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Gender, socioeconomic development and health-seeking behaviour in Bangladesh

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Abstract

In efforts to reduce gender and socioeconomic disparities in the health of populations, the provision of medical services alone is clearly inadequate. While socioeconomic development is assumed important in rectifying gender and socioeconomic inequities in health care access, service use and ultimately, outcomes, empirical evidence of its impact is limited. Using cross-sectional data from the BRAC-ICDDR,B Joint Research Project in Matlab, Bangladesh, this paper examines the impact of membership in BRAC's integrated Rural Development Programme (RDP) on gender equity and health-seeking behaviour. Differences in health care seeking are explored by comparing a sample of households who are BRAC members with a sample of BRAC-eligible non-members. Individuals from the BRAC member group report significantly less morbidity (15-day recall) than those from the non-member group, although no gender differences in the prevalence of self-reported morbidity are apparent in either group. Sick individuals from BRAC member households tend to seek care less frequently than non-members. When treatment is sought, BRAC members rely to a greater extent on home remedies, traditional care, and unqualified allopaths than non-member households. While reported treatment seeking from qualified allopaths is more prevalent in the BRAC group, non-members use the para-professional services of community health care workers almost twice as frequently. In both BRAC member and non-member groups, women suffering illness report seeking care significantly less often than men. The policy and programmatic implications of between group and gender differences in care seeking are discussed with reference to the literature.

Keywords: Health seeking behaviour; Socioeconomic development; Micro-credit; Gender; Health

Introduction

In efforts to reduce disparities in the health of populations, it is well recognized that the provision of medical services alone is inadequate. In Bangladesh, inequities, or inequalities in attainment that are judged unacceptable or unfair, are particularly evident in gen-

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der and socioeconomic spaces (Whitehead, 1992). Gender is the socioculturally constructed role of the men and women in the society in contrast to sex, which refers to biological differences, and places a variety of expectations and constraints on women. It influences the health of women by putting emphasis on women's reproductive roles, resulting in early and excessive childbearing; sex preference manifested in discrimination against female children in health, nutrition and general care; lack of autonomy leading to lack of decision-making power and independent income, and to violence and abuse, causing severe repercussions on health and self-respect and so on (Okojie, 1994; Vlassoff, 1994). Gender inequity in health is manifested by marked inequalities between males and females in health related options and outcomes (e.g. child survival and life expectancy), and attributed to powerful social and cultural forces that overwhelm the supposed biological advantage of women (Chen, Huq & D'Souza, 1981; Waldron, 1983; Koenig & D'Souza, 1986; Bhuiya & Streatfield, 1991). Thus, in Bangladesh, women have a lower life expectancy at birth compared to men, and male-biased sex ratios (105 male per 100 female) contradict expected patterns. Food and health care are disproportionately distributed to male children, and neonatal, infant and child mortality rates are higher among girls. Levels of female literacy remain among the lowest in Asia (24%) while the maternal mortality rate (4.5 per live births) ranks among the highest in the developing world (MOHFW, 1998). Equally vivid in Bangladesh are socioeconomic differentials between the health status of the wealthy few and the vast legions of the poor, due to inequalities in education, health care access and ability to pay.

Socioeconomic development is generally regarded as an important means of reducing gender and socioeconomic inequities in health care access, service use and ultimately, outcomes (Caldwell, 1986; Evans, Barer & Marmor, 1994). Indeed, a host of non-governmental development organizations (NGOs) in Bangladesh have organized to improve the health and livelihood of the poor in general, and women in particular, through the support of integrated socioeconomic development activities including women's micro-credit and education. Implicit in these activities is the assumption that increased income and awareness arising through involvement in socioeconomic development programmes will result in more enlightened health-seeking behaviour, and hence, relative improvements in the health status of women and the poor. To date, however, a systematic examination of the validity of this assumption is lacking in the published literature.

Health-seeking behaviour refers to the sequence of remedial actions that individuals undertake to rectify perceived ill health (Christman, 1977; Ward, Mertens & Thomas, 1996). Health-seeking behaviour is initiated with symptom definition, whereupon a strategy for treatment action is devised (Christakis, Ware & Kleinman, 1994). Previous research has established, however, that symptoms will not necessarily be identified in biomedical terms nor will their recognition necessarily result in health action of the variety that "scientific medicine" deems most appropriate. Treatment choice involves a myriad of factors related to illness type and severity, pre-existing lay beliefs about illness causation, the range and accessibility of therapeutic options available, and their perceived efficacy (Zola, 1966; Kleinman, 1980; Kleinman & Gale, 1982; Young, 1981; Helman, 1995).

Like much of the developing world, medical pluralism, or the existence of several distinct therapeutic systems in a single cultural setting, is an important feature of health care in Bangladesh. Indeed, a wide range of therapeutic choices is available, ranging from self-care to folk and western medicine, although both illness incidence and treatment options are importantly determined by poverty and gender. Kleinman provides a useful typology that establishes popular, folk and professional domains or sectors of health care and their interconnected and overlapping function (Kleinman, 1980). The popular sector refers to the lay, non-professional arena of care where the symptoms of ill health are first recognized and health-seeking initiated. It includes all the therapeutic options that people employ without recourse to paid consultations with folk or professional practitioners. Among these options are self-care or self-medication, whereby people function on their behalf in health promotion and prevention, and in disease detection and treatment (Levin, 1981).

The 'folk' sector includes diverse practitioners of sacred or secular healing who tend to adopt a holistic approach that takes into account physical and emotional symptoms in the broader context of people's lives. Because folk healers articulate and reinforce the cultural values of the communities in which they live, they have advantages over the professional sector in their ability to define, explain and treat the social, psychological and moral dimensions of ill-health. Although traditional medical systems may also become professionalized to some extent, in Kleinman's typology, the 'professional' sector refers to organized, legally sanctioned practitioners of modern scientific medicine, also known as allopathy or biomedicine.

Using a set of cross-sectional data from Matlab Thana in Bangladesh, this paper tests the hypothesis that socioeconomic development will have positive externalities for gender equity and health seeking behaviour. Specifically, it proposes that participation in socioeconomic development programmes will increase informational and material resources for preventive and therapeutic health care, and support their equi-

table distribution between male and female household members. Among beneficiary households, these changes will be manifested in a shift from folk and popular care seeking to the professional sector, and increased gender equality in treatment seeking among those reporting ill-health.

Data and methods

The BRAC-ICDDR,B Joint Research Project

Founded in 1972, BRAC is a large indigenous NGO involved in rural poverty alleviation. BRAC's Rural Development Programme (RDP) targets the poorest of the poor with special emphasis on improving the health and socioeconomic condition of women and children through group formation in village organizations (VOs), skill development training and the provision of non-formal education and collateral free loans for income-generating activities. Initiated in late 1993, the Essential Health Care (EHC) component of RDP includes the promotion of safe water and sanitation, health and nutrition education, as well as immunization, family planning and basic curative services. Voluntary community health workers (Shasthya Sebikas), who are selected from among the VO members and trained in preventive health care, deliver these services by means of regular household visits. Preventive health and nutrition education is mainly disseminated through a 'health forum' held monthly in each VO and reinforced during household visits (BRAC, 1996).

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) has been operating a Demographic Surveillance System (DSS) in Matlab thana (pop. 200,000) since the early 1960s. In one-half of the DSS area designated "treatment area", ICDDR,B provides intensive maternal and child health and family planning extension services through community health workers (CHWs), supported by midwives based in four health sub-centres. With the initiation of BRAC's development interventions in Matlab in 1992, a research collaboration between BRAC and ICDDR,B was established to examine prospectively the relationship between socioeconomic development and the health and well being of the rural poor (Bhuiya, Chowdhury, Vaughn, Adams & Mahmud, 1995). As part of this collaboration, a survey of 14 villages in the DSS area of Matlab was undertaken in 1995. The analysis in this paper is based on health and sociodemographic data collected as part of this survey.

The data

Two sets of pre-tested structured questionnaires were administered to a randomly selected sample of 608 BRAC member households and 1659 non-member households that met eligibility criteria for BRAC membership (i.e. possess less than 0.5 acres of land, and rely on labour selling activities for more than 100 days per year).[1] A sample of non-poor or non-eligible households (n = 1550) was also surveyed and provide a point of comparison in several of the analyses.

The survey questionnaires aimed to assess the general health and socioeconomic situation of sample households three years after the initiation of BRAC's rural development activities in select areas of Matlab. As reported elsewhere, while the characteristics of BRAC member and poor non-member households along education, occupation and demographic dimensions are similar, the BRAC group tend to fare better on socioeconomic measures (Zaman, 1996). At this early stage, however, it is difficult to discern whether this is evidence of a selection bias, or rather reflects the benefits of the programme.

The first questionnaire gathered general demographic and socioeconomic data from the household head or any knowledgeable adult household member present at the time of survey. Of pertinence to this analysis are data on the sex (male or female), literacy (the ability to read and/or write) and occupation of the household head. Occupation is defined as the activity in which the household head spends the major part of the working day, and is categorized as labour selling or non-labour selling. Labour selling households tend to be of lower socioeconomic status given their dependence on variable seasonal employment.

Additional variables used in multivariate analysis include whether or not the surveyed households are located within or outside the embankment, a large system of dams constructed on the banks of the rivers

[1] The discrepancy in sample size is due to two principal reasons. First, although approx. 60–65% of households in any village meet BRAC's eligibility criteria, less than two-thirds of these households join BRAC at any one time. For this reason, the probability of obtaining a larger group of eligible non-member households is greater when random sampling techniques are employed. Second, the random selection of households occurred within the context of a four cell experimental design as required by all studies connected with the BRAC-ICDDR,B Joint Research Project. Of the four cells, only two contain villages where BRAC programmes are operating (BRAC only and BRAC and ICCDR,B cells). The remaining two cells, from which equal sized samples of eligible households were randomly selected, are comprised of villages where BRAC programmes do not operate. One cell includes villages where neither BRAC nor ICDDR,B programmes are present (comparison group), and one cell where only ICDDR,B's MCH-FP programmes are in place.

Meghna and Dhonagoda for the purposes of flood control, drainage and irrigation. Households located within the embankment area are presumed to be socio-economically better off due to the agricultural benefits of irrigation (Vaughn, 1997). A second variable important to analysis indicates whether or not the surveyed households are located in ICDDR,B's treatment area, where intensive health extension activities are undertaken.

The second questionnaire solicited information on household illness and related health-seeking behaviour from the spouse of the household head or any knowledgeable female member of the family. All illness episodes occurring among household members during the preceding two weeks were elicited. Illness categories were deduced from the lay reporting of symptoms by survey respondents. Symptoms were then classified into categories or "types" of illnesses by means of a comprehensive coding system, and cross-checked by a physician. When more than one episode of illness was reported, data were collected with reference to the major illness, i.e. the illness with the longest duration.

A considerable literature discusses the limitations of self-perceived morbidity reporting (Murray & Chen, 1992; van Ginneken, 1983). Among these concerns is its extreme sensitivity to diverse factors including inaccurate recall and the particularities of an individual's knowledge and illness experience (Kleinman, 1980). Also of concern is the observation that women from low socioeconomic classes tend to under-report illness symptoms (Okojie, 1994), and the problem of respondent bias (i.e. when individuals feel compelled to respond in a manner consistent with perceived expectations). Cognisant of these limitations, efforts to improve the reliability and validity of morbidity reporting included the use of culturally appropriate language, limiting the recall period to 15 days, and deploying an independent quality control team to re-survey 5% of the household sample within three days of the main survey. Additionally, during training, interviewers were instructed on how to establish an atmosphere of neutrality conducive to the collection of accurate and complete reports of treatment action.

Data on types of health care sought were obtained by asking the respondent about the nature and order of treatment measures undertaken at home or elsewhere. These treatments were subsequently grouped into five categories. The category 'home remedies' comprise traditional and modern forms of self-treatment such as analgesic and anti-pyretic tablets, oral rehydration solutions (ORS), antacids, etc., which are commonly available in rural households, and taken without prescription. 'Traditional' methods include treatment seeking within faith healing and traditional systems of medicine including *kabiraji/hakimi* and homeopathy (Ahmed, 1993).

The 'Para-professional' category of treatment-seeking consists of consultations with: *palli chikitsoks* (village practitioners who receive a year-long training in diagnosing and treating common rural ailments); medical assistants (who undertake a comprehensive three-year medical training); and government and non-government community health workers who obtain a very basic preventive and curative health training and treat mainly with allopathic drugs. The category 'unqualified allopaths' refers to itinerant and untrained pharmacists, market sellers, and road-side "quacks" who practice allopathic medicine with little or no professional training. 'Qualified allopaths' are individuals who have undergone professional medical training.

Data analysis

Data analysis is performed in two stages using SPSS 7.5 for Windows. First, bivariate analysis is used to characterize gender and group-level differences in the health-seeking behaviour of BRAC members and poor non-member households. Second, a logistic regression is run to explore the influence of membership in BRAC, and gender on the health-seeking behaviour of individuals with respect to: (1) 'any' type of treatment sought; (2) use of 'para-professionals'; and (3) use of 'qualified' allopathic medicine. Other independent variables included in the analysis are age, the gender, literacy and occupation of the household head, and whether or not the household is located within the embankment, or the "treatment" area of ICDDR,B where intensive health extension services are provided.

Results

Morbidity profile

As seen in Table 1, the prevalence of reported morbidity during the preceding 15 days, including current illness ranges from 12 to 17% (Table 1). When comparing BRAC member households and poor non-members who meet the eligibility criteria for BRAC membership, morbidity prevalence is significantly less among the BRAC group ($P < 0.001$). This finding is not altered when controlling for age, literacy, occupation of the household head, and the proximity of household to the health extension services of ICDDR,B (not shown). Also, no significant gender differences in the rate of self-reported morbidity are apparent. Table 2 indicates no significant differences in the types of illness experienced by individuals belonging to BRAC member households or poor non-member households. Among both groups, the three most frequently reported illnesses are fever of various types and duration, gastrointestinal diseases including diar-

Table 1
Self-reported illness during the preceding 15 days by gender and BRAC membership, Matlab 1995

Gender	% Individuals reporting illness				Significance (χ^2)	
	BRAC member hholds	Poor non-member hholds	Non-poor hholds	All hholds		
	(1)	(2)	(3)	(4)	(1) vs (2)	(1) vs (3)
Male	12.5	20.4	12.0	15.4	$P<0.001$	NS
n	(1513)	(3650)	(3830)	(8993)		
Female	13.3	20.3	14.1	16.6	$P<0.001$	NS
n	(1634)	(3845)	(4002)	(9481)		

rhoea and dysentery, and pain/aches in different parts of the body.

Health-seeking behaviour

Table 3 presents the health-seeking behaviour of males and females by membership status. Overall, there is no discernible difference in the likelihood of seeking care between members and poor non-members. However, when the health-seeking patterns of men and women are compared, females are significantly less likely to seek care than males in both member and poor non-member households.

Table 3 also indicates that a greater proportion of ill persons from BRAC member households seek treatment from traditional practitioners, and qualified and unqualified allopaths than sick individuals from poor non-member households. This trend remains even when controlling for age, literacy and occupation of the household head, and whether or not intensive health extension services are available (not shown). Among the poor non-member group, care is predominantly sought from para-professionals (i.e. community health workers), followed by unqualified allopaths.

As shown in Table 4, when health-seeking behaviour is considered according to three major illness categories (fever, gastrointestinal disorders and pain/aches), these trends prevail. In BRAC households, it appears that individuals suffering from these conditions decide against treatment more frequently than their counterparts in poor non-member households. In cases where treatment is sought, there is a greater proclivity to consult qualified and unqualified allopaths among sick individuals in BRAC member households. For non-member households of equivalent socioeconomic status, the predominant treatment choice for all three types of illness is para-professional care.

Table 5 presents the results of logistic regression for predicting the odds of seeking any type of health care (Model 1), and seeking health care from 'para-professionals' (Model 2) or 'qualified allopaths' (Model 3). To predict whether or not health care was sought, any type of health care sought was coded "1" and no health care sought as "0"; to predict whether health care from para-professionals was sought, para-professionals were coded "1" and all others as "0"; and lastly, to predict whether health care from qualified allopaths was sought, qualified allopaths were coded as "1" and all others as "0". Based on the results of bivariate analysis, independent variables include the

Table 2
Self-reported illness types by BRAC membership, Matlab 1995

Type of illness	% Individuals reporting illness				Significance (χ^2)	
	BRAC member hholds	Poor non-member hholds	Non-poor hholds	All hholds		
	(1)	(2)	(3)	(4)	(1) vs (2)	(1) vs (3)
Fever	45.2	45.5	39.9	43.5		
Gastrointestinal diseases	20.9	20.7	21.5	21.0		
Pain/aches	14.3	11.5	12.9	12.3	NS	NS
Respiratory diseases	5.4	5.7	5.9	5.7		
Skin/Eye/ENT diseases	3.7	4.1	2.5	3.5		
Others	10.6	12.6	17.4	14.0		
n	(407)	(1527)	(1025)	(2958)		

(the probability is twice as great among households in ICDDR,B's treatment area). Finally, the Eye, Skin and ENT categories of illness appeared to predict the seeking of health care to a greater extent than other disease categories.

In Model 2, which considers the variables predicting the use of para-professionals, the effects of gender, literacy of household head and the receipt of intensive health extension services are removed. Emerging as significant are BRAC membership status (members are less likely to use para-professional care), age (those aged 31–45 years are significantly more likely to seek para-professional care) and category of illness (whereby all illness types negatively predict the use of para-professionals).

Like the first model, in Model 3, age (31–45 years), male gender and the presence of a literate household head positively predict the use of qualified allopaths. BRAC membership also has a strong positive effect on the likelihood of using allopathic care, individuals from member households are nearly twice as likely to use qualified allopathic care than poor non-members.

Table 5
Odds ratios of seeking different types of health care among poor households, Matlab 1995

Characteristics	Types of health care sought in last 15 days (odds ratios)		
	Model 1 any type	Model 2 para-professionals	Model 3 qualified allopaths
Age (years)			
≤ 15	1.00	0.00	1.00
16–30	1.69***[a]	1.23	1.51
31–45	1.43*	1.45*	2.11**
46–60	1.17	1.10	1.53
60+	1.26	1.24	0.96
Gender			
Female	1.00	1.00	1.00
Male	1.73***	0.98	1.64*
Gender of HH head			
Female	1.00	1.00	1.00
Male	0.89	0.93	1.27
Literacy of HH Head			
Illiterate	1.00	1.00	1.00
Literate	1.30*	0.88	1.48*
HH Size	1.06	1.05	0.95
Labour-selling status of HH			
Non labour-selling HH	1.00	1.00	1.00
Labour-selling HH	0.92	1.06	0.75
BRAC membership of HH			
Poor non-member	1.00	1.00	1.00
BRAC member	0.87	0.35***	1.92***
Location of the HH			
Inside embankment	1.00	1.00	1.00
Outside embankment	0.95	0.80	0.62*
Village Health extension services present			
No	1.00	1.00	1.00
Yes	2.00***	1.14	1.33
Categories of illness			
Fever	1.00	1.00	1.00
Gastrointestinal diseases	1.18	0.53***	1.97**
Pain/aches	0.69	0.62**	2.31**
Respiratory diseases	0.77	0.59*	1.77
Skin/Eye/ENT	0.37***	0.34***	3.33**
Others	0.68*	0.41***	2.79***
-2 log likelihood	1833.07	2418.32	995.103
Model improvement	95.70***	132.48***	69.18***
Overall predicted	80.1%	64.5%	92.1%

[a] Significance levels *$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.

The location of the household in the treatment area of ICDDR,B, where intensive health extension services are provided, has no effect on the proclivity to seek allopathic care; however, location of the household with respect to the embankment does. Households located outside the embankment are significantly less likely to seek allopathic treatment than those inside.

In all three models, age and type of illness are important determinants of treatment choice among poor households. Male gender and literacy of the household head are significant determinants of seeking any type of health care, and seeking allopathic care in particular. The location of poor households vis à vis health extension services is significant only in the model predicting health-seeking behaviour in general. BRAC membership status, on the other hand, predicts both para-professional and allopathic care seeking. Specifically, BRAC membership has a significant negative effect on seeking para-professional care, and a positive effect on the seeking of allopathic care.

Discussion

This paper explores the impact of BRAC's integrated socioeconomic development programme on health-seeking behaviour and gender equity by means of a cross-sectional comparison of beneficiary households and a sample of non-member households of similar socioeconomic status. One important limitation of the data is that the measurement of health-seeking behaviour is based on reported illness and treatment action, and not directly observed as the illness process unfolds. By limiting the recall period to the past 15 days, and focusing on the major morbid experience, attempts were made to minimize problems of inaccurate recall. Given evidence from rural Kenya that there a 60% under-reporting of self-medication when a recall period of 2 weeks is used (Schulpen & Swinkels, 1980), it is likely that an under-reporting of minor illnesses occurred, especially for common conditions that go untreated or are routinely dealt with by means of self-care.

A second limitation relates to the possible effect of illness stage on treatment choice; that more advanced illness may be treated differently than early stage disease where home and folk remedies may initially suffice (Mwenesi, 1993). Fortunately, the cross-sectional nature of the study, and the inclusion of all reported illness occurring in the previous two weeks irrespective of severity, helps obviate the potential confounding influence of illness stage in analysis.

Finally, it may be that observed differences may be an artifact of selection bias on health seeking behaviour (i.e. that poor households joining BRAC are quite distinct from non-member households despite similarities in measures of socioeconomic status used to assess eligibility). Preliminary analysis occurring in the context of other studies associated with the BRAC-ICRRR,B Joint Project indicate that certain unobservable characteristics appear to give BRAC member households "an edge" over non-members.[2] However, given the uncertain implications of the nature and magnitude of this bias on variations in health seeking behavior, consideration of a full range of explanations is deemed useful and appropriate.

Overall reported morbidity for the study population is comparable to the national average of 16.7% for all of Bangladesh, and 17.2% for the rural population alone (BBS, 1995). Of particular note is the significantly lower prevalence of reported morbidity among BRAC households compared to non-member households of an equivalent socioeconomic status. This finding suggests that over the three year period since the initiation of BRAC's interventions in Matlab, member households have benefited in a palpable manner from the preventive health inputs of EHC, and/or improved household economic conditions resulting from BRAC's income-generating inputs like credit, skill development training, etc. Supporting this latter hypothesis are data reported elsewhere that indicate a significant (and positive) difference in land and livestock holdings, productive assets, savings, and monthly food-expenditure when comparing BRAC member households and their poor non-member counterparts (Hussain, Hasan, Mahmud, Chowdhury, Bhuiya & Khan, 1996). It might be speculated, therefore, that the increase in informational and material resources for preventive and therapeutic health care (cash income for self-medications, latrine construction, improved nutrition etc.) arising through participation in BRAC's rural development programme has benefited the overall health of household members.

As regards health-seeking behavior, study results

[2] In a model of the impact of BRAC on consumption poverty, Zaman (1998) employs a Heckman two step procedure to test and control for the potential endogeneity of the BRAC variable. He concludes that member households are likely to have certain underlying unobservable characteristics that "give an edge" over the typical eligible non-member. Huda and Mahmud (1998) use logistic regression to predict participation in RDP based on a model that includes a series of individual and household level factors considered endogenous to women's membership. They find that decision to participate is not based on a women's individual characteristics or cost-benefit calculation (age, marital status, presence of small child), but is largely a household decision based upon the household's net utility (credit demand, family size, landholding). The model also suggests that women in better health, and those who are in less egalitarian gender relationships are more likely to participate.

indicate the important role of a new cadre of "para-professional" trained to provide basic preventive and curative medical services at the village level. Results also suggest the need to extend Kleinman's typology of health care to include a large and growing fourth sector of non-qualified allopathic providers engaged in the traffic of modern pharmaceuticals, yet lacking formal medical training.

At first consideration, the health-seeking behaviour of BRAC member households appears perplexing. With the development of health awareness, and the increased availability of para-professional services to member households, it might be assumed that this group would seek qualified medical care more readily, and lessen their reliance on traditional care, and/or the dubious medical advice of unqualified allopaths. Contrary to these expectations, however, study findings indicate that the proportion of ill persons who do not seek treatment is greater among BRAC households than poor non-member households. Furthermore, in cases where illness-treatment is sought, BRAC members report using home remedies, traditional care, and unqualified allopaths to a greater extent than poor non-member households. While their use of qualified care is greater than poor non-member households, they seek para-professional care far less frequently. Indeed, non-member households report the use of para-professional care almost twice as frequently as BRAC member households.

One possible interpretation of these findings is that "exposure" to functional education and essential health training, enhances the health-seeking capacity of BRAC members and their ability to function effectively on their own behalf in health promotion and decision-making. As a consequence, individuals from BRAC member households may be better equipped to recognize and diagnose illness and to apply appropriate treatment actions without the consultation of health practitioners. Indeed, a similar tendency is noted in a recent study of pharmaceutical practice in Bombay, India, whereby people of higher socioeconomic status tend to engage in self-diagnosis and self-prescription to a greater extent than those of lower socioeconomic status (Kamat & Nichter, 1998).

Access to credit, skills development and the accumulation of savings may also function to increase income available for health care, and enhance the capacity of BRAC households to actively seek and meet more costly "modern" care, whether qualified or not (Cominsky, 1987). It is also likely that the ability of BRAC members to negotiate with medical personnel, and to extend options for qualified medical therapy in times of severe illness, is strengthened as a result of regular interactions with NGO personnel and credit peer group members (Lindenbaum, 1990; Caldwell, 1986).

The greater propensity of BRAC member households to seek qualified medical treatment than poor non-member household lends support to the interpretations above. However, this relative preference for qualified care seems trivial in face of the overwhelming dependence of BRAC households on unqualified care compared to poor non-member households. Among these unqualified practitioners, the lack of awareness of specific indications, dosages, and contraindications, and the widespread practice of prescribing only partial courses of medicines, has raised considerable concern about the development of resistant microbial strains, and the potential dangers of drug side effects and toxic poisoning.[3]

While time series data available in 1999 will assist in determining whether this is a transitory phenomenon or a trend of serious public health concern, interventions to modify inappropriate and dangerous health-seeking practice are clearly needed. Patient empowerment through information, education, and the provision of basic pharmaceutical training among allopathic prescribers (qualified and unqualified) represent possible areas for intervention (Thawani & Gharpure, 1997; Kamat & Nichter, 1998). However, in these efforts, due consideration to the problematic notion of what constitutes "rational practice" is important. Clearly, health behaviours guided by cultural or social rationality will not easily be modified to accord with notions of clinical or scientific rationality (Etkins & Tan, 1994). Furthermore, given that education and training efforts are necessary but not sufficient to change practice, managerial and regulatory interventions are needed to control the availability and free selling of certain allopathic drugs, without creating problems of black market activity and/or massive non-adherence (Trostle, 1996).

A second issue of concern arising from this analysis is the persistence of gender differentials in health-seeking behaviour despite BRAC membership. Although women of reproductive age appear to suffer equally from the burden of illness as men, they seek treatment significantly less often. These gender differentials in treatment seeking most probably reflect the powerful influence of patriarchy in rural Bangladeshi society.

[3] Among these practitioners, standard therapies are rarely followed. Rather, treatment tends to be a function of negotiation between patient and provider regarding what the patient or their family can afford. Medicines are usually sold per tablet, capsule or spoon in case of syrup on the basis of what is described by a relative, and seldom involve the direct examination of the patient (Ashraf, Chowdhury & Streefland, 1982).

Patriarchy, or the myriad institutional mechanisms that limit women's social and economic autonomy from men, enforce women's subordinate position in society, and condition health seeking behavior in both private and public domains (Okojie, 1994). The religious dictates of Purdah, a Muslim practice that secludes women and enforces social standards of female modesty, further reinforce prevailing norms and practices that circumscribe women's ability to choose and obtain treatment. The fact that gender inequities in care-seeking persist in BRAC households belies the complexity and strength of social, economic, religious and legal forces that prevent women from perceiving their ill health as sufficiently important to warrant treatment.

On a more hopeful note, women from BRAC member households appear more likely to use qualified allopathic care than their poor non-member counterparts, a finding which may reflect their greater comfort in interacting with the outside world. However, the balance of evidence suggests that since the initiation of BRAC's socioeconomic development interventions three years ago, gender differentials in health seeking have not narrowed to any perceptible degree. While this may be due to the brevity of the intervention (i.e. it is unreasonable to assume that fundamental social change will occur in three short years), results suggest the importance of increasing the sensitivity of extant health and socioeconomic programmes to equity considerations. In this respect, concerted programmatic efforts are required to raise community awareness about the immediate and future benefits of improving women's health, and to increase the cultural and financial accessibility of health care for women in particular.

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