**Health Information Seeking Behaviour Study in Bangladesh: Household Survey**

To explore the role of ICTs in health information seeking, the UK Institute of Development Studies (IDS) and the International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) jointly conducted a household survey during March to May 2014 in three locations of Bangladesh; Chakaria (a rural sub-district), Mirzapur (a peri-urban sub-district) and Dhaka (five largest slums of the capital city). In the absence of prior variance estimates of the outcome variables,[[1]](#footnote-1) a value of 0.5 (the maximum for dichotomous variables) was used to calculate the required sample size to obtain 95% confidence limits with a precision of ±10%, assuming a design effect of 2. This implied a sample size of 840 households for each location, allowing a 5% buffer for the probable non-response rate.

In the rural and peri-urban sites (Chakaria and Mirzapur), the sample was selected using systematic cluster sampling from pre-existing frames (Health and Demographic Surveillance Sites). For each location, the 840 households were selected from 28 villages (30 households/village). In Dhaka, three slums were randomly selected from the six largest in the city. Using household lists, 10 locations were selected in each slum and 28 households sampled from each location using systematic sampling.

In the majority of cases (over 81%) information was gathered from the head of the household or the spouse of the head. Where this person was not present or unwilling to respond, the respondent was usually an adult child of the head or the spouse of a child. The sampling at household level was designed to produce a sample which obtained data from twice as many women as men.

The survey questionnaire was devised on a web based application developed by icddr,b. This runs on both Windows and Android platforms and has two components: the front-end (or user interface), and back-end (or administration database). The former was used both for data collection and management while the latter was exclusively used for data management. The questionnaire was developed both in Bangla and English, with the Bangla version used for data collection in the field. To minimize errors, the questionnaire incorporated both skip logic and conditional branching. The questionnaire was tested in two sites; a slum in Dhaka and a peri-urban residence in Savar (a sub-district under Dhaka). During the field test, both the overall quality of the questionnaire and effectiveness of the electronic version (on android based 7 inch tablets) were assessed and the questionnaire revised where necessary. Based on the final version, a detailed codebook explaining the questions and associated response categories and codes was created.

A team of 14 trained researchers (one supervisor, ten enumerators, a quality controller, a data manager and a technical support officer (to troubleshoot application issues) collected data from March to May 2014. The team used 11 standard android tablets (7 inch) to which the mobile version of the questionnaire was uploaded. It took four days to approve/finalize each day’s collection. The electronic questionnaire was equipped to store collected data locally on the tablet. However, the field team was instructed to upload the collected data to an assigned server (located centrally at Dhaka office) at the end of each day. As soon as the syncing process was completed, stored data was automatically removed from the tablet. The next day, a data management team (located centrally) randomly selected 5 to 10 questionnaires and emailed identifiers to the supervisors and the quality controller to recheck the collected data. At the end of day 3, the supervisor uploaded the rechecked data into the server and on day 4 the data management team updated the data to the main database. For synchronization, although the central team could use a dedicated WiFi based internet connection, the field team used the mobile phone network if WiFi was not available.

1. A. Socio-demographic characteristics (descriptors that capture access to resources, gender and education etc.); B. Access and use of ICT (drawn from other studies of ICT use to be able to relate the findings for wider applicability); C. Access and use of social networks and awareness of health messaging (draws on surveys conducted around these subjects); and D. Intra-household decision making regarding health information seeking (hypothetical scenario as well as actual experience of health information seeking) [↑](#footnote-ref-1)