

Sex, Gender and Health Seeking Behaviour Determinants

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Abstract : *There is a growing literature on gender and health seeking behaviour both in the context of developed and developing countries. This paper presents an extensive review of literature which delineates the concept of gender and other socio-economic factors responsible for shaping up health seeking behaviour in these countries. After reviewing the results of various researches, it can be seen that there are more or less differences in health seeking behaviour between men and women throughout the world. However, because of the traditional social system of developing countries including Bangladesh, the status of women is relatively lower than that of men, and this influence also can be noticed in their health and illness behaviour. These women lag behind men in education, and income generating activities, and as well as their health evaluation, health expenditure and access to healthcare services. Besides, women are more prone to self care at home, delayed treatment and taking the advice of quacks. On the other hand, women in developed countries tend to be more conscious about their health, even though their functional health is worse than that of the men. Although the men of these countries are better at maintaining in social network than women, they are more risk taker such as smoking and drinking. Overall, the differences between men and women in health and illness behaviour are clearly evident in all countries irrespective of their development. But it is to be mentioned here that it is possible to reduce these differences by elevating the social status of women through education and income.*

Keywords: Health; Illness; Sex; Gender; Health Seeking;

Introduction

The difference between gender roles is significant in the patterns of health-seeking behaviour between men and women (Verbrugge, 1985). Gender roles are significant in influencing the decision making process associated with health-seeking behaviour. Differences in the way society values men and women and accepted norms of male and female behaviour influence the risk of developing specific health problems as well as health outcomes. Sex and gender affects risk-taking behaviour, exposure to risks and health-seeking behaviour; it also determines the degree to which women and men have access to and control over the resources and decision-making needed to protect their health. The results can be inequitable patterns of health promotion, health risk, access to health services, use of health services and health outcomes.

There have been considerable improvements in the world's health during the twentieth century. The health of the population has undoubtedly improved but what the aggregated data fails to show us is whether the improvement has been uniform across social groups and geographical regions (Clarke, 2001). Health related behaviour is one of the most important factors behind inequalities in health and gender difference. Gender relates to

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culturally appropriate behaviour of men and women, whereas sex refers to biological difference (Gabe et al., 2004). Gender is a socially constructed difference between men and women. Patterns of health and illness in women and men show marked differences. It has been widely confirmed by representatives' studies that women live longer than men, but they experience poorer health, have more health problems and use more health care services than men (Blaxter, 1990; Gee and Kimball, 1987; Verbrugge, 1989; Rodin and Ickovics, 1990). This paradox has attracted considerable research interest in past decades (Parslow et al., 2004).

Throughout the developing nations, girls and women often spend long hours in heavy labour and, in many nations, they receive less nutrition than do boys and men. In addition, girls are less likely than boys to be immunized against diseases, to receive health care when ill, and to receive health care promptly (Messer, 1997). Even in rich countries like the United States, poor women find themselves without access to health care more often than men from the same social group (Krieger and Zierler, 1995; Zierler and Krieger, 1997). In addition to these economic, social and cultural obstacles, the emotional and cognitive capacities of women themselves may limit their health-oriented activities (Papanek, 1990). Past research has established that socio cultural factors influence health related behaviours (Corin, 1994; Wilkinson, 1994). Measures of socio economic status (education, occupation, income) provide evidence of their differential effects on health and illness behaviour of men and women. Women are mainly engaged in private sphere while men work in public sphere (Bonilla and Rodriguez, 1993). Compared to men women have limited cash money which lead them to cope with illness. In most cases men are breadwinner as well as decision maker of households, making women dependent on men for accessing health services.

In almost all cultures and settings around the world and across social groups, women have less access to and control over resources than most men, and are denied equal access to facilities like health and education (UN DESA, 2009; WHO, 2009; World Bank, 2011). Gender based differences in access to or control over resources, in power or decision making, and in roles and responsibilities, have implications for women's and men's health status. This paper reviews a large number of studies on the determinants of health seeking behaviour and its relationship with gender from the perspectives of both developed and developing countries. It also provides an overview on gender inequalities in health seeking behaviour in Bangladesh.

Understanding Health Seeking Behaviour

The concept 'health seeking behaviour' has gained popularity for many years in medical sociology, medical anthropology, social epidemiology, social psychology and health education as an important vehicle for exploring and understanding decision making process and health-related actions across a variety of health conditions. The term is used interchangeably with health seeking and is described as part of both illness behaviour and health behaviour. Health-seeking behaviour consists of two components, that of health behaviour and illness behaviour (Joseph

and Phillips, 1984). People engage in various activities to prevent or eliminate illness and try to maintain a healthy body. Kasl and Cobb (1966) suggest that the activity undertaken by a person who believes himself or herself to be healthy for the purpose of preventing health problems is called health behaviour. In its widest sense, health behaviour includes all those behaviours associated with establishing and retaining a healthy state, including aspects of dealing with any departure from the state. It includes the behaviour of people to seek control over disease as well as the activity to achieve a positive body image. This means the primary goal is to look and feel good, rather than to be healthy. To lead a healthy life and to avoid health risks people adopt many health measures. Indeed different people have different habits and health measures. These habits are determined by his or her socio-economic status, ethnicity, socialization process and other factors that shape their lifestyle.

Health lifestyles include contact with physicians and other health personnel, but the majority of activities take place outside the healthcare delivery system (Cockerham, 2004). As part of the lifestyle for the preservation of health, people adopt many health measures such as doing exercise, having healthy diet, ensuring sufficient sleep, giving up or moderating smoking and drinking habits and so on. Leisure activities like relaxation, gardening, games, walking can all be viewed as health measures. Personal hygiene like brushing teeth, bathing are also treated as health measures. Consumption of vitamins and tonics is considered as a popular measure for ensuring good health. In addition, there are many preventive health measures which include regular health check-ups, visit to dentists, vaccination, ante-natal examination and so on.

Illness is an unavoidable fact of life; sooner or later everyone experiences illness. In a general sense, illness behaviour refers to the way in which people define and interpret their symptoms of illness and the action they take in seeking help. Kasl and Cobb (1966) conceptualize illness behaviour as to the ways in which individuals with ill health define their state of health and the activities they do in hope of getting well. By this definition illness behaviour is conceptualized as how individuals define their state of ill health and the activities they do for relief or getting well. Illness behaviour refers to the varying ways individuals respond to bodily indications, how they monitor internal states, define and interpret symptoms, make attributions, remedial actions and utilize various sources of informal and formal care (Mechanic, 1995). Folkman and Lazarus (1980) explained illness behaviour as tendency to seek or avoid medical care for symptoms or to exaggerate or undertake their importance. Illness behaviour is much more complex with many factors influencing decisions to seek medical help. According to Cockerham (2004: 118), some people recognize particular physical symptoms such as pain, a high fever, or nausea or seek out a physician for treatment; other with similar symptoms may attempt self medication or dismiss the symptoms as not needing attention. To the ill individual, illness can be perceived as a purely internal and personal experience. But illness is also a social phenomenon, with social roots and social consequences (Weitz 2004).

Health Seeking Behaviour: Theory into Action

The study of health-seeking behaviour is relatively new field in social sciences. Traditionally biomedical model defines health simply as 'the absence of disease'. In contrast, social scientists believe that body is not treated as a self-enclosed machine rather health and illness are understood in their social and cultural context. This view has gained popularity in the last few decades. A biomedical approach essentially tests health and illness from the biological perspective, whereas social scientists relate health and illness with socio-cultural and psychological factors. Thus, in recent years the social determinants of health has received more attention from the discipline of medicine and public health and there has been more interdisciplinary research on health.

Health and treatment-seeking behaviour models which emerged from social psychology, medical sociology and medical anthropology allow for considerable extension to understand the determinant factors in relation to an individual's knowledge attitudes and practices (KAP). In public health, probably the most utilised models from social psychology are the Health Belief Model (HBM), the Theory of Reasoned Action (TRA) and its later development to the Theory of Planned Behaviour (TPB). Most known from medical sociology and medical anthropology are, respectively, the Health Care Utilization or Socio-Behavioural Model by Andersen and its diverse posterior variations, and the Decision Making Model. All models contain associations of variables which are considered relevant for explaining or predicting health-seeking behaviours. Models of health seeking behaviour are still debated, but the growth of operational research into health service delivery has sponsored a more pragmatic approach to the area. In recent years the dichotomy of the "qualitative" versus "quantitative" approach has been in part superseded at the level of measuring health seeking behaviour by a combined approach. The different models of health seeking behaviour can be studied to produce a broad framework to inform investigation and intervention, particularly in the context of looking at use and non-use of "modern" medical services in developing countries.

Health Seeking Behaviour: Perspective from Developed Countries

In an extensive US study,Meininger (1986) noted gender differences in illness behaviour regarding the tendency to respond to their symptoms. This was found during the process when medical care, lay consultation or self treatment were required. The study used data from a household survey in an urban Fort Wayne area of Indiana which revealed sex differences in the behavioural responses to symptoms. More specifically, significant differences between men and women were found in relation to their social class and response to medical care or lay consultation. The study showed that men of higher social classes were more likely to use medical care, whereas, among women, those in higher social classes were more likely to use lay consultations.

The study by Meininger (1986) also reported that women who rated their symptoms very serious and were highly uncomfortable visited a physician, while those worried about their symptoms sought lay consultations. Some similarities between the sex groups were

also found in this study. Both believe that a doctor could do something to relieve the symptoms. Apart from that numbers of days of disability were positively related to use of medical care for both men and women. Similarly, duration of the symptoms episode negatively related to use of physician services for both men and women. Besides, employment status, number of children and age of the youngest child did not have significant effects on illness behaviour of men and women. However, the data support the view that the presence of children in the home had a significant effect on men but not women treatment seeking behaviour. Although this study aimed at investigating the differences between men and women in the use of medical care or alternative services, it excluded some vital factors of the respondents, such as their level of education, socialization process that could influence illness behaviour. Moreover, the sample of the study was drawn from white families, therefore the findings may not be generalized for all ethnic groups living in USA.

Prus and Gee (2003) have produced evidence from Canada for the determinants of health. In their study the authors found that the factors determining health can be seen in health seeking behaviour of elderly people. This study used data from the cross-sectional household component of the 1994-1995 National Population Health Survey (NPHS) in Canada, and found that men significantly higher levels of income, education, smoking and financial stress compared to women. Conversely, other social factors were significantly higher among women, such as higher levels of social supports and personal stress. The study demonstrates clearly that though women have poorer functional health, they rate their health more positively than men. Income and education played an important role in rating self-rated health. The study showed that there is a strong positive relationship between income and health for older women than older men. One noteworthy aspect of the study is that social support has a beneficial effect on health for older women.

A recent study (Tolliver 2007) examined the factors associated with perceived health of adults living in Colorado, USA. The study collected data from 5,979 respondents through interview. The researcher found that the majority (87.3%) of Coloradans enjoy good to excellent health. However, the findings of the study support the poor self rating health is related to lower socioeconomic background of women who tend to view their health status in a negative manner than men from lower socioeconomic background. The study also revealed that married and never-married women reported higher health statuses more often than those who were divorced, separated, or widowed.

There is abundant evidence of correlations between gender and quality of life. Guallar-Castillon et al. (2005), for example, in a cross-sectional study of older people in Spain, found that quality of life varies across gender. Their study was conducted between October 2000 to February 2001 through home-based personal interview, which reveals that women have substantially worse health compared to men. To measure the quality of life across gender, the authors used a range of indicators, such as socio-demographic factors, lifestyle, social network, chronic morbidity and use of healthcare services. The data show that women less likely to engage in paid work, live alone and have lower level

of education. Assessing the degree of social network, it was found that men maintained good social relationship and frequently visited friends and neighbours, whereas women mostly lived alone. Lifestyle factors also varied between men and women. The rate of smoking and consumption of alcohol is significantly higher among men than women. Reflecting on the issue of health and treatment seeking behaviour, the authors noted that women take more medications; more frequently use primary care services and present with a higher number of chronic diseases than men.

Lahelma et al. (1999) have produced evidence from Finland to report the gender differences in ill health. The study examined the patterns and magnitude of gender differences across various indicators of ill health and the changes in the patterns and magnitude of gender differences. It also assessed whether social determinants, such as age, region, socioeconomic status, employment status, parental status, family status and family and friendship relations, have any bearing on the patterns and magnitude of observed gender differences in ill-health. The data were derived from two nationwide surveys on 'living conditions', conducted by the governmental statistical authorities in 1986 and in 1994. There were 17,300 respondents (52% female) of whom 7,047 (55% female) were over 50 years. Questions regarding perceived illness, long-standing illness, mental symptoms, somatic symptoms and disabilities were asked. The results show that the magnitude of gender differences in ill-health was relatively small, except for mental and somatic symptoms, and disabilities for respondents above 50 years. However, the results revealed that male who were 50 years or older showed poor perceived health.

Kawamura et al (1999) conducted an analytical study on gender differences in oral health care among Japanese employees. The study data found significant gender differences in dental care. Females (81.8%) more likely than males (58.8%) feeling uncomfortable to go to sleep without brushing their teeth. The results also found that more males (36%) than females (18%) agreed that tooth-brushing once a day is sufficient if it is done carefully. Irrespective of age, women showed healthier dental hygiene and dental care habit than men. Similarly, Fukai et al. (1999) found that women are more likely than men (88.8% and 60.9% respectively) to brush their teeth everyday at bed time. This study also used survey data in Japan of a sample of 207 males and 196 females and revealed gender to have significant effect on oral health behaviour.

Overall gender differences in health seeking behaviour were found in developed countries. However, there were no common factors explaining the observed gender differences. Female have reported poor functional health (Guallar-Castillón et al. 2005; Prus & Gee 2003) that has attracted considerable interest. It was found that men were more likely to engage in health risk behaviour while women in health promoting behaviour. The explanatory factors commonly found in differential health and illness behaviour were associated with socioeconomic status. Income and education played significant role in self rated health. However, analyses from the surveys studied here show that being unemployed is not related to illness behaviour of men and women.

Health Seeking Behaviour in Developing Country Context

Many studies in Africa report evidence of poor health due to 'gender role' in traditional families. Kimhi (2004) mentioned the importance of 'gender role' in health and nutritional status of Ethiopian families. He collected data from 583 households of peasant communities in southern Ethiopia and found relatively little gender differences in health and nutrition. The data show that there is no significant gender difference in the allocation of calories within the household. However, using the Body Mass Index (BMI), the nutritional status of females varied across age relative to that of males. The study found that young females have a higher BMI than males of the same age group, while older females have lower BMI than males of the same age group. Similarly, there were no marked gender differences in difficulty of performing activities in everyday life.

The 'gender lens tool' can be used to identify differences in disability and diseases from a gender perspective. The study of Kimhi (2004) showed that females suffer more from poor eyesight and heart problems, while males suffer more from poor hearing and walking difficulties. Moreover, females have higher tendency to report headaches, back pain and weakness than males. Although females more frequently suffer from illness, the rate of consultation to the health professional is much lower among females than that of males. Moreover, male tend to visit government or NGO facilities for treatment, whereas females tend to go private facilities or traditional healers.

In a study of gender difference, education and health inequality in rural China, Wu J et al. (2004) found that education related health inequalities are greater among women than among men. People with lower educational levels clearly have a greater disposition for illness. The authors note that health inequalities among women are greater compared to males. Health dissimilarity between bottom and top educational level increased for women. The study also revealed that the rate of unhealthy lifestyle decreased with educational attainment. Higher educated people tend to avoid risky health behaviour, such as smoking cigarettes and drinking alcohols - rather they practice healthy lifestyle, such as physical exercise and proper healthcare use. Similarly, the study found that the rate of hospitalization is lower among the higher educated people in rural China. The author arrived at conclusion stating that, in addition to educational factors, cultural context, differential social roles and constraints still exists between men and women in health behaviour.

Among Socioeconomic Status (SES) education is considered as 'social capital' which has profound positive impact on self-rated health. In fact, higher education has always been a resource helping an individual to enhance health knowledge and confidence. In a recent study (Montazeri et al. 2008), findings supported the view that higher educated Iranian rated their health significantly better than lower educated people. In the population-based study, 1997 males and 2166 females were interviewed and it was suggested that women rate their health more poorly than men. However, both married males and females showed better health than widowed and separated.

Fuller et al. (1993) analysed the social determinants of health seeking behaviour and found that gender differences in the illness profile was quite pronounced among Thai people. The authors suggest a number of reasons why health seeking behaviours differ across gender. In their study of 2017 married couples, the authors note that Thai women live longer compared to men. Difference was found virtually in health problems between Thai men and women. Females significantly reported more health problems than males do. Besides, they utilize more healthcare services than do men. From their results it appears that women are significantly less able to rest when sick.

The findings of the Thai study found that women have significantly more psychological distress than men. Factors such as having preschool children, education and income contribute to women's psychological health. Other factors like lack of social network have a greater negative health effect for women's health. The study found that women have weaker emotional ties with relatives and neighbours. Wife relatives are not as close at hand as are the relatives of husbands. Furthermore, wives have fewer good friends compared to husbands. These differences might lead poorer health of women than men. The findings of the study suggest that employment status of women has no significant effect on health behaviour. Although this study reports on a number of social determinants in relation to health seeking behaviour, it underscores the importance of the pattern of healthcare utilization related to reproductive health. This is because, the role of reproductive system of women may contribute to gender differences in health and healthcare utilization. Women with a recent reproductive experience are more likely to have utilized the healthcare services and also more likely to have been admitted to a hospital.

Available research from south Asia points to the existence of gender issues in treatment seeking behaviour. A study conducted by Hunte and Sultana (1992) examined the treatment-seeking behaviour of rural people in Pakistan. The study used primary data from 41 village households in northern Balochistan and found that for the majority cases of illness people obtain treatment from different medical systems for a single episode. The study also showed that the villagers of the study area expect quick result from health treatments and if not achieved, they quickly switch to another treatment. Women perceived both supernatural and natural causes that influence their and their children's illness. The study found that both males and females often use series of treatments from different medical systems that include home/self treatment, indigenous practitioner treatment, intermediate practitioner treatment and cosmopolitan practitioner treatment. When they do not get quick relief often they switch another type of medical treatment.

The gender difference in treatment seeking behaviour is also quite pronounced, as can be seen from the study of Hunte and Sultana (1992). From this study a striking finding concerning treatment cost revealed gender differences in rural Pakistan (Hunte & Sultana 1992). The amount per illness episode showed that for male children the expenditure is four times higher as compared to female children. Moreover, the differences in location of treatment are found between the illness episode of women and children. Women are more likely to visit city centre and utilize more cosmopolitan medicine than children.

There is considerable consensus from many previous studies which document gender differences in treatment seeking behaviour. For example, a study conducted in India revealed that treatment-seeking behaviour during common childhood illness is influenced by gender and the level of education (Ghosh 2004). The study examined 'source of treatment' and 'no treatment' for two childhood diseases, namely, diarrhoea and acute respiratory infections (ARI) and analyzed how maternal education affects gender differences in treatment seeking behaviour. The study found that in general illiterate and middle school completed mothers tend to discriminate against their girl child in seeking any formal medical care than higher educated mothers. The relationship is that as maternal education increases, gender bias in treatment seeking behaviour decreases. An interesting finding of the study was that, gender discrimination in treatment seeking behaviour does not exist statistically when the child is affected by diarrhoea, irrespective of the level of maternal education; but it does exist in case of ARI among illiterate and middle school educated mothers. In general, the proportion for treatment seeking is higher for boys than girls among illiterate and middle school completed mothers. However, the study used secondary sources of data and therefore some important variables like seasonal variation of diseases, perceived severity of the diseases and accessibility and availability of health facilities had not been considered in the study.

In a study Pandey et al. (2002) found that girls in West Bengal, India are discriminated against in all stages of health-care seeking behaviour regarding acute diarrhoea, acute respiratory infections and fever. In the study, observations were based on the surveillance period of one year from June 1998 to May 1999 in which children aged 0-59 month(s) were included. The study collected data from 530 children (263 boys and 267 girls) and found that household level girls were less likely to get oral rehydration solution (ORS) during diarrhoea. No gender difference was observed in quantity of fluid intake during ARI and fever. Qualified health professionals were consulted more often and sooner for boys than for girls. Parents also travelled longer distance for boys seeking health-care than for girls. Significant difference was found in the amount spent in treatment of a boy in comparison to that for a girl. Logistic regression analysis revealed that chance of spending more money was higher for boys. The boys were more likely to be taken early for medical care, and to be seen by qualified allopathic doctors compared to girls. In the case of girls, care providers relied on unqualified practitioners, such as quacks or compounders available within the village. Also, no association was found to be there between the level of education of mothers and the seeking of treatment. These findings show that there exists prevailing inequalities and discrimination against female children in seeking healthcare in rural West Bengal.

Findings from previous studies have provided information on gender issues in relation to health seeking behaviour in the Nepalese population. In their study, Pokhrell et al. (2005) analysed 8112 individual observations (people aged >15 year old) that were made in 2847 houses of 274 communities. The analysis was carried out in 1996 by observing the health care seeking behaviour of the parents for their children. Questions chosen for analysis were a) whether or not a child is reported ill, (b) whether the sick child is offered an

external care given illness, (c) to which provider the child was taken to, and (d) depending upon what type of provider chosen how much is spent for the treatment of the sick child. In the analysis it has been presumed that there was no statistically significant difference between boys and girls by demographic, socio-economic and geographical characteristics. In seeking answer to these four questions it has been found that a boy had a 15% more chance to have been reported ill than a girl regardless of the parent's income. Gender had no effect in the choice of health care seeking from a private provider compared to no or informal care. Also observed is the pattern that households would spend more money with private providers if the child was a boy. This shows that gender bias exists in terms of health-seeking behaviour for a child. The implications of this study are that there is a strong son-preference in Nepal shown by the health-seeking behaviour that is followed regardless of any economic factors at play.

Women in Third World countries suffer from health inequalities which has deep roots in traditional culture. A substantial amount of scholarly literature from South Asia report evidence of gender discrimination in relation to morbidity, mortality and access to health care. For example, in a review article, Okojie (1994) outlined several authors' agreement about gender inequalities in health in developing countries. The author emphasizes that women's roles responsibilities not only expose them to ill health but make it difficult to manage time for healthcare. For example, women's workloads do not allow them to adopt sick role. They experience different types of structural as well as social barriers to healthcare. The study also revealed that sometimes women suffer in silence and feel shy to go to health providers, especially when the illnesses are not immediately life-threatening.

Health Seeking Behaviour: A Gendered Perspective from Bangladesh

Findings from rural Bangladesh have provided additional information on gender differences in relation to health seeking behaviour as well as accessing to medical services (Islam et al. 2002). The study found significant gender differences in health status and use of medical services. Women were more likely to use traditional health care services compared to men although the rate of the average illness incidence was higher among women compared to men (5.15 per person per year vs. 3.80).

In a review of literature, Ahmed et al. (2000) found consistent reports of gender inequality in health seeking behaviour. In this extensive study, the authors used data from the BRAC- ICDDR,B joint research which collected data from 608 BRAC (Bangladesh Rural Advancement Council) household members and 1659 BRAC-eligible non-members. The main focus of the study was to explore the impact of BRAC's integrated socioeconomic development program on treatment seeking behaviour with a focus on gender issues - by making comparisons between beneficiary and non-beneficiary household members. The study showed that there was no significant gender difference in self reported morbidity rate. Further data show that the morbidity prevalence is significantly high among the BRAC non-member group than member group. As regards to treatment-seeking behaviour, there was no significant difference in the likelihood of

seeking care between members and poor non members. The study also showed that sick individuals from BRAC member households seek care less frequently than non member group. When treatment is sought, BRAC members use home remedies, traditional care and unqualified allopath than non-member households. On the other hand, non-member group frequently use para-professional services than member group. Women from BRAC member households are more likely to use qualified allopathic care than their non-member counterparts. These findings point out BRAC member group and non-member group differ in treatment-seeking behaviour though they belong to same socioeconomic status.

Some recent research findings from Bangladesh suggest that there is an association between gender, age and health seeking behaviour. Ahmed et al. (2005) found that within the younger population female ratio of seeking health care is significantly higher compared to males. However, amongst the older population such a high disparity according to gender does not exist in terms of seeking healthcare. Structured interviews of those with age >20 were conducted in 966 households having at least one member above 60 years old. Amongst the younger population prevalence of illnesses within the 15 day recall period was found to be significantly more for women (25.5%) than in men (13.5%). The elderly population did not have a significant gender based disparity in the proportion of those who are ill. The findings show that within the younger population men (27.1%) spend slightly more health care services than females (21.4%). However it has been found that this disparity reverses and women (37.5%) spend significantly more than men (15.3%) within the older population. The elderly population did not have a significant disparity in seeking of healthcare in terms of gender. No significant difference was found concerning health-care expenditure in respect of gender. However, self care is shown to be more common amongst women than men.

Knowledge of illnesses may contribute to health seeking behaviour and such knowledge tends to vary between people of different genders as well as rural or urban areas of residence. Differences in health knowledge between urban and rural people are well documented. In a recent study, Rahman (2009) examined the urban-rural differences on knowledge and awareness about AIDS in Bangladesh. The study mentioned that although the prevalence rate of HIV among adult population is still low in Bangladesh, the country's vulnerability is very high due to lack of awareness. He found that 80% of urban women are aware of HIV/AIDS, whereas half of the rural women still do not know about this deadly virus. The study also mentioned that women were less aware about HIV/AIDS, and they were less informed due to their less exposure to mass media. Moreover better SES, especially higher educational attainment, was found to be positively related to health knowledge.

A more explicit interpretation of gender-based health seeking behaviour is also to be found in the study of Begum (1997). In her article the author analysed level of morbidity, disease pattern, medicine use pattern and utilization of health care based on gender-role. In this study, an in-depth household survey was conducted in the finally selected village to collect information. One of the findings was that the morbidity risk for rural male and

female population particularly for acute and major illnesses did not seem to have much variation. However, sharp gender variation existed for repeated illness. The morbidity rate for male for such illness is 8 per cent and for female 11 per cent. Diarrheal diseases, dysentery, cold cough, viral fever and fever with unknown nature are the dominant diseases in rural Bangladesh. The findings also revealed that rural males were somewhat disadvantaged in the early (up until 14 years of age) and late stages of life (over 60 years). In between ages of 15-59 the situation is reversed - women were found to be much disadvantaged for health in these ages than the men and their relative disadvantage were the highest in the age group of 30-44. This age period of women coincides with the reproductive period and is suggested to be linked to their reproductive role which has remained a hazardous part of women's life for variety of conditions and reasons. In the extreme poor category, men were found to be more vulnerable to health risk than the women although this difference is negligible in the moderate poor and reverse in the non-poor. It has been suggested, poverty causes greater vulnerability to men than women which is attributed to the need for excessive hard work and the tension to ensure the survival of the family and also for males it becomes more apparent for women as they compete for work in the labour market where it is identified easily.

The pattern of medicine-use was found to have little variation across sexes. Neither was there any major variation in the utilization of various sources of health care across sexes in rural area. However, both for acute and major illnesses, rural women currently seem to make lesser use of the public sector facilities than the rural men do. The proportion of receiving health care by women from public facilities is significantly higher for major illnesses than for acute ones suggesting that despite reservations the poor women of rural area perhaps need to depend on the government facilities for health care at times of dire necessity.

Health seeking behaviour among elderly men and women (over 60 years of age) in rural Bangladesh associated with illness perception has been reported by Biswas et al. (2006). The authors conducted a qualitative baseline study which was a part of a multi-country health care intervention study aiming at improving health and quality of life of elderly people. The results show that perception is a factor regarding the severity of illness. For example, a sudden dramatic deterioration of a "regular" health problem is considered severe. Illness and decision to seek care of women affect the ability to work and look after oneself physically or, even more importantly, requires the care of other family members is also considered to be severe. Severity was perceived high among women than men. However, self-care, home remedies and drug bought from a drug store by family members is most commonly practiced by women than men. It was also observed that regardless of gender the respondents tended to avoid going to qualified doctors with formal medical training because of the high cost and did not consult them unless the situation deteriorated too much.

The literature on Bangladesh found that older women have self-reported health problems in both urban and rural areas than men. A study was carried out by Kabir et al. (2003) that aimed at analyzing gender differences in health status of older people (60 years and

older). In the study, health status has been indicated by both self-reported health problems by the interviewees with description of the problems and their functional ability – i.e. whether the subject is able to carry out Activities of Daily Living (ADL) tasks without assistance or not. From a total of 786 samples, 89% of the older men and women were interviewed. The findings show more self-reported health problems for women than for men - approximately 80% of the elderly women in both the regions reported having four or more health problems compared with 42% and 63% elderly men in the urban and rural regions, respectively. A greater proportion of older women were also unable to do at least one ADL task compared to the men. Use of help was reported more in the urban areas compared to the rural. In the rural region, only 'cough' was reported significantly more by men than women. In the urban region there was increased reporting of certain health problems such as 'fever' and 'lower back pain' for women and in the rural region it was 'frequent urination', 'dizziness' and hearing difficulties. The implication of the study is that although the older population in Bangladesh is growing rapidly, health care needs of the older population as a group are not being dealt with systematically in the primary health care system in the country.

Conclusion

This paper has described the relationship between gender and health seeking behaviour, presenting a special accent on both developed and developing countries. It has been found that gender differences in health seeking behaviour are usual and varies across other socio-economic variables. Socio-demographic variables such as age, region, education, family status and gender are influential in determining an individual's health status and their attitudes towards health seeking behaviour. However, the results from developed countries (e.g. Finland) show that the magnitude of gender differences in ill-health is relatively small (except for mental and somatic symptoms) and overall no evidence of widening gender differences were found according to the health indicators.

Bangladeshi women's utilization of health care services is predicted by socio-demographic variables such as their education, family income and being employed. The women with a higher education, those with a higher family income, and those who were employed made greater use of the available health care services. The review shows that being older greatly enhanced the likelihood of women's intention to perform more health promotion activities. Apart from socio-economic status, patriarchy, social capital/social network and multiple roles are integral parts of health seeking behaviour among people in developing countries – these issues have not been explored. Moreover, there is a dearth of literature on lifestyle factors and health knowledge from developing countries which are integral to shaping health behaviour. Socio-cultural factors including social roles of men and women have largely been ignored in the studies reviewed.

Our aim is to examine whether, when and why various aspects of men's and women's health seeking behaviour are different, so that we can identify possible ways to improve health. The extent of the gender difference in health seeking behaviour varies greatly across developed and developing countries and within the same country across regions.

These variations in terms of gender illustrate the importance of the social environment in creating social inequalities in health. With the advent of decentralization in Bangladesh, policy is formulated to address the health needs of grass-root people at the remote level. Therefore, policy makers must understand health behaviours and health care use at the local level, and give enough credence to these facts so that policies could be designed appropriately.

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