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Original Research Article

Knowledge and practices on prevention of dengue fever among urban slum dwelling adults

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ABSTRACT

Background: Dengue fever is a fast-spreading mosquito-borne virus disease in the world and it has become the major global health concern, which are currently a burning public health issue in Bangladesh. This research evaluated the knowledge and practices on the prevention of dengue fever and examined factors associated with knowledge levels.
Methods: The study was a descriptive cross-sectional study on 346 adults in the Korail slum of Dhaka in January to December 2023. The survey was conducted through a face-to-face interview with the help of the pre-tested standardized and structured questionnaire and analyzed through SPSS. The predefined criteria that were used to calculate knowledge and practice scores. Using descriptive statistics, participant characteristics were compiled, and the relationships were assessed using Pearson's chi-square test.
Results: The present study revealed only 17.3% of the respondents being good in knowledge about dengue prevention. When it comes to practices, 57.8% had satisfactory preventive practices. Strong relationships were identified between level of knowledge and source of information given by health personnel, radio, books/newspapers, social media, and advertisements ($p<0.05$). Although the awareness is high, there are significant misunderstandings on transmission, breeding location and warning signs, which serve to highlight the existence of a knowledge-practice gap.
Conclusions: Urban slum dwellers were also lacking in correct knowledge and preventive measures. Formal sources of information enhanced understanding and it should be mentioned that specific health education and community-based intervention are necessary to decrease the risk of dengue.

Keywords: Knowledge, Practice, Prevention of dengue fever, Urban slum, Adults

INTRODUCTION

Dengue fever is a speedily spreading mosquito-borne viral illness in the world, and it has turned into the primary worldwide health issue of concern. The World Health Organization (WHO) determines dengue to be endemic in over 100 countries most typically in the tropical and subtropical regions and almost half of the

whole population globally is at risk of being affected.[1] Over the recent decades, dengue has been rising at an alarming rate in the world because of the rapid urbanization, population explosion, climate change, human mobility and poor control of vectors. WHO approximates that in the world about 390 million dengue infections rise each year, a significant percentage of which lead to clinical disease.[1,2]

Asia carries the greatest dengue burden of almost 70 percent of all world risks of the disease.[1] South and Southeast Asian countries often have seasonal epidemics especially during the monsoon and post monsoon seasons where the environment supports breeding of Aedes mosquitoes.[3] The growth of dengue transmission has been caused by rapid and unplanned urbanization, inefficient waste management systems, water storage and dense population in most Asian cities.[4] Moreover, changes in climate and the development of temperatures have enhanced the geographic range and the seasonal spread of dengue vectors in the region.[5]

The level of incidence of dengue in Bangladesh has been increasing significantly in the last 20 years, thus making the disease an emerging health hazard. The incidence and magnitude of the dengue epidemics have increased since the first major outbreak in 2000, and seasonal dengue outbreaks are reported every year.[6] The largest outbreak took place in 2019, when over 100,000 cases were reported, and the death toll was high, with even more massive outbreaks in the following years.[7,8] Over the last few years, Bangladesh has been reporting historic cases and deaths due to dengue, and this raises awareness of the repetitive and increasing trend of the issue.[9] Bangladesh this is based on the capital city of Dhaka which has turned out to be the epicenter of dengue transmission. Dense population, accelerated urbanization, poor drainage systems, poor waste disposal, and mass storage of water have provided favourable breeding conditions to Aedes mosquito.[8,10] The fact indicates that the rate of the hospitalized dengue cases is the highest in Dhaka, and the outbreaks in the city usually lead to the further distribution of the disease to other regions of the country.[8]

Urban slum dwellers are likely targets of dengue infection because of their poor living conditions, over crowdedness, low access to safe water and low access to sanitation services. It is estimated that a significant portion of the population in Dhaka is living in informal settlements where water is often kept in open vessels, waste items are found lying around and sometimes not properly managed in the environment: all these conditions encourage the proliferation of Aedes mosquitoes.[11,12] Knowledge of community and preventative actions are key elements of the control of dengue disease, particularly in the absence of specific anti-viral treatment and predomination of vector control as a primary preventative strategy. The individuals must understand the breeding areas of the mosquitoes and how to manage and prevent the breeding of the mosquitos as well as how to conduct themselves to prevent the spread.[1,4] In turn, the evaluation of the situation of knowledge and preventative behaviour of the high-risk groups like the population of the urban slums have the paramount role in the development of the suitable community-based interventions and preventive policies in the sphere of the population health.

This research endeavors to assess the degree of information and awareness of prevention of dengue activities among adult inhabitants of urban slums in Dhaka, Bangladesh. The results obtained in the course of this research should contribute to the existing literature on the topic and will facilitate the development of special awareness campaigns and other vectors-control programs by policymakers and health officials to serve vulnerable groups.

METHODS

Study design and setting

The study was carried out as a descriptive cross-sectional research study of 346 respondents in the Korail slum of Mohakhali, Dhaka, 2012. They were recruited in diverse environments, such as residential families, local bazaars, and government institutions, to ensure that they would get data from a heterogeneous group in the slum environment. The study period was one year from 1st January to 31st December 2023.

Study population and eligibility criteria

The study included male and female adults (18-60 years old) living in Korail Slum, Mohakhali, Dhaka, for a period of at least 2 years and were accessible in the data collection period were included in the study, and provided informed consent to participate. Those who did not consent to participate or were not able to give informed consent were excluded.

Data collection techniques

Data collection was done using convenience sampling; a face-to-face interview was conducted with the participants. As far as possible, we clarified the study details to every respondent and had them sign an informed consent.

Data analysis

In this study, data collection and processing were explained and analyzed according to the objectives and variables by IBM software SPSS. Descriptive statistics: frequency, percentage, means, and SD (standard deviation) were used to describe socio-demographic characteristics and selective attributes of the respondents. Inferential statistics: Chi-square test at 5% level of significance were performed because it was necessary to see association and statistical significance between the independent variables and dependent variables. The p value of less than 0.05 was taken to be significant.

The answers were divided into three (3) categories- "yes," "no," and "do not know" - in order to calculate the score for the knowledge-related questions. The right response to each knowledge question was scored as 1, while the wrong response and "don't know" were marked as 0. Those with a total score of 8 or higher were regarded as having strong knowledge; the score ranged from 0 to 11. The final section consists of practice questions with responses divided into two groups: "yes" and "no." The codes for "yes" and "no" were 1 and 0, respectively. As a result, the total ratings varied from 0 to 10, with a score of 6 or higher indicating appropriate preventive practice.[13]

Ethical considerations

The local authority gave permission, a written informed consent was made to respondents, and information that will be collected will be published to facilitate research and technical use without giving the name and address of the respondents. Throughout the study, individuals were allowed to leave at any moment. No physical and mental harm would be applied to the respondents, and the study assured them that this would be so since no invasive procedure would be applied.

RESULTS

Table 1 describes the socio-demographic characteristics of the 346 participants. The study population was predominantly male, with females representing a smaller proportion. The largest group of participants belonged to the 26–45 years age category. The mean (±SD) age of the respondents was 35.5±10.6 years. Regarding educational status, a large proportion of the participants were illiterate. In terms of occupation, nearly half of the respondents were involved in labor work. The mean (±SD) monthly family income was Tk. 14,208±2,922.68. With respect to health history, the majority of the respondents reported that they had never been infected with dengue (Table 1).

Table 1: The participants' sociodemographic attributes (n=346).

Characteristics		Frequency (f)	Percentage (%)
Gender	Male	253	73
	Female	93	27
Age (years)	18-30	133	38.4
	31-45	155	44.8
	46-60	58	16.8
	Mean±SD	35.5±10.6	
Education	Illiterate	154	44.5
	Primary	127	36.7
	Above primary	65	18.8
Occupation	Unemployed	40	11.6
	House wife	88	25.8
	Labor	168	48.6
	Small business	24	6.9
	Service holder	26	7.5
Monthly family income (in Dhaka)	<10000	52	15
	10001-15000	148	42.8
	>15001	146	42.2
	Mean±SD	14208±2922.68	
Dengue infection	Infected	31	9
	Not infected	315	91

Table 2: The respondents were distributed according on their answers on their level of dengue fever knowledge (n=346).

Statements	Yes		No		Do not know	
	(F)	(%)	(F)	(%)	(F)	(%)
Dengue fever is caused by female aedes mosquito bite	288	83.2	0	0	58	16.8
Dengue fever is a normal flu or viral disease	36	10.4	7	2.0	303	87.6
Dengue fever outbreak starts in the rainy season	315	91	1	0.3	30	8.7
Female aedes mosquito could breed in dirty/clear stagnant water	302	87.3	0	0	44	12.7
Female aedes mosquito could breed through discard objects containing water	269	77.7	0	0	77	22.3
Aedes mosquito likes to bite early in the morning and late	238	68.8	4	1.2	104	30.1

Continued.

Statements	Yes		No		Do not know	
evening						
Dengue fever can be spread from one infected individual to another	56	16.2	76	22	214	61.8
Dengue fever can be spread by sharing utensils and clothes of an infected individual	43	12.4	79	22.8	224	64.7
Common symptoms of dengue infection are high fever, rash, cold, headaches, muscle pain and nausea	266	76.9	2	0.6	78	22.5
Warning signs of dengue infection is bleeding from the nose or gums	18	5.2	8	2.3	320	92.5
Paracetamol is used in dengue infection	332	96	2	0.6	12	3.5

Table 3: Distribution of the respondents according to their response regarding preventive practices of dengue fever (n=346).

Statements	Yes		No	
	(F)	(%)	(F)	(%)
Do you use a mosquito bed net?	181	52.3	165	47.7
Do you use a mosquito repellent coil?	133	38.4	213	61.6
Do you use a mosquito repellent spray?	7	2	339	98
Do you use a fan to reduce mosquitoes?	334	96.5	12	3.5
Do you practice covering water containers at home?	316	91.3	30	8.7
Do you keep the tubs clear and drain the stagnant water?	290	83.8	56	16.2
Do you use screen windows to reduce mosquitoes?	45	13	301	87
Do you maintain the proper disposal of garbage?	234	67.6	112	32.4
Do you examine any discard things/objects that con hold water around your house?	305	88.2	41	11.8
Do you keep neat and clean surrounding?	281	81.2	65	18.8

Table 4: Respondents' distribution based on their informational sources on dengue fever (n=346).

Source of information	Frequency (f)	Percentage (%)
Health personnel	88	25.40
TV	324	92.80
Radio	7	2.00
Books or newspaper	36	10.40
Social media	122	35.30
Family and friends	335	96.80
Advertisement/billboards	14	4.00

*Multiple response

Table 5: Relationship between respondents' sources of information and their level of dengue fever knowledge (n=346).

Sources of information	Response	Level of knowledge regarding dengue fever			Chi-square test (p value)
		Good knowledge	Poor knowledge	Total	
		F (%)	F (%)	F (%)	
Health personnel	Yes	27 (30.7)	61 (69.3)	88 (100)	P<0.001*
	No	33 (12.8)	225 (87.2)	258 (100)	
Television	Yes	57 (17.8)	264 (82.2)	321 (100)	P>0.464
	No	3 (12)	22 (88)	25 (100)	
Radio	Yes	5 (71.4)	2 (28.6)	7 (100)	P<0.001*
	No	55 (16.2)	284 (83.8)	339 (100)	
Books or newspaper	Yes	18 (50)	18 (50)	36 (100)	P<0.001*
	No	42 (13.5)	268 (86.5)	310 (100)	
Social media	Yes	31 (25.4)	91 (74.6)	122 (100)	P<0.003*
	No	29 (12.9)	195 (87.1)	224 (100)	

Continued.

Sources of	Response	Level of knowledge regarding dengue fever			Chi-square
Family and friends	Yes	59 (17.6)	276 (82.4)	335 (100)	P>0.463
	No	1 (9.1)	10 (90.9)	11 (100)	
Advertisement/ Billboard/ Banners	Yes	8 (57.1)	6 (42.9)	14 (100)	P<0.001*
	No	52 (15.7	280 (84.3)	332 (100)	

*Statistically significance

Figure 1 illustrates the level of knowledge regarding dengue fever among the 346 respondents based on 11 knowledge-related questions. A total of 286 respondents obtained a score of 7 or less and were categorized as having poor knowledge. In contrast, 60 respondents scored between 8 and 11 and were classified as having good knowledge about dengue fever (Figure 1).

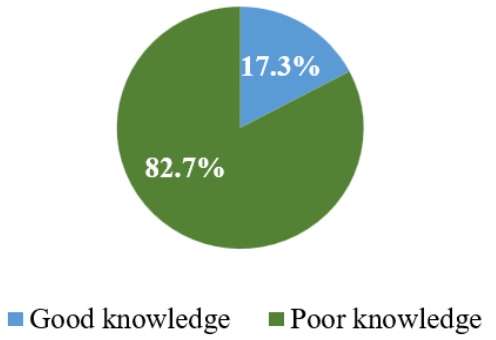


Figure 1: Distribution of the respondent's according to their level of knowledge regarding dengue fever (n=346).

The findings of the current research revealed that most of the respondents did not know that dengue fever is transmitted by the bite of a female Aedes mosquito; a relatively small number of respondents did not know the name of the mosquito that transmits dengue fever. Many of the respondents were not sure what dengue fever is and could not determine whether the condition is common flu or a viral disease. Most of the participants revealed that dengue outbreaks tend to start during the rainy season. Though nearly all the respondents had heard about dengue fever, most of them were still deficient in essential information about dengue fever. There were also misperceptions, especially on the breeding places of the dengue vector. This is because many of the participants thought that dirty or polluted water, e.g., sewage drains, are the main breeding sites of the dengue mosquitoes. The majority of the respondents also indicated that the female Aedes mosquitoes have the ability to breed in stagnant and clean or dirty water. Besides this, a high percentage of participants were aware that abandoned items that could hold water could be breeding places of these mosquitoes (Table 2).

Table 3 presents the distribution of respondents according to their practices related to dengue prevention. Regarding personal protective measures, more than half of the participants reported using mosquito bed nets, while a considerable proportion used mosquito repellent coils. Only a very small number of respondents reported using mosquito repellent sprays. Almost all participants reported using electric fans at home as a method to reduce mosquito presence. In addition, the majority of respondents stated that they regularly covered water storage containers to prevent mosquito breeding. Most participants also reported cleaning household tubs and draining stagnant water. However, only a small proportion of respondents had window screens installed in their homes. A large proportion of participants reported maintaining proper garbage storage and disposal practices to reduce potential mosquito breeding sites. Most respondents also said that they frequently checked abandoned items or containers in the area around their homes that could contain water, including cans, buckets, or stored water in the yard. Also, the majority of the respondents said that they had a neat and clean home set up. When it came to reducing their risk of contracting the dengue virus, over half of the participants (57.8%) reported following preventive measures. However, a sizable portion (42.2%) had inadequate preventive measures (Table 3). The distribution of the information sources on dengue fever among the respondents is depicted in table 4. The most frequent source of information was recognized as the family members and friends, then television. The importance of social media as a source of information on dengue was also reported by a significant percentage of the respondents. A minority of respondents had a population composition that they had communicated with health personnel. Only a limited number of participants reported newspapers as a source of information, while very few mentioned advertisements or billboards. Radio was the least reported source of dengue-related information among the respondents.

Table 5 presents the relationship between the level of knowledge about dengue fever and the information sources of respondents (n=346). There was a statistical significant value between good knowledge and information received by health personnel ($p<0.001$), radio ($p<0.001$), books or newspapers ($p<0.001$), social media ($p=0.003$), and advertisements/billboards ($p<0.001$). Nonetheless, television ($p>0.464$) and family and friends ($p>0.463$) did not show any significant correlation. In general, formal and structured sources of information were significantly related to more knowledge about dengue fever.

DISCUSSION

This research paper has investigated the information sources on dengue fever and their relationship with the

level of knowledge of people living in the urban slum areas. The results indicated that the most frequent sources of information were family members and friends (96.8%) and the television (92.8%). These, however, were not the sources that were significantly linked to good knowledge ($p>0.05$), and that implies that though informal networks and mass media have far-reaching, they may not offer the much-needed detailed and accurate information to improve overall understanding. Likewise, community-based research has established similar results, according to which exposure to mass media was not enough to ensure sufficient knowledge, unless it was accompanied by formal education.[14]

In contrast, formal sources such as health personnel, radio, books or newspapers, social media, and advertisements showed statistically significant associations with good knowledge ($p<0.05$). Participants who received information from health personnel demonstrated better knowledge, emphasizing the credibility and effectiveness of professional guidance. The World Health Organization highlighted that direct communication by trained health workers improves community understanding and disease prevention practices.[15] Furthermore, social media was significantly associated with knowledge ($p=0.003$), reflecting the growing importance of digital platforms in public health communication. Chan et al noted that evidence-based information disseminated through social media can substantially enhance public awareness.[16]

Conversely, formal sources including health personnel, radio, books or newspapers, social media and advertisements were statistically significant with good knowledge ($p<0.05$). The respondents that were informed by health workers showed higher levels of knowledge focusing on the degree of trust and efficacy of professional advice. The World Health Organization also pointed out that face-to-face communication via trained health workers enhances understanding of the community and disease prevention behavior.[15] Moreover, knowledge was connected to social media considerably ($p=0.003$), as digital tools become increasingly relevant in communicating about public health. Chan et al observed that evidence-based information provided on social media has the potential to improve the awareness of the population to a significant extent.[16]

The current investigation showed that most of the respondents were poorly aware about dengue fever yet most of them were aware of the disease. Although a high percentage of them were able to identify the role of the female Aedes mosquito and the season when dengue took place in the rainy season, significant gaps and misinformation were identified. Many of the participants did not know how dengue is transmitted and instead had the misguided notion that dengue can be transferred by sharing utensils, or clothes. The same results have been observed in prior community-based surveys that found the lack of knowledge regarding the transmission of dengue in the presence of general awareness.[17] The myths can have adverse impact on prevention practices in the susceptible societies.

Most of the respondents were aware of stagnant water as the breeding site, but the most common misconception was that dengue mosquitoes breed in dirty water, yet Aedes mosquitoes are the principal breeders in clean stagnant water.[15] Awareness of warning signs was especially low and the majority of respondents could not recognize bleeding as one of the signs of danger. It is necessary to identify warning symptoms early to prevent severe complications and timely treat them.[18] These data suggest that even with high awareness, there is still no in-depth knowledge on dengue, which means that the targeted health education initiatives about the transmission, breeding habitats, and warning signs are required to enhance the practice of dengue prevention.

The current research established that despite the large number of preventive measures that were widely used by the urban slum residents towards dengue fever prevention, there are still gaps in the overall prevention practices. Over half of the respondents said they used mosquito bed nets and took general preventive measures, whereas such practices as applying repellent sprays and installing window screens were relatively low showing that the respondents partially but not sufficiently followed effective protection measures. These results are consistent with the earlier studies, which indicate that the population of the low-resource urban areas tends to use the simplest household activities such as covering water containers and ensuring environmental hygiene but exhibits a low adoption of more sophisticated preventive measures because of the financial barrier or lack of awareness.[18,20] Also, the relatively high percentage of respondents who had poor preventive strategies implies that, there are still gaps in knowledge-practice, and specific health education and community-based interventions should be provided. Other researchers have emphasized that dengue prevention practices among vulnerable communities can be improved through better awareness initiatives and control programs on vectors.[19] Thus, health promotion strategies and access to preventive resources should be reinforced in order to improve the dengue prevention practice of the communities residing in urban slums.

Limitations

There are some limitations in this study. First, it was done within one slum area and the convenience sampling process could have led to selection bias and restricted generalizability of the results. Second, cross-sectional study design only gives a snapshot of study population and cannot draw causal inferences. Thirdly, the answer to the closed ended structured questionnaire and data collection through the interviewer might have caused some response and interviewer bias. Finally, the results might have been more representative if the study had

been conducted at more study sites and with a larger sample size.

CONCLUSION

This research assessed the knowledge and preventive measures in dengue among urban slum dwellers and found that there is a stark difference between the knowledge and the correct interpretation. Despite the fact that the majority of the respondents had heard about dengue, many did not possess the right information on how to transmit the disease, the breeding places of mosquitoes, and serious symptoms, and misconceptions about the disease were still widespread. Although measures such as covering water containers and other basic measures were used, more effective methods as repellents and window screens were not utilized. The informal sources of information were prevalent, yet less credible, though formal sources were associated with superior knowledge. The results highlight the importance of specific health education and community-based interventions to enhance the correct knowledge and enhance dengue prevention among the vulnerable groups.

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