Time of bite		
Morning/Evening	77	67.00
Night	38	33.00
Exposure circumstances		
Provoked	54	47.00
Unprovoked	61	53.00
Place of bite		
Street	60	52.20
Bazaar	11	9.60
Own house	36	31.30
Neighbor's house	8	7.00
Current state of the biting animal		
Alive	92	80.00
Dead	2	1.70
Unknown	21	18.30
Bitten in the past		
Yes	26	22.60
No	89	77.40
Type of animal that bitten in the past (n=26)		
Dog	14	53.80
Cat	12	46.20
Vaccination status for past bite (n=26)		
Yes	15	57.70
No	11	42.30
Any measure taken after animal bite (n=115)		
Yes	85	73.90
No	30	26.10
Treatment seeking pathway of patients attending ARV clinic		
Direct to ARV clinic	93	80.90
Private clinic to ARV clinic	7	6.10
Government set up to ARV clinic	15	13.00
Time of visit to ARV clinic after bite		
≤24 hour	75	65.20
>24 hour	40	34.80
Source of health care at the beginning		
Indigenous	2	2.40
Local pharmacy	5	5.90
Self-washing	55	90.60
Traditional healer	1	1.20
Knowledge about rabies (n=115)		
Yes	71	61.70
No	44	38.30
Knowledge on causes of rabies		
Bite of a rabid animal	66	93.00
Scratches exposed to saliva	5	7.00

Continued.

Attribute	Frequency (N)	Percentage (%)
Economic problem		
Yes	12	10.40
No	103	89.60
Transportation problem		
Yes	5	4.30
No	110	95.70
Company to come to health center		
Yes	108	93.90
No	7	6.10
Distance of health center from residence (in km)		
11-20	28	24.34
21-50	14	12.20
51-100	3	2.60

Table 3: Association between socio-demographic characteristics and measures taken after animal bite among victims (n=115).

Variables	Measures taken after bite		Total N (%)	P value
	Yes, N (%)	No, N (%)		
Gender				
Male	61 (73.50)	22 (26.50)	83 (100)	0.869
Female	24 (75.00)	8 (25.00)	32 (100)	
Marital status				
Married	44 (63.80)	25 (36.20)	69 (100)	0.004
Unmarried	41 (89.10)	5 (10.90)	46 (100)	
Age (years)				
20-30	30 (88.20)	4 (11.80)	34 (100)	0.082
21-35	31 (72.10)	12 (27.90)	43 (100)	
36-50	16 (59.30)	11 (40.70)	27 (100)	
51-60	8 (72.70)	3 (27.30)	11 (100)	
Educational qualification				
Secondary	20 (80.00)	5 (20.00)	25 (100)	0.006
HSC	19 (76.00)	6 (24.00)	25 (100)	
Graduation and above	16 (100.00)	0 (0.00)	16 (100)	
Family type				
Nuclear	51 (75.00)	17 (25.00)	68 (100)	0.75
Joint	34 (72.30)	13 (27.70)	47 (100)	
Family member				
4	34 (73.90)	12 (26.10)	46 (100)	0.429
6	31 (68.90)	14 (31.10)	45 (100)	
8	20 (83.30)	4 (16.70)	24 (100)	
Residence				
Rural	15 (65.20)	8 (34.80)	23 (100)	0.288
Urban	70 (76.10)	22 (23.90)	92 (100)	
Monthly income				
15000-30000	28 (68.30)	14 (31.70)	42 (100)	0.366
31000-50000	43 (76.80)	13 (23.20)	56 (100)	
51000-80000	14 (82.40)	3 (17.60)	17 (100)	
Type animal bitten				
Dog	62 (73.80)	22 (26.20)	84 (100)	0.635
Cat	22 (75.90)	7 (24.10)	29 (100)	
Rat	1 (50.00)	1 (50.00)	2 (100)	
Ownership status				
Stray	54 (75.00)	18 (25.00)	72 (100)	0.595
Pet	30 (73.20)	11 (26.80)	41 (100)	

Continued.

Variables	Measures taken after bite		Total N (%)	P value
	Yes, N (%)	No, N (%)		
Unknown	1 (50.00)	1 (50.00)	2 (100)	
WHO exposure category				
Category 1	3 (75.00)	1 (25.00)	4 (100)	
Category 2	29 (80.60)	7 (19.40)	34 (100)	0.622
Category 3	53 (70.70)	22 (29.30)	75 (100)	

Table 4: Relationship of educational, residential, and exposure factors with knowledge about rabies (n=115).

Variables	Knowledge about rabies		Total N (%)	P value
	Yes, N (%)	No, N (%)		
Educational qualification				
Illiterate	2 (50.00)	2 (50.00)	4 (100)	
Primary	22 (48.90)	23 (51.10)	45 (100)	
Secondary	14 (56.00)	11 (44.00)	25 (100)	0.007
HSC	17 (68.00)	8 (32.00)	25 (100)	
Graduation and above	16 (100.00)	0 (0.00)	16 (100)	
Residence				
Rural	7 (30.40)	16 (69.60)	23 (100)	0.001
Urban	64 (69.60)	28 (30.40)	92 (100)	
Bitten in the past				
Yes	21 (80.80)	5 (19.20)	26 (100)	0.023
No	50 (56.20)	39 (43.80)	89 (100)	
Gender				
Male	54 (65.10)	29 (34.90)	83 (100)	0.238
Female	17 (53.10)	15 (46.90)	32 (100)	

Table 5: Association between residence and time taken to reach ARV clinic.

Variable	Knowledge about rabies		Total N (%)	P value
	Yes, N (%)	No, N (%)		
Residence				
Rural	8 (34.80)	15 (65.20)	23 (100)	0.001
Urban	67 (72.80)	25 (27.20)	92 (100)	

DISCUSSION

Bangladesh has declared the elimination of dog- mediated human rabies deaths by 2030 as a national goal. This strategy for elimination is focused on dog vaccination, bite prevention education programs, establishment of a rabies surveillance system in domestic and wild animals, and prompt post-exposure prophylaxis (PEP) with rabies immunoglobulin (RIG) for humans with exposures to suspected rabid animals with a recent bite receives PEP.[14] In this study, about three fourths (72.20%) victims were male and more than one fourth (27.80%) were female. Similarly, Kumar et al reported 72.80% victims were male in their study. In my study, association between gender and measure taken after bite was not statistically significant (p=0.869).[15] In this study, majority, (37.40%) of the participants were in the age group of 21-35 years followed by 5-20 years 29.6% and majority (39.10%) of the participant were at primary level education followed by secondary and higher secondary level 1.7% respectively, 13.9% graduation and above and remaining 3.5% were illiterate. The mean±SD age was 33.61±15.305 years and majority (60%) of the participants were married and 40% were unmarried. Bhuiyan et al. reported 18 years of age and above years of age 60%. There was no significant association between age and measure taken after bite (p=0.082). Among 60% of the participants had no education or received at least primary education, around 30% had received secondary education and above and married participants were 49%. Association between marital status and measure taken after bite was statistically significant (p=0.004).[16] Considering types of exposure, majority (67.0%) were bites and the remaining (33.1%) of exposure was not bite related, and due to incidents, such as scratches, coming into contact with secretions from rabid animal. Similarly, Penjor et al reported 71% were due to bites and the remaining 29% of exposure was not bite related, and was due to incidents such as scratches, handling rabid animal carcasses or coming into contact with secretions from rabid animals.[17] Majority of the participants were bitten by dog 73.0% followed by cat 25.2%. Stray and pet animal were involved in 62.6% and 35.7% respectively. Similarly, Wani et al stated majority

(73.34%) of the patients had a history of dog bite, followed by cat bite 20.60%, history of dog bite (73.34%) followed by cat bite (20.60%) and others (6.03%) respectively, which is consistent with our study.13 Considering exposure circumstances, majority (53.0%) were unprovoked which is consistent with Pemunta et al stated that majority (64.7%) bites were unprovoked.[18] In this study, it was seen that highest number of injury (67.0%) occurred at morning and evening (from 6.00 am to 6.00 pm) and rest (33.0%) at night (6.00 pm to 6.00 am). Similarly, Charulatha et al reported that on analysis of exact cause of injury, it was found that unprovoked injury was more than half number of cases (53.0%) and remaining (47.0%) were provoked.[9] Considering current state of the animal after bitten, majority (80%) of the animal was alive, unknown (18.3%) and dead (1.7%). Islam et al assessed consequences of animal bite were alive (97.9%) dead (2.1%).[19] In this study, almost (73.9%) of the participants had taken measure and remaining (26.1%) of the participants had taken no action on being bit. Among (80.9%) of the participants had approached to ARV clinic directly, 13.0% through government set up and remaining 6.1% through private clinic. Ganasva et al studied that more than one third (37.6%) of the patients had taken no action on being bite. About 93.8% had approached to other health facilities before coming to the ARV clinic, like private clinic or Government health facilities.[7] Majority of the participants 90.6% followed self -washing method as a primary measure of the wound, 5.9% consulted to local pharmacy 2.4% followed indigenous source and remaining 1.2% went to traditional healer as a source of health care at the beginning. Kumar et al reported nearly half of the respondents 48.2% washed wound with soap and water initially after bite whereas 6.1% respondents did not wash the wound.[15] Majority (61.7%) of the respondents had knowledge about rabies and 38.3% had no knowledge about rabies. Among 61.7% those who had knowledge about rabies majority (93%) of them stated that the cause of rabies was bite of a rabid animal remaining 7% stated scratches exposed to saliva. Penjor et al reported (99%) of the respondents knew that rabies is transmitted from dog bites, 49% of the respondents believed that contact with secretions from a rabid animal over intact skin and touching of the animal 54% will transmit rabies.[17] In this study, majority (89.6%) of the participants faced no economic problem and remaining 10.4% faced economic problem. Majority (95.7%) participants faced no transportation problem and remaining 4.3% faced transportation problem. majority (93.9%) had a person to accompany and remaining 6.1% had no person to accompany. Wani et al. reported 8.5% lack of money, 1.5% lack of transport and 2.0% had no person to accompany.[13]

Limitations of the study

Sample size was not sufficient enough to generalized the findings. Possible recall bias by the animal bite victims. Due to the short data collection period were unable to explore seasonal variation of animal bite.

CONCLUSION

Animal-related injuries pose a major public health concern in Bangladesh, which ranks third globally for human rabies deaths, with 2,000–2,500 deaths annually over 95% caused by rabid dog bites. This cross-sectional study at the Infectious Diseases Hospital, Mohakhali, Dhaka, explored the pattern of animal bites and healthcare-seeking behavior among victims. Most bites occurred among males, middle-aged, urban residents, particularly students and businessmen. Dogs were the main biting animals, with the leg being most affected and most exposures classified as category 3. Nearly three-fourths sought treatment, and 90.60% washed the wound. Over 80% visited the ARV clinic directly, mostly within 24 hours. Literate and married individuals showed better awareness and timely healthcare-seeking behavior.

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Ethical approval: The study was approved by the Institutional Ethics Committee

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