The Editorial

CONDUCTING GLOBAL ADULT TOBACCO SURVEY (GATS) USING DIGITAL TECHNOLOGY IN BANGLADESH

Tobacco is one of the leading causes of death worldwide. These deaths are preventable. Three-quarter of the tobacco users live in 15 countries, Bangladesh being one of them. Bangladesh identified tobacco epidemic as one of its important public health problems. In response, it has enacted the tobacco control law in 2005 and formulated its rules in 2006[1]. National Strategic Plan of Action for Tobacco Control, 2007-2010 has been developed and implemented with technical assistance from WHO[2]. Some visible progresses have been made in tobacco control in Bangladesh in spite of poor enforcement of the law by the authority. However, public in general (and non-smokers in particular) have supported this law and socialized this by means of protests and requests. Public etiquettes have improved regarding smoking in public places and transports.

A recent study conducted by WHO all over the country indicates that 37 percent of people aged 15 years and above use tobacco in any form, smoking or smokeless. In 2004 tobacco use attributed to 57 thousand deaths. Bangladesh incurred a net loss of 2,600 crore Taka in that year[3]. Generation of evidences at regular interval in standardized manner is needed for policies and programmes. Community interventions aided by cessation support has already been proved to be effective in Bangladesh[4].

For global comparability, data collection using similar approach through out the world is needed. Bloomberg Philanthropies New York, USA came forward to support the tobacco free initiatives taken by WHO and other organizations. With this financial support CDC Foundation and WHO initiated as survey entitled Global Adult Tobacco Surveys (GATS) to monitor global tobacco use among adults. Bangladesh is a part of this initiative to determine the prevalence of tobacco use among general population aged 15 years and above. The second objective was to strengthen the capacity of national institutes to conduct studies in future. Therefore a huge investment has been done in developing the electronic tools and establishing systems of digital survey. This is a real example of digitalization of Bangladesh in line with current Governments commitment to the people.

Steering and technical committees were formed to guide the study. The implementing agency of this study is the National Institute of Preventive and Social Medicine (NIPSOM). Collaborating organizations are Bangladesh Burea of Statistics (BBS) and National Institute of Populations Research and Training (NIPORT). Investigators were drawn from NIPSOM and Bangabandhu Sheikh Mujib Medical University (BSMMU).

Bangladesh Bureau of Statistics has traditionally been using mouja (in rural) and mahalla (in urban areas) as primary sampling units. Four hundred (200 urban, 200 rural) PSUs are

used for GATS. BBS updated the mapping and listing of these 400 randomly selected Primary Sampling Unit (PSU) throughout the country. Enumerators have collected data using iPAQ (a PDA), then transferred data to their supervisors' laptop computers through SD card. It is important to note that female enumerators interviewed females and male interviewers interviewed males (see pictures). The supervisors sent the data to central FTP server established in NIPSOM daily by email using EDGE modems. NIPORT has worked as an independent quality control agent. Beside the quality control done by NIPORT, there were regular quality control checks from NIPSOM investigators and WHO technical officers. BBS officials assisted the field force to in resolve any problem related to the mapping and listing. Therefore it was feasible to successfully complete data collection even in remotest part of the country. The detail of the study and its findings will be released in Dec 2009.

This is the first ever countrywide study in public sector using electronic means. Bangladesh has proved its capability to be one of the champions in this field once again. Rigorous training with active participation of CDC Foundation and WHO, monitoring field implementation, involvement of multiple partners and above all commitment of the Ministry of Health and Family Welfare made this challenging task possible.

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3. Zaman MM, Nargis N, Perucic AM, Rahman K (eds). Impact of Tobacco-related Illnesses in Bangladesh. SEARO, WHO New Delhi 2007.
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