Abstract

In the words of Nobel Laureate Amartya Sen, health, like education is among the basic capabilities that gives value to human life (Sen1999). It contributes to both social and economic prosperity. Health in itself is of great value as it enables people to enjoy their potential as human beings. Therefore, it is important to protect health through healthcare, besides other means such as socioeconomic development.

Health, a basic human right that is vital to sustainable development, eludes the majority of women. Although women in most societies live longer than men (for biological reasons), women suffer greater burdens of illness and disability than their male counterparts. About half a million women die every year from the complications of pregnancy and child birth.
As a result of visible and invisible discrimination, subornation and under valuation experienced throughout life, women are more vulnerable to poverty, poor nutrition, preventable diseases, uncontrolled fertility, premature death, violence, disability, alienation and loneliness. The quality of women's lives is further impaired by insufficient education, poor housing and sanitation, long hours of work in physically demanding and often dangerous and inaccessible health care services and lack of family and community support.

Better health translates into greater and more equitably distributed wealth by building human and social capital and increasing productivity (Bloomet al.2004, WHO 2001), though the concept of good health is relative. In health care context, ethics require a principle of access according to need and equal access for equal need is followed (Mooney 1992 cited in Gillstron 2001).

Access being defined as the ease with which health care is obtained (Agency for Policy and Research 1995 cited in Lawthers et al. 2003) or the freedom to use health care (Thiede 2005).
However, the consistently inequitable nature of health systems limits the access of quality health care especially among groups that need the services most of whom women are a key population. Health systems are frequently ineffective in reaching to the disadvantaged and marginalized groups in the society and most especially to the poor households, neglect, abuse and marginalization by health system is part of their everyday experience (WHO 2002). Experience suggests that the poor people most of whom are women will be effectively excluded unless services are geographically accessible or decent quality, fairly financed and responsive (Narayan et al.2000)

Women as part of the disadvantaged populations suffer a diminished capacity to take advantage of opportunities for better health and are often denied those opportunities, whether due to internal or external factors. The

women are unable to participate fully in social and economic activities , as well as those pertaining to decision making, and this social exclusion denies them the consumption of essential goods and services such as health care that are available to others.

This study uses the Uganda Demographic Health Survey data and the Uganda National Household Survey publications to investigate the main determinants associated with seeking health care. We find significant differences in health care seeking behavior to be related to age, gender, residence, standards of living and increased levels of education are consistently related with seeking health care from clinics/hospitals and private doctors as compared to self medication, friends, traditional healers indicating that people regard their quality as inferior. The probability to access any type of health care was found to be greater for men than for women.

Improving health is contingent upon reducing poverty among a host of other non monetary issues to be worked upon. Reducing poverty through specific targeting of the disadvantaged groups with a pro- poor health system that is a health system accessible irrespective of ability or willingness to pay and responsive to their needs and priorities.

The standard of living that is evidenced by the wealth index quintiles is strongly associated with health care demand especially for women. Our findings revealed a relatively significant demand for clinics/hospitals /private doctors for most women and this was more realized in cases where the women would change from low levels of standard of living to middle or higher. Therefore this suggests that the abolition of cost sharing has coincided with an increase in women's demand for government provided health care, more than for men.

Both men and women are revealed to prefer using clinic/hospitals/private clinics because the services are efficient and the providers treat clients with respect as compared the predominantly government aided health units.

Men increasingly use private care while women have an overall higher demand for government hospitals than men. This partly reflects the importance of standard of living and income quintile levels and work status on women's decision to seek health care when sick. Given the interesting gender differences and cultural barriers especially regarding the status of women in Uganda associated with health care seeking behavior, this automatically deserves further attention. Lack of control over money is a major inhibiting factor in seeking health care.