WHAT IS THE EFFECT OF GARMENT WORK ON WOMEN'S HEALTH AND EMPOWERMENT IN INDIA?
AN ANALYSIS OF INDIA'S NATIONAL FAMILY HEALTH SURVEYS

by

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

Evidence suggests that employment for women can reduce poverty and inequality resulting in improved living standards**.** The garment industry is an important source of income for Indian women. This thesis tested the effects of garment work as an income source on women's health-care utilization practices and decision-making in comparison to both agricultural labourers and general women in India. Cross-sectional data collected from India's National Family Health Survey-3 were used to generate descriptive statistics. Statistical modeling was used to test the effect of garment work on a) barriers to health care services and b) decision-making abilities of Indian women. Results suggest garment workers are younger, more educated, urban, and wealthier, make more cash earnings, and have more access and control over their own money as compared to agricultural labourers. Results indicate female garment workers report facing fewer barriers to accessing health care services. As well, access to cash earnings increases their decision-making abilities.

LIST OF ABBREVIATIONS USED

ASHA	Accredited Social Health Activist
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ANOVA	Analysis of Variance
BPL	Below the Poverty Line
CGHS	Central Government Health Scheme
CHC	Community Health Centre
CSDH	Commission on Social Determinants of Health
CSR	Corporate Social Responsibility
DALY	Disability-Adjusted Life-Years
DGFASLI	The Directorate General Factory Advice Service and Labour Institutes
ESIS	Employee State Insurance Scheme
ILO	International Labour Organization
JAP	Jan Aushadhi Programme
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
MDG	Millennium Development Goals
MNC	Multinational Corporations
MOHFW	Ministry of Health and Family Welfare
MPW	Multipurpose Worker
NFHS	National Family Health Survey
NGO	Nongovernmental Organization
NRHM	National Rural Health Mission
OBC	Other Backward Class
PHC	Primary Health Centre
RSBY	Rashtriya Swasthya Bima Yojna
SDH	Social Determinants of Health
SES	Socio-Economic Status
TBA	Traditional Birth Attendant
UFWC	Urban Family Welfare Centre
UHC	Urban Health Centre
UHP	Urban Health Post
UN	United Nations
UNFPA	United Nations Population Fund
UNW	United Nations Women (UN Entity for Gender Equality and the Empowerment of Women
US	United States of America
WHO	World Health Organization
WTO	World Trade Organization

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CHAPTER 1: INTRODUCTION

1.1 Introduction

The World Health Organization (WHO) established the Commission on Social Determinants of Health (CSDH) in 2005 on the principle that improving the Social Determinants of Health (SDH) would vastly reduce the many inequities in health(1). The Commission's final report launched in 2008 had three overarching themes: To: 1.) Improve daily living conditions 2.) Tackle the inequitable distribution of power, money and resources and c) Measure and understand the problem and assess the impact of action(2). Employment falls under the first theme: to improve daily living conditions. According to the WHO, "Employment and working conditions have powerful effects on health equity. When these are good, they can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial illness"(2). Employment for women can reduce poverty and inequality resulting in improved living standards. The garment industry is an important source of income for Indian women.

India, the largest democracy in the world, had a population of 1,170,938,000 people in 2010(3). The Indian garment industry "provides direct employment to over 33million people and is the second largest provider of employment after agriculture"(4). About 21.9% of total manufacturing jobs in India belong to the garments industry with smaller factories and home-workers making up a large portion of India's informal sector of over 433 million(5). As such, the garment industry represents a large source of revenue for Indians, especially to Indian women. Approximately 80-90% of all supplier communities of textile and clothing manufacturers are female. Researchers in the field have suggested that workers often lack social support systems, including such aspects as child care, employment insurance, and pensions~~,~~ (6). Since, "developing countries produce half the world's textile exports and nearly three-quarters of the world's clothing exports"(7), the actual social and economic impact that the garment industry can have in the lives of these women and their families is enormous. The first step to achieving good health and empowerment outcomes for this population is to conduct an environmental scan and accurately describe the current state of health, health care utilization, and the current state of empowerment in female garment workers.

The Millennium Development Goals (MDGs) set by world leaders at a United Nations summit in the year 2000 outline eight specific goals which address many facets of extreme poverty(8). This project addresses MDG3 which aims to promote gender equality and empowerment of women. The importance of MDG3 is great, as Amartya Sen made clear, "There is overwhelming evidence that women's empowerment through schooling, employment opportunities, et cetera, has the most far reaching effects on the lives of all – men, women and children..."(9)

The present study uses data collected from the latest Indian National Family Health Surveys (NFHS), NFHS-3 which was conducted in 2005-06. The surveys are analogous to Canada's Community Health Surveys and include self-reported information on the use of health-care services, health behaviours, economic characteristics, and demographics. To date three phases of data collection and analysis have been conducted for the NFHS.

The focus of this thesis is to test the effects of garment work as an income source on health care utilization and the prevalence of barriers to accessing health care between female garment workers in comparison to both women in agricultural labour (the occupation most women in India participate in) and women in general in India. Of particular interest is whether women's empowerment indicators such as decision making and gender role attitudes differ between these occupational groups. It is particularly crucial to understand complex social relations—i.e., gender roles in labour and household—to uncover whether garment work is a catalyst in empowering women to take part in more active decision making and in decreasing barriers to accessing health care services.

1.2 Theoretical Framework & Objectives

The theoretical framework (Figure 1) for this study attempts to simplify complex connections between women's employment, empowerment and barriers to health care.

The focus of this framework is on garment work as a source of income and its relationship to women's health and empowerment. The framework is not an exhaustive compilation of the different factors and connections between these concepts but instead provides a clear presentation of the hypothesis that is to be tested.

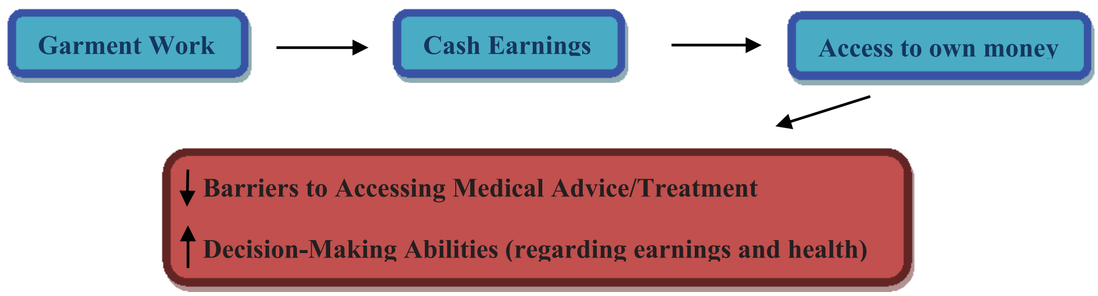

Figure 1: Theoretical Framework

Figure 1 suggests that garment work provides women with cash earnings, which give them access to their own money. This framework of empowerment expects that this access to personal monies results in a) decreased barriers to accessing medical advice or treatment and b) increased decision-making abilities regarding their own health and earnings.

Using the proposed theoretical framework the study attempted to test the following questions through the use of India's latest National Family Health Survey (NFHS-3):

1.) Does garment work positively affect health care utilization practices and decrease the prevalence of barriers for accessing health care services for female garment workers in comparison to both women in general, and women in agricultural labour in India?

2.) Does garment work increase indicators of women's empowerment such as self-reported decision-making for female garment workers in comparison to both women in general, and women in agricultural labour in India?

The current scientific literature on garment workers has generally provided insight into occupational illnesses and injuries experienced by women working in garment factories. As well as some background context about the general state of health care for women in India. There have been no studies reported to the literature that have used India's National Family Health Surveys to examine these questions for female garment workers in India. The following review of literature provides a general overview of empirical evidence in the conditions of garment workers regarding: 1) their work conditions; 2) access to health services and welfare; and 3) challenges in women's empowerment which would affect their health.

1.3 Review of Literature

1.3.1 The Work Environment of the Garment Industry

Researchers have characterized garment factory buildings as having inadequate ventilation(10), unsafe drinking water, insufficient washroom facilities and workers frequently denied washroom breaks by supervisors (11). As well, some factories do not have fire exits or fire alarms and violate many fire codes (10). Working in the different sectors of the garment industry has shown to result in various occupation related health problems (12)(13). Informal garment workers who work as tailors from home are not captured in scientific literature.

The most commonly reported occupational diseases in the garment industry are: byssinosis (exposure to endotoxins from bacteria found on cotton), infections (from contaminated drinking water), musculoskeletal disorders (mostly lower back pain and sciatica from static positions), stress-related disorders (harassment by supervisors and domestic violence at home), dermatitis (toxic chemicals) and needle-stick injuries (outdated machines and lack of protective gear) (14). Female-specific health issues are also reported: "Women of reproductive age are susceptible to specific adverse effects on reproduction, like abortions and malformations of the fetus from exposure to toxic chemicals in the work place"(14). However, the most common complaints expressed by women have been experiences of dysmenorrhoea, menstrual irregularities, anemia, severe abdominal pain, as well as urinary tract infections (11).

The Directorate General Factory Advice Service and Labour Institutes (DGFASLI) reports an incidence rate of 3.94 industrial injuries per thousand workers employed in all textiles in 2005, signifying the second highest incidence rate after the electricity, gas and steam sector (15).

Historically, the working environment in the garment industry has been characterized by poor working conditions. However, the boom of the garment industry in India, specifically the increase in multinational companies that engage export-oriented factories with required socially responsible workplace policies have led to some positive changes to the working environment of garment workers who work in these export-oriented factories. As major multinational corporations (MNCs) like Wal-Mart and Inditex outsource to countries like India, supplier factories attempting to attract their business are improving their workplace conditions and providing workers with social support. The recent popularity and increasing adherence to Corporate Social Responsibility (CSR) principles by MNCs and governments internationally also plays a role in building higher ethical standards in supplier factories (16). CSR was established to provide guidelines for MNCs to actively and publically practice ethical responsibility and social and environmental sustainability while conducting business overseas and within their own borders(16). In fact, for the year 2009 DGFASLI reports an increase in the number of *crèches* (day care centre's in the workplace) to 5326 from 5085 in 2007, increase in full-time medical officers to 2586 from 2142 in 2007 and an increase in ambulance vans to 2273 from 2126 in 2007 in registered factories in India(15) (17) . However informal garment workers working from home do not have access to these services.

As part of a CIDA-funded graduate student internship I and other members of our team had the opportunity to visit several export-oriented garment factories as well as informal home-based operations in the southern state of Karnataka, India in the fall of 2010. We observed that general managers of garment factories, especially those that are export-oriented, have recognized the importance of maintaining high quality work environment standards for the benefit of the health of their employees and their factory's output. Many MNCs place certain conditions on supplier factories, one of which is to have an in-house ambulatory room with a full-time nurse or medical officer. During our visits we observed various models of in-house ambulatory care rooms depending on the size and business capacity of the factory. Although, these ambulatory care rooms can be beneficial for the garment worker if she falls ill or is injured at work, it does not provide her with access to preventive forms of health care, such as primary health care facilities for her or her family. However informally run home-based operations garment do not provide access to these services.

1.3.2 Health Care Provision Overview

1.3.2.1 Health Care Legislature

After gaining independence from the United Kingdom in 1947, India's health policy, was affected by a strong egalitarian ideology leading to the provision of health care to be the sole responsibility of the government(18). The government however, did not officially recognize health as an essential component of human development. A combination of low political will, low investment, poor policies, and unsuccessful programmes resulted in poor quality health care services provided by the public sector(18). The private sector, which was already prevalent at the time of independence continued to grow rapidly, "to become the default option in many cases. In an unregulated environment, neither the private sector nor the public sector provided an assurance of quality or access"(18).

Quality in providing health care services is heavily influenced by several factors: high rates of absenteeism amongst health care professionals, lack of proper knowledge or qualification (one study showed that 40% of private providers in rural Rajasthan did not have medical degrees, with 20% not having completed secondary school education), inadequate supply of drugs and poor working environments(19). According to the NFHS-3, 58% of households cited 'poor quality of care' as the main reason for why they did not utilize government facilities (20).

Health care costs in India have soared for a multiplicity of reasons: a physician-centered approach to healthcare leading to an underproduction and underuse of other health professionals, an imbalance that favours specialist-delivered hospital-based high-tech medical care over primary care, poor resource allocation, weak regulations and wide-spread corruption (one study reported 77% of doctors and 67% of hospital staff accepted bribes to provide proper treatment during admission (19).) Currently, the majority of health care services in India is delivered privately, with 65% of households seeking health care from the private medical sector(20).

Due to the increasing inequalities and inequities in health care provision, the Indian government has recently proposed some schemes to promote universal health care in India such as the National Rural Health Mission (NRHM), the Janani Suraksha Yojana (JSY), the Rashtriya Swasthya Bima Yojna (RSBY) and the Jan Aushadhi Programme (JAP) (For more information on these programs consult (18). These programs will likely benefit informal garment workers who work from home or in other home-based operations.

Although, India's economy has seen consistent growth in recent years, total expenditure on health was 4.2% of its GDP in 2009(21), of which 1.1% (2008-2009) accounted for public expenditure on health(19). Indeed, India has not increased its investment in or efficiency of health care, the Human Development Index ranks India as 119 among 169 countries with comparable data(22). Health care services are largely paid for out-of-pocket "with India having one of the highest proportions of household out-of-pocket health expenditures in the world. -71.1% in 2004-05"(19) and is a major cause of poverty for many low and middle income families with 39 million additional people becoming poverty-stricken every year as a result(19), this effect is not distributed equally across the population. There is a large disparity in health care services based on factors such as gender, caste (a social stratification in India based on ancestry and therefore immutable), wealth, education and geography (19). For example, in rural India during 2005-06, the mortality rate for infants born to mothers with no education was 71.1 per 1000 livebirths, however the same rate was 29.6 per 1000 livebirths for mothers with 12 or more years of education (20).

The extent of economic development of the different states in India is closely associated with the health of its population, for example people who live in the state of Madhya Pradesh have a life expectancy of 56 years, whereas the life expectancy is 74 years for those who live in the state of Kerala(19). As well, the disparity in states' expenditures on health plays a major role in whether the state can provide sufficient and suitable physical access to good-quality health care services. "For example, per person public health expenditures in Bihar were estimated to be INR 93 compared with INR 630 in Himachal Pradesh in 2004-05"(19). The quality of health-care services also have extreme variations, a small population of people with means have access to the best possible care, whereas the large majority cannot access the most basic or essential health care services, especially in rural areas(18). In fact, the inequalities that exist in resource allocation by states perpetuate urban-centered curative services, which "suggest an urban bias and rural disadvantage in access to health-care services"(19).

The right to health and the right to health care were officially established in the National Health Bill by the Indian government in 2009. The Bill was written to allow the legal system to formally recognize these rights and to also address the social determinants of health(19). However, the limitations that exist within India's institutions to implement policies that will bring about equity in health care have yet to be addressed.

1.3.2.2 Health Care Utilization in India

According to the WHO, life expectancy at birth for females and males born in India are 66 and 63, respectively (23). The probability of death for children under the age of 5 is 66 per 1000 live births, which is higher than the regional average for southeast Asia (59 per 1000 live births)(23). Representing 18% of deaths and 20% of disability-adjusted life-years (DALYs), India signifies a large portion of the global burden of childhood related mortality and illness(19).

Health care utilization is commonly measured in terms of: a.) visits to health care providers (physician visits, specialist visits etc.) b.) type of health care facility used (public hospital, community health centre etc.) c.) type of service sought (family planning, immunization etc.) and health care coverage (private health insurance etc.). Patterns of health care utilization are important to study as it provides information on differential use of health care services across populations, for example in India, 10% of people in urban households have health insurance as opposed to only 2% in rural households(20), this would have an impact on their use of health care services. Analyzing various relationships with health care use, such as the effect of socioeconomic status (SES) on health care utilization allows for appropriate changes to be made to existing policies to increase improved health care outcomes.

In India, according to the NFHS-3, only 5% of households reported that at least one member of their household was covered by a health scheme or health insurance(20). Of those with coverage, 28% had privately purchased insurance, 26% were covered by the Employee State Insurance Scheme (ESIS) and the third most dominant form of coverage was under the Central Government Health Schemes (CGHS) with 20% of people reporting using CGHS(20). Interestingly, both the ESIS and CGHS are mandatory or government run schemes and to a large extent the "existing insurance is largely limited to a small proportion of people in the organized sector"(24). Having health coverage plays a large role on whether people can access health care services or not. The ESIS is particularly relevant for this study as a majority of garment workers in the organized sector in India are covered under ESIS.

The ESI Act in India was enacted in 1948 in order to allow for sick workers to have access to medical benefits as well as cash benefits equal to about half their daily wage per day for a period of 56 days per year(25). The Act also entitles employees to have access to ESI maintained hospitals to seek medical treatment, which is provided by the State Government. However, during our visits to garment factories garment workers reported difficulties in attaining sick leave and accessing care during hospital hours, this is echoed in the literature(11). As well, wage deductions per sick day are also quite common. If a worker is absent too often due to illness, she runs a high risk of being fired from her position(11) since this is a country with a large supply of workers. Informal garment workers do not have access to this benefit. Therefore, many females continue to work in strenuous work environments with their illnesses and without access to medical advice or treatment thereby risking converting their acute disease into a chronic illness.

The quality of health care delivered also has an impact on health care use, which in turn can lead to better health outcomes in a population. According to the NFHS-3, 36% of women visited a health facility or health camp for themselves or their children in the three months preceding the survey, of those 87% reported that the health care provider respected their privacy when needed and 65% of women reported that their last visit to a facility was very clean(20). The percentage of women who reported visiting a clean facility increases with increasing education and increasing wealth quintiles(20). There is very little literature on health care utilization by female garment workers in India, especially studies that specifically address the quality of care that is available to them.

1.3.2.2.1 Access to Health Care

Access to health care is a complex multidimensional concept and it can be measured in several ways. Health care utilization is one measure of access. Early definitions of *access* include that of Aday and Andersen who proposed that "it is perhaps most meaningful to consider access in terms of whether those who need care get into the system or not"(26). They also differentiate between 'having access' which means having the ability to use a service if required and 'gaining access' which "refers to the initiation into the process of utilizing a service"(26). In order to have access to health care services, there must first be a sufficient supply of health care services(26). The effect of having an adequate supply of health care services on access is that these services will be available whenever it is wanted or needed. Service availability can be measured using a number of indicators, the most common being measures such as the number of doctors or hospital beds per capita(26).

Mooney suggested that the costs of travel and other costs related to obtaining care can also be used as a measure of service availability from a health economic perspective(26). He argued that "access is wholly a question of supply; utilization is a function of both supply and demand…It is important to stress that equality of access is about equal opportunity: the question of whether or not the opportunity is exercised is not relevant to equity defined in terms of access"(26). Several factors affect the supply of health care, most notably the efficient allocation of resources between primary, secondary and tertiary care, human resources, and the effect of geography on physical access to health care services(19).

Service availability or adequacy of supply is one measure of access, but perhaps another more useful measure would be the actual utilization of health care services, in terms of affordability, physical accessibility and acceptability of services. Often health care services are available and yet many encounter difficulties in accessing these services. Therefore Donabedian suggested that "the proof of access is use of service, not simply the presence of a facility"(26). Pechansky and Thomas added to this discussion by developing the 'degree of fit' between patients and the health care system(26). Pechansky and Thomas "extended the concept of access beyond service availability, to consider the personal, financial and organizational barriers to service utilization"(26).

1.3.2.2.2 Barriers to Health Care Services

Personal barriers to accessing health care services are often encountered when a patient first identifies their own need to utilize health care services and actively makes the decision to seek care. At this point the patient's own set of social and cultural practices and beliefs, their own opinion of their needs as well as their attitude and past experiences with health care services will shape the patients decision to access health care services (26). Personal barriers are exemplified by the non-uptake of recommended preventive services and low patient compliance. In India, 7% of all women report that getting permission to go for treatment is a big problem(20), speaking to the effect of cultural and social practices.

Geography also affects a patient's ability to access health care. Distance to health care facilities is a larger hurdle for families living in rural areas, for example distance to health facilities was a big problem for 33.2% of women living in rural residences in comparison to 8.3% women living in urban neighbourhoods. Also, need for transport was a big problem for 30.8% of rural women as opposed to 6.6% of urban women; these findings would be similar to what we would find in a Canadian context. Another barrier that women reported in relation to distance to health care facilities was not wanting to go alone to seek medical advice or treatment, where 15.1% of women from rural areas cited not wanting to go alone as a big problem whereas 4.7% of urban women reported the same.

Financial barriers to accessing care are prevalent globally. The cost of health care can affect health care utilization. There are costs associated with all aspects of health care utilization, such as user charges for specific services, prescription medication, costs as a result of time lost from work or travelling to and from a health care facility(26). Gulliford states that "equal costs do not necessarily give equal access"(26), implying that the impact of charges at the point of service affects different SES groups differently. This is demonstrated by 34.8% of women in the lowest wealth index in India citing money as a big problem to accessing medical advice or treatment as opposed to 3.0% of women in the highest wealth index (20). The removal of financial barriers to health care has shown to enhance women's health. "Evidence from several countries shows that removing user fees for maternal health care, especially for deliveries, can both stimulate demand and lead to increased uptake of essential services" (27). The complications of removing financial barriers to care must be taken into account.

Organizational barriers include long waiting lists and waiting times before obtaining treatment. The median waiting time for seeing a health care provider as reported by women in the NFHS-3 is 21 minutes (range 15-30 minutes) before being offered services (20). These barriers can be a consequence of poor design of health care services, systematic variations in referral practices from primary to secondary care, and ineffectual policies which result in the "inefficient use of existing capacity"(26). Other barriers that women reported to encounter in the NFHS-3 are a concern that no provider would be available (22.7%), that no female provider would be available (18.7%),and that no drugs would be available (22.9%)(20). These barriers address the issue of acceptability as a dimension of access, acceptability defined as "the match between how responsive health service providers are to the social and cultural expectations of individual users and communities"(28).

In recognition of these barriers, the quest for optimal access is never ending. Rogers et al defined optimal access as "providing the right service at the right time in the right place"(26). Central to the concept of access is the ability to provide appropriate and adequate health care resources to address the various needs of different groups. Equity is popularly defined as "fairness in access for groups with equivalent needs. This horizontal form of equity may be assessed with respect to health service availability, health service utilization or health care outcomes"(26). Equity in access is essential as it intertwines notions of social justice and fairness into the equation. Health care utilization is often the preferred measure of access, with the "relationship between utilization and need being expressed in the form of use/needs ratios"(26). Inequity in access to health care is difficult to assess as the health problems, health care needs, priorities and values of different groups are so diverse. Access, in short, is multi-dimensional and difficult to measure appropriately, although health service availability, health service utilization or health service outcomes are all accepted indicators of access, equity may be the most important measure albeit the most difficult to test(26).

1.3.2.2.3 Health Care Utilization and Access to Health Care Services for Female Garment Workers in India

The literature addressing health care utilization patterns and access to health care services for female garment workers, specifically in India is limited, especially for informal garment workers. A study by Haque et al. conducted in Dhaka, Bangladesh found that most female garment workers from factories once sick, accessed treatment primarily from pharmacies (43.7%) followed by government hospitals (9.7%), Ayurvedic doctors (9.3%) and homeopaths (6.0%) (29). Poor females in India fall victim to rationing, referring to the distribution of curative healthcare among sick members of a family with limited resources (29). A well-balanced diet is required for maintaining good health, especially when working long hours in stressful conditions. One study found that the incidence of anemia in female garment workers in certain factories in Bangalore to be as high as

29.6% (30), this is most likely attributed to a diet deficient in valuable nutrients. Many workers also report cases of irritable bowel disease and parasites acquired through drinking water from contaminated sources(30). Women do not always have access to wholesome food and clean water to overcome their sickness due to low wages and large family sizes(31). Existing literature does not clearly describe health care utilization patterns of female garment workers, nor does it specifically report on the barriers that they face in accessing health care services. It is important to note that encouraging positive health practice behaviours in female garment workers is key, as women tend to be "excellent carriers or multipliers of healthy behaviours for the family and society at large(32)."

As previously mentioned, the boom of the garment industry in India, specifically the export-oriented factories have brought about some positive changes. As major companies like Wal-Mart and Inditex outsource to countries like India, factories attempting to attract their business are improving their workplace conditions and providing workers with social support. Gokaldas Exports Limited (GEL) is perhaps India's largest apparel exporter and is located in Bangalore. Clients include everyone from Nike to Zara (Inditex). GEL aims to promote social initiatives by providing their employees and their families with access to free healthcare centers and making available an ambulance that is on call 24x7(33). However, GEL does not offer any further descriptions on what their medical centres are equipped with or whom they staff.

Studies on occupational disease in anonymous garment factories in India mention 'ambulance rooms,' but never characterize them. Studies lack specific information regarding: a.) the number of these centers that exist b.) the types of services they offer c.) how they operate and d.) who staffs them(34). Silpasuwan et al. evaluated occupational health nursing units in textile factories in Bangkok(35) from the nurse' and management' viewpoints. This descriptive study concluded: "1.) The quality of health care services in the workplace is a significant part of quality assurance in the health and safety of the work force. 2.) Service quality can be evaluated by its structure, process, and outcome. 3.) Quality of nursing service units could be improved by management's attention to unit design, arrangement of nursing units, and nurses' education. 4.) Qualification of nurses employed in occupational health nursing units should be mandated"(35).

The health care services provided to informal garment workers are not captured in the literature.

1.3.3 Challenges in Women's Empowerment

1.3.3.1 Gender Equality in India

The United Nations Women (UNW) defines empowerment as composed of important elements such as "gaining the ability to generate choices and exercise bargaining power," and "developing a sense of self-worth, a belief in one's ability to secure desired changes, and the right to control one's life"(36). The United Nations Population Fund (UNFPA) stress important issues that affect women's empowerment throughout their life cycle: access to good reproductive health; stewardship of natural resources; and economic, educational and political empowerment(37). Gender-based discrimination prevents women from obtaining gender-equality in these matters.

Disparities between genders exist worldwide, however this difference is much more prominent in developing countries such as India(27). The United Nations update on the Millennium Development Goals reports that this disparity in gender begins at a very early age, notably for girls born into impoverished households or living in rural communities where they are at a distinct disadvantage(38). Differences in both biology and behaviour result in a longer life span in general for women(11). In Asia especially "these advantages are overridden by gender-based discrimination so that female life expectancy at birth is lower than or equal to that of males"(27) Women have shown to face greater barriers in accessing health care services particularly because of gender-based inequalities such as education, income and employment.

Worldwide women are targeted for developmental programmes, especially those that address maternal and child health(20). Women tend to be the primary caregivers in their households thus targeting and providing them with tools for empowerment will help remove their low status in Indian society(20). The removal of this barrier will increase not only maternal and child welfare but also other demographic outcomes. "An understanding of the status and empowerment of women in society and within their households is thus critical to promoting change in reproductive attitudes and behaviour, especially in patriarchal societies"(20). There is a wide gap in knowledge regarding women's empowerment indicators specifically for female garment workers.

1.3.3.1.1 Employment

Employment is used as a proxy indicator of women's empowerment. Associated with employment is the control over income. If women have access to their own financial resources, several studies suggest that women have more bargaining and decision-making power at home(36). The NFHS-3 reports that nationally only 43% of currently married women between the ages 15-49 were employed sometime in the 12 months preceding the survey(20). Of those women, 51% earned only cash and 13% earned both cash and in-kind payments, and about one in four women did not receive any payment at all(20). Notably, 99% of currently married men aged 15-49 were employed in the same period and 92% earned cash for their work(20). Therefore it is interesting to note that "not only are currently married women less than half as likely as currently married men to be employed, but when employed, they are only 70% as likely as men to be paid only in cash and five times as likely as men to not receive any earnings at all"(20).

Employment rates in currently married women increase from 31% in women between the ages 15-19 to 50% in women between the ages 35-39 and then decline to 45% in the oldest age group of 45-49(20). Employment of women also varies across the different states in India. Employment for women (currently married) in Punjab was 23% in contrast to 76% in Arunachal Pradesh(20). In contrast there was little variation in employment patterns across states for currently married men in India. In all states 96% or more men were employed at some time during the past 12 months before the survey(20).

Employment provides women with their own source of income which in turn reduces gender based inequalities and improves women's empowerment.

1.3.3.1.2 Control over Earnings

Control over cash earnings is an important indicator of financial empowerment. Notably, " a married woman's ability to convert earnings into empowerment in her own household may also depend on the perceived relative importance of these earnings to the household"(20). In India, according to the NFHS-3 most employed women (currently married) who earned cash decided alone (24%) or jointly with their husbands (57%) how to spend the money that they earned(20). Interestingly, 15% of these women said that the husband mainly decides how to spend their earnings, whereas one in six women do not participate at all in making these decisions(20), "the proportion of women who themselves mainly decide the disposition of their own earnings increases with age, education and wealth, whereas the proportion for whom the husband mainly decides, decreases with age, education and wealth"(20). According to the World Bank, when women play larger roles in deciding how household money is spent, a larger share gets spent on child and welfare expenditures(20).

1.3.3.1.3 Decision Making

Another important indicator of empowerment is the ability to make your own decisions about your healthcare, mobility and other freedoms. In India as a total, 27% of currently married women make their own decisions about their own health care, 9% make decisions about major household purchases, 32% make decisions about daily household purchases and 11% make their own decision about visiting their family or relatives(20). The rest of the women make these decisions jointly with their husband, mainly by their husband, or by someone else entirely. Employment with cash earnings increases the likelihood of women participating in decision making(20).

1.3.3.1.4 Access to Own Income

Access to multiple financial resources also plays an important role in allowing for financial flexibility and providing increased choices. In India "45 percent of all women aged 15-49 say that they have some money that they can use; 15 percent have a bank or savings account that they themselves use; 39 percent know of a programme that gives money to women to start or expand a business of their own; and only 4 percent of all women have ever taken a loan from such a programme"(20). These indicators increase for women who are employed for cash.

1.3.3.1.5 Freedom of Movement

Freedom of movement is a major element of women's autonomy and empowerment, especially in a patriarchal country like India(20). Women in India were asked by the NFHS-3 about their freedom of movement. The responses were: 38% were allowed to travel alone to places outside their village or community, 51% were allowed to go to the market by themselves and 48% were allowed to go to a health facility by themselves(20). Again, employment for cash increases a woman's freedom of movement.

1.3.3.2 Domestic Violence

1.3.3.2.1 Domestic Violence in the Indian Context

Gender role attitudes such as the perceived expectations of behaviour, rights and privileges based on sex need to be rejected in order to decrease gender-based discrimination and achieve gender equality. This is a fundamental aspect of women's empowerment. A normative behaviour that is commonly accepted in India, especially in the less educated and rural dwelling population is the 'right' of husbands to have power over their wives' behaviour and bodies through whatever means necessary(20). Women who believe that husbands should control their wives may be perceived to be less empowered and their acceptance of these norms are worth noting(20). Attitude of wife-beating was assessed by the NFHS-3, to which 41% of women answered that a husband is justified in beating his wife 'if she shows disrespect for her in-laws', 35% found wife beating acceptable 'if she neglects the house or children', and 20% found wife-beating justified 'if she doesn't cook food properly'(20).

1.3.3.2.2 Consequences of Garment Work

Several studies suggest that domestic violence is also unabated in the lives of Indian female garment workers(39)(40). Rocca et al assessed domestic violence as an unintended consequence of women's empowerment in India. The authors noted that two-thirds of participants reported working before marriage, most of whom worked as garment factory workers. Fifty-six percent of these women had experienced physical domestic violence; 27% reported having experienced physical domestic violence in the past 6 months(41). Marital violence can be a crime of power, “a sadistic assertion of control which is not limited to a particular section of the society”(42). Unfortunately, domestic violence is seen as a ‘private family matter’ and thus remains largely invisible in Indian society. “Women speak of being beaten till they lose their teeth or miscarry; hammered till they lose consciousness; or even being set ablaze”(42). At times the violence is so great that women resort to suicide. Shrivastava says every year in Mumbai alone there are at least 500 cases of suicides among city housewives (42). Mental torture is another overt form of abuse by husbands: women are frequently isolated from family and friends, demeaned in front of others, and denied money(42). Indian society is slowly building social supports to help these women in times of need, but bureaucracy still predominates in many women’s shelters. “Some [shelters] do not admit a person till she can prove that she has been married, others do not admit children with the women, some give shelter for such short durations that it is of no use”(42).

On average, factory-based female garment workers work 9-10 hour shifts only to go home and cook, clean the house, and feed and take care of any children and elderly family also living with them(42). The multiple roles filled by women inevitably leads to mental and physical fatigue or burnout(32) without any support. When women are sick, what are the consequences for them and their family? There is a lack of research addressing this multifaceted question. Female garment workers are sometimes the sole breadwinners for the family or support an already struggling household with their meager income(11).

Importantly, working women in India feel that “their obligation, domestic and outside work, often caused imbalances one way or the other, resulting in mental and physical tension, anxiety and worry”(42). Therefore, the inner conflict of dual commitment itself may submit these workers to stress related illnesses. A study assessing working women (in both the organized and unorganized sector) in North Bengal, India found that 40% from organized and 36% from unorganized sectors felt that their families were neglected because they did not have enough time for domestic chores(42). As well, 24% from the organized sector and 8% from the unorganized sectors felt that it was impossible to care for their children while they worked outside. Concurrently, 24% of children of women in the organized sector and 28% of children of women in the unorganized sector did not like their mothers working outside(42). The traditionalist attitude of husbands may be one reason that 24% of women from the organized sector and 50% of women in the unorganized sector have marital maladjustment(42). Therefore, working women feel that they do not have enough time for household duties, caring for their children, and their husbands.

The prevalence of sexual harassment and abuse is noted to occur in the workplace but is seldom reported for fear of losing employment(43). Women who are widowed, deserted, divorced or are single mothers are often subject to stigmatization and discrimination(10). In addition, "women's low status in society, their burden of work and the violence they experience"(27) all contribute to mental ill health.

Reports of community harassment of female garment workers have been identified in the literature. At work, garment workers are charged with meeting hourly production targets and if these are not met are faced with verbal and physical abuse(11). One worker says, "I have been verbally abused many times whenever I don't meet the production targets and cloth lengths were thrown at my face"(11). Female garment workers have also reported episodes of sexual harassment by mainly male supervisors. These supervisors frequently make comments with sexual overtones or engage in unwelcome physical contact. Unfortunately, women workers tolerate such indecencies in order to keep their jobs. "The supervisor talks to me sweetly and in a personal way. He does not touch me but I feel harassed by his way of talking. I have to tolerate it if I want to keep my job"(11) says one garment worker.

As seen in the review above, current literature generally reviews the state of health and health care for women in India as well as report on common occupational injuries of garment workers. However, similar outcomes of health and health case, as well as factors influencing health and health care decision making within female garment workers, especially those who work in the informal sector have not been studied in detail. As of yet, no study has been published using India's NFHSs to study female garment workers' health and health care access issues in India. The focus of this paper, therefore, is to characterize whether health care utilization and the prevalence and severity of barriers to accessing health care differs between female garment workers in comparison to both women in agricultural labour (the occupation most women in India participate in) and women in general in India.

Figure 2: Women working in domestic market-oriented Indian garment factory visited during internship

Figure 3: Women working in an export-oriented Indian garment factory visited during internship

Figure 4: A home-based tailoring operation (informal employment) run by this woman in southern India, visited during internship

CHAPTER 2: METHODS

2.1 STUDY POPULATION

<u>2.1.1 The National Family Health Survey, India:</u>

Data from India's National Family Health Surveys (NFHS) was used for all statistical analysis. The NFHS-3 was used for all descriptive statistics and the statistical modeling using multivariable logistic regression. The surveys include self-reported information on use of health-care services, health behaviours, economic characteristics, and demographics. To date three phases of data collection and analysis have been conducted for the NFHS. Data collection for the fourth phase will commence shortly. "All three surveys were conducted under the stewardship of the Ministry of Health and Family Welfare, Government of India, with the International Institute for Population Sciences, Mumbai, serving as the nodal agency. ORC Macro, Calverton, Maryland, USA, provided technical assistance for all three NFHS surveys. NFHS-1 and NFHS-2 were funded by the United States Agency for International Development, with supplemental funding from UNICEF. NFHS-3 funding was provided by the United States Agency for International Development, the Department for International Development (United Kingdom), the Bill and Melinda Gates Foundation, UNICEF, the United Nations Population Fund, and the Government of India" (cite the national family health survey).Table 1 compares the three NFHS' that have been conducted up to date.

The NFHS-1 was conducted in 1992-93 and collected information on a nationally representative sample of 88,562 households and 89,777 ever-married women ages 13-49 years in 24 states and in what was then known as the National Capital Territory of Delhi. The NFHS-2 (1998-99) sampled 91,196 households and interviewed 89,199 ever-married women in 26 states. The key study population for this research were the women interviewed for the NFHS-3. The NFHS-3 (2005-06) sampled a total of 109,041 households, 124,385 women ages 15-49, and 74,369 men ages 15-54 from all 29 states. The key difference between the first two NFHS' and the third NFHS was the inclusion of unmarried women. For the purposes of this study the majority of the data analyses will be conducted on data from the NFHS-3.

Table 1: Comparison chart of India's three National Family Health Surveys

<table>
<tr><td></td><td colspan="6">National Family Health Surveys</td></tr>
<tr><td></td><td colspan="2">NFHS-3</td><td colspan="2">NFHS-2</td><td colspan="2">NFHS-1</td></tr>
<tr><td>Year Conducted</td><td colspan="2">2005-2006</td><td colspan="2">1998-1999</td><td colspan="2">1992-1993</td></tr>
<tr><td>Sample Size</td><td>♂
All Men
Age: 15-54
74369</td><td>♀
All Women
Age: 15-49
124,385</td><td>♂
N/A</td><td>♀
Ever-married Women
Age: 15-49
89,199</td><td>♂
N/A</td><td>♀
Ever-married Women
Age: 13-49
89,777</td></tr>
<tr><td>Sample Design</td><td colspan="6">• "The target sample size for each state in NFHS-3 was estimated in terms of the number of ever-married women in the reproductive ages to be interviewed since a large number of the key indicators to be estimated from NFHS-3 refer to ever-married women in the reproductive ages of 15-49".(44)
• "The initial target sample size was 4,000 completed interviews with ever-married women in states with a 2001 population of more than 30 million, 3,000 completed interviews with ever- married women in states with a 2001 population between 5 and 30 million, and 1,500 completed interviews with ever-married women in states with a population of less than 5 million". (44)
• "In addition, because of sample-size adjustments required to meet the need for HIV prevalence estimates for the high HIV prevalence states and Uttar Pradesh and for slum and non-slum estimates in eight selected cities, the sample size in some states was higher than that fixed by the above criteria."(44)
• "The urban and rural samples within each state were drawn separately and, to the extent possible, the sample within each state was allocated proportionally to the size of the state's urban and rural populations."(44)
• "A uniform sample design was adopted in all the states. In each state, the rural sample was selected in two stages: the selection of Primary Sampling Units (PSU's), which are villages, with probability proportional to population size (PPS) at the first stage, followed by the random selection of households within each PSU in the second stage."(44)
• In urban areas, a three-stage procedure was followed. In the first stage, wards were selected with PPS sampling. In the next stage, one census enumeration block (CEB) was randomly selected from each sample ward. In the final stage, households were randomly selected within each sample CEB"(44)
Similar sampling was used for both the NFHS- 1&2 minus the HIV prevalence.</td></tr>
<tr><td>Sample Weights</td><td colspan="6">• "NFHS-3 is designed for self weighting at the domain level. The domains are the urban and rural areas of each state, and the slum and non-slum areas of each of the eight selected cities. This means that all households and individuals in the same domain will share a common household weight and individual weight, respectively."(44)
• "The design weight is the inverse of the overall sampling fraction in each domain. The overall sampling fraction is the product of the selection probabilities at each sampling stage (two stages in rural areas and three stages in urban areas). "(44)
• "The design weight was adjusted for household non-response in the calculation of the household sampling weight. The household sampling weight was further adjusted for individual non-response to obtain the individual sampling weight. Both adjustments for non-response were done at the domain level in order to preserve the self-weighting nature of the sample within domains."(44)</td></tr>
</table>

	National Family Health Surveys
Sample Weights	• "The sampling weights were further normalized at the national level to obtain national standard weights and at the state level to obtain standard state weights for each of the 29 states. The national standard weights were normalized so that the total number of weighted cases equals the total number of unweighted cases at the national level. The state standard weights were calculated to ensure that the total number of weighted cases equals the total number of unweighted cases for each state."(44) • " Weights for the men's subsample, the HIV subsample, and the subsample of women selected for the domestic violence section of the questionnaire were calculated in a similar way." (44)
Standard Error	• "The NFHS-3 sample is the result of a multi-stage stratified design, and, consequently, it was necessary to use more complex formulae. The computer software used to calculate sampling errors for NFHS-3 is programmed in SAS. This procedure uses the Taylor linearization method for variance estimation for survey estimates that are means or proportions."(44) • The Jackknife repeated replication method is used for variance estimation of more complex statistics such as total fertility rate and child mortality rates. In addition to the standard error, the design effect (DEFT) for each estimate is also computed, which is defined as the ratio between the standard error using the given sample design and the standard error that would result if a simple random sample had been used."(44)

Definition of garment workers: In the women's questionnaire of all three NFHS', an open -ended question was asked about women's occupation. The responses were then recoded into appropriate categories during the data processing stage. For the purposes of this paper, the term *Garment Worker* encompasses all women who have been employed in the past 12 months and were employed as spinners, weavers, knitters, dyers, tailors, dress-makers, sewers, upholsterers and related workers at the time of survey data collection. The combining of similar but different occupations may affect the accuracy of the results. Similarly, agricultural laborers were all women who have been employed in the past 12 months and were employed as agricultural labourers at the time of survey data collection; these women were already coded and grouped into one occupational category.

2.2 Data Analysis

Variables of interest were identified from the women's questionnaire data set of the NFHS-3 and imported into SAS Version 9.2. Two data sets were created, the first one containing the two occupation groups: all garment workers (n=4983) and all agricultural labourers (n=11,441) and the second containing all other women who were neither garment workers nor agricultural labourers (all women sample). To reduce computational burden, a third data set was created from the all women sample by randomly selecting a subsample of women (n=21,583). Finally, the three datasets were merged to create the working dataset containing all three samples: garment workers, agricultural labourers and the all women (total n=38,001). The garment workers served as the referent group and the other two as comparison groups for the multivariable logistic regression. Frequencies and histograms were run to detect inaccuracies and to assess the distribution of data. Duplicate variables were deleted.

Descriptive statistics were computed with a macro generated for categorical variables using the SURVEYFREQ procedure in SAS. The SURVEYFREQ procedure is designed to take into account the weights often found in survey data. The STRATA, CLUSTER, and WEIGHT statements are used under the SURVEYFREQ procedure and provide "sample design information for the procedure, so that the analysis is done according to the sample design used for the survey, and the estimates apply to the study population"(45)**.** Descriptive statistics for continuous variables were analyzed using the SURVEYMEANS procedure in SAS, which also allows us to adjust for survey design. The STRATA, CLUSTER, and WEIGHT statements are also used to add survey design information to the analysis. The state and place of residence (urban/rural) of respondents were used for the STRATA statement, and cluster and weight variables provided by DHS was used for the CLUSTER and WEIGHT statements for all data analyses. The Rao-Scott modified chi-square test (a modified version of the Pearson chi-square test that adjusts for design)(46) was used to identify whether categorical variables were statistically ($p<0.05$) different across the three groups (garment workers =referent group, agricultural workers, all women). Analysis of Variance (ANOVA) was used for continuous and ordinal variables to test for differences between means across each comparison group.

Odds ratios were computed for two broad outcomes (Barriers to accessing medical advice or treatment and Women's decision making) each relating to one of the two main objectives. The two outcomes were each composed of 2-4 outcome variables, which were selected based on significance attributed to them in the literature. Each outcome variable was coded into a binary variable in order to analyze the sample using logistic regression, excluding observations with missing values.

Variables of interest were identified from the literature to be considered for the multivariate logistic regression. Firstly, bivariable analysis was conducted on variables of interest using the SURVEYLOGISTIC procedure in SAS. “The SURVEYLOGISTIC procedure fits linear logistic regression models for discrete response survey data by the method of maximum likelihood. For statistical inferences, PROC SURVEYLOGISTIC incorporates complex survey sample designs, including designs with stratification, clustering, and unequal weighting”(45)**.** Those variables with a p-value of ≤0.25 (a p-value of 0.05 was not used at this step as important variables can be overlooked(47) on the Wald chi-square test under the Type 3 Analysis of Effects in PROC SURVEYLOGISTIC were considered for the multivariable logistic regression.

Once variables were selected from the bivariable analysis, they were used to model each outcome using the original weights. Each model was re-weighted by dividing the original weight with the sum of the actual weights used then multiplied by the number of observations used. Each model was then re-run with the new weights followed by the iterative process of variable selection to create the most parsimonious model using forward selection. Insignificant (p>0.05) explanatory variables on the Wald chi-square test under the Type 3 Analysis of Effects in PROC SURVEYLOGISTIC were removed from the original model and the nested model was rerun. If the difference in the fit statistics -2 log likelihood values (of the intercept and covariables) of the nested model compared with the original model was insignificant (p>0.05) on the chi-square distribution table, the variable was removed. If the difference was significant the explanatory variable was kept and the next least significant explanatory variable was added to begin the process again. Both Wald and -2 log likelihood tests were used to be more conservative.

A POWER procedure was run in SAS to determine whether the sample size was adequate. We have a power of 0.980 with an alpha equal to 0.05 to reject the null hypothesis. The c statistic (the area under the ROC curve) was also analyzed as a measure of accuracy of the model. The c statistic is a measure of goodness-of-fit and is used to evaluate the fit of a logistic regression model. The c statistic ranges from 0.5 to 1.0 with larger values indicative of better fit. According to Hosmer and Lemeshow, c statistic values ranging from 0.69 to 0.76 show acceptable discrimination between observations at different levels of the outcome, whereas values of 0.8 to greater than or equal to 0.9 demonstrate excellent discrimination(47).

CHAPTER 3: RESULTS

3.1 DEMOGRAPHIC DATA

Results suggest garment workers in India were younger than both agricultural labourers and all women in India. Garment workers had a median age of 26 while agricultural labourers had a median age of 30 and the all women group had a mean age of 27 as reported in Table 2. Table 2 consists of select demographic characteristics of all three comparison groups, a more comprehensive description can be found in the appendix (Table A). Garment workers had a median height of 151.87cm and were shorter than all women who had a median height of 152 cm. Agricultural labourers had a median height of 150.54 cm making them marginally shorter than garment workers. Garment workers had a median weight of 46.52 kg, agricultural labourers had a median weight of 42.70 kg and all women had a median weight of 45.81kg (Table 2).

Garment workers (67%), agricultural labourers (87 %) and all women (80%) were mostly Hindu, then Muslim. However more garment workers (27%) were Muslim than in either the agricultural labourers (7%) or all women (14%) groups. The three other most popular religions to which all three groups belonged to was Christianity, Sikhism and Buddhism/Neo-Buddhism. There were significant differences ($p<0.0001$) in caste distribution between the three groups. The majority of people in each comparison group belonged to Other Backward Class' (OBC): 43% of garment worker's, 47% of agricultural labourers and 39% of all women. The second most popular caste designation for garment workers and all women was the 'none of the above' category: 37% and 35% respectively, whereas agricultural labourers belonged to the scheduled caste (29%).

Table 2: Demographic Characteristics of Comparison Groups

Demographics	Garment Workers (Referent Group) (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Age (years)	**Median (Min-Max)**		**Median (Min-Max)**		**Median (Min-Max)**	
Median age	25.65 (15.00-49.00)		29.71 (15.00-49.00)		27.01 (15.00-49.00)	
Height (cm)	**Median (Min-Max)**		**Median (Min-Max)**		**Median (Min-Max)**	
Median height	151.87 (130.00-196.90)		150.54 (100.0-198.90)		152.0 (107.50-198.70)	
Weight (kg)	**Median (Min-Max)**		**Median (Min-Max)**		**Median (Min-Max)**	
Median weight	46.52 (23.10-126.50)		42.70 (15.10-99.90)		45.81 (22.10-150.30)	
Religion	**% (n)**	**SE%**	**% (n)**	**SE%**	**% (n)**	**SE%**
Hindu	67.06 (3131)	2.17	87.23 (9266)	0.77	80.02 (15,549)	0.71
Muslim	27.31 (1275)	2.23	7.42 (1241)	0.64	14.24 (2868)	0.69
Christian	2.18 (260)	0.38	1.97 (413)	0.26	2.41 (1991)	0.17
Sikh	2.37 (123)	0.31	0.64 (141)	0.12	1.94 (504)	0.15
Buddhist/Neo-Buddhist	0.63 (32)	0.20	1.30 (117)	0.27	0.71 (306)	0.10
Jain	0.14 (9)	0.07	0.00 (0)	0.00	0.35(107)	0.07
Jewish	0.00 (1)	0.00	0.00 (0)	0.00	0.01 (2)	0.01
Donyi Polo	0.01 (5)	0.00	0.02 (47)	0.01	0.03 (64)	0.01
No religion	0.00 (0)	0.00	0.04 (7)	0.02	0.03 (11)	0.02
Other	0.22 (141)	0.05	1.26 (194)	0.26	0.20 (157)	0.04
Caste of Household Head	**% (n)**	**SE%**	**% (n)**	**SE %**	**% (n)**	**SE %**
Scheduled caste	15.99 (693)	1.32	28.78 (2871)	0.96	17.53 (3368)	0.55
Scheduled tribe	3.07 (277)	0.47	13.49 (1867)	0.85	7.88 (2892)	0.42
Other Backward Class	43.11 (1601)	1.93	47.42 (4875)	1.18	39.32 (6637)	0.71
None of the above	37.23 (1874)	1.87	9.57 (1161)	0.58	34.57 (7777)	0.71
Don't Know	0.39 (15)	0.15	0.46 (64)	0.11	0.38 (77)	0.07
Missing	0.21 (11)	0.08	0.28 (34)	0.08	0.33 (77)	0.06
Marital Status	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Never married	34.40 (1986)	1.07	14.14 (1824)	0.43	20.95 (5364)	0.38
Married	59.39 (2736)	1.09	78.89 (8843)	0.47	74.77 (15,291)	0.40
Widowed	3.88 (156)	0.39	4.84 (539)	0.23	2.95 (631)	0.16
Divorced	0.74 (41)	0.18	0.30 (34)	0.06	0.24 (74)	0.04
Not living together	1.59 (64)	0.27	1.83 (201)	0.15	1.08 (223)	0.10
BPL Card	**% (n)**	**SE%**	**% (n)**	**SE%**	**% (n)**	**SE%**
No	71.33 (3795)	1.36	55.63 (6549)	0.85	70.03 (16,192)	0.55
Yes	24.60 (1003)	1.39	40.26 (4411)	0.85	23.55 (4243)	0.53
Not de jure resident	3.38 (132)	0.40	3.72 (413)	0.22	5.97 (1013)	0.22

Demographics	Garment Workers (Referent Group) (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Wealth Index	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Poorest	7.27 (152)	1.07	37.87 (3965)	0.89	14.30 (1980)	0.46
Poorer	13.37 (406)	1.18	31.51 (3378)	0.66	17.16 (2804)	0.41
Middle	20.32 (1046)	1.15	22.17 (2768)	0.63	20.03 (4051)	0.45
Richer	33.54 (1938)	1.47	7.77 (1177)	0.42	22.71 (5388)	0.50
Richest	25.50 (1441)	1.52	0.68 (153)	0.09	25.80 (7360)	0.59
Education Level	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No education	23.20 (977)	1.22	69.97 (7656)	0.68	36.12 (6187)	0.58
Primary	18.62 (768)	0.98	15.00 (1791)	0.42	14.96 (3096)	0.34
Secondary	54.10 (2931)	1.48	14.81 (1959)	0.50	40.30 (9800)	0.52
Higher	4.09 (307)	0.43	0.21 (35)	0.05	8.61 (2496)	0.31
Place of Residence	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Urban	58.90 (2935)	-	6.54 (748)	-	48.68 (10,507)	-
Rural	41.10 (2048)	-	93.46 (10,693)	-	51.32 (11,076)	-
Use of Tobacco	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Does not use tobacco	92.83 (4387)	0.59	82.66 (9397)	0.57	89.72 (18,845)	0.34
Use of Alcohol	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Drinks alcohol	0.96 (56)	0.25	4.48 (603)	0.43	1.91 (537)	0.16
Frequency of alcohol use among those who drink alcohol:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Almost every day	17.27 (6)	8.14	14.80 (85)	2.64	17.27 (73)	2.56
About once a week	19.86 (10)	8.56	46.82 (272)	3.26	45.16 (197)	3.18
Less often	62.69 (39)	12.77	37.47 (242)	3.36	36.47 (265)	3.12

More garment workers belonged to the never married category (34%) compared to 14% of agricultural labourers and 21% of all women. Fifty-nine percent of garment workers are married in contrast to 79% of agricultural labourers and 75% of all women. In addition, 0.74% of garment workers are divorced compared to 0.30% of agricultural labourers and 0.24% of all women.

Fewer garment workers (25%) had a BPL card in comparison to agricultural labourers (40%). Twenty-four percent of the all women group had a BPL card. The three comparison groups also belonged to different wealth indices. More garment workers (34%) belonged to the 'richer' category than either the agricultural labourers (8%) or the all women (23%). Also, more garment workers (54%) had completed secondary schooling than either the agricultural labourers (15%) or the all women (40%) groups.

Garment workers (59%) lived predominantly ($p<0.0001$) in urban centers in contrast to either the agricultural labourers (7%) or the all women group (49%). Garment workers were distributed all over India, with the majority of them living in the state of Manipur (18%) and Uttar Pradesh (11%) (Table A - appendix).

Garment workers were less likely to engage in risk-taking behaviours such as drinking alcohol (0.96% used alcohol) and using tobacco (7% used tobacco) than both agricultural labourers (4% used alcohol and 17% used tobacco) and all women (2% used alcohol and 90% didn't use tobacco). As well, among those who did consume alcohol, garment workers consumed less often than once a week (63%), whereas agricultural labourers mostly consumed about once a week (47%) similar to all women (45%).

Table 3 presents a comparison of changes in several demographic indicators for garment workers across two cross-sectional time points from data collected from both NFHS-3 and NFHS-2. The median age of garment workers decreased from 31 years of age to 26 years of age from the NFHS-2 to the NFHS-3. The number of Hindu garment workers also decreased from 75% to 67%. The numbers of garment workers who belonged to either the scheduled caste or other backward class (these are groups of historically disadvantaged people in India) have increased since the NFHS-2. Garment workers are also more educated, with 54% having completed secondary education in the NFHS-3 sample than the 37% who had completed secondary education in the NFHS-2. Garment workers have also become more urban-centered, more of them work away from home, more of them make cash only and work all year round since the NFHS-2.

Table 3: Comparison chart of demographic indicators for garment workers from NFHS-2 to NFHS-3

Demographics	Garment Workers (4,983)		Garment Workers (1,979)	
Survey	**NFHS-3 (2005-06)**		**NFHS-2 (1998-99)**	
Sample (ages 15-49)	**All women**		**Ever-married women**	
Age (years)	**Median (Min-Max)**		**Median (Min-Max)**	
Median age	25.65 (15.00-49.00)		31.17 (15.00-49.00)	
Religion	**% (n)**	**SE%**	**% (n)**	**SE%**
Hindu	67.06 (3131)	2.17	74.92 (1413)	2.13
Muslim	27.31 (1275)	2.23	18.78 (339)	1.97
Christian	2.18 (260)	0.38	3.09 (130)	0.52
Sikh	2.37 (123)	0.31	1.17 (36)	0.20
Buddhist/Neo-Buddhist	0.63 (32)	0.20	1.18 (19)	0.50
Jain	0.14 (9)	0.07	0.42 (5)	0.21
Jewish	0.00 (1)	0.00	0.00 (0)	0.00
Donyi Polo	0.01 (5)	0.00	0.00 (0)	0.00
No religion	0.00 (0)	0.00	0.02 (2)	0.02
Other	0.22 (141)	0.05	0.44 (34)	0.09
Caste of Household Head	**% (n)**	**SE%**	**% (n)**	**SE %**
Scheduled caste	15.99 (693)	1.32	11.69 (230)	1.34
Scheduled tribe	3.07 (277)	0.47	4.42 (153)	0.64
Other Backward Class	43.11 (1601)	1.93	36.10 (567)	2.43
None of the above	37.23 (1874)	1.87	47.79 (1017)	2.13
Don't Know	0.39 (15)	0.15	0.00 (0)	0.00
Missing	0.21 (11)	0.08	0.00 (0)	0.00
Marital Status	**% (n)**	**SE %**	**% (n)**	**SE %**
Never married	34.40 (1986)	1.07	0.00 (0)	0.00
Married	59.39 (2736)	1.09	90.73 (1805)	0.87
Widowed	3.88 (156)	0.39	5.63 (102)	0.74
Divorced	0.74 (41)	0.18	0.91 (16)	0.28
Not living together	1.59 (64)	0.27	2.72 (56)	0.41
Education Level	**% (n)**	**SE %**	**% (n)**	**SE %**
No education	23.20 (977)	1.22	30.85 (600)	1.91
Primary	18.62 (768)	0.98	24.36 (458)	1.75
Secondary	54.10 (2931)	1.48	37.15 (742)	1.80
Higher	4.09 (307)	0.43	7.64 (179)	0.82
Place of Residence	**% (n)**	**SE %**	**% (n)**	**SE %**
Urban	58.90 (2935)	-	49.57 (981)	-
Rural	41.10 (2048)	-	50.43 (998)	-
Earns cash for work	**% (n)**	**SE %**	**% (n)**	**SE %**
No	7.16 (344)	0.72	12.43 (209)	1.77
Yes	92.84 (4639)	0.81	87.57 (1769)	1.77

Demographics	Garment Workers (4,983)		Garment Workers (1,979)	
Respondent employed all year/seasonally:	**% (n)**	**SE %**	**% (n)**	**SE %**
All year	68.97 (3482)	1.39	65.49 (1210)	1.74
Seasonal	18.37 (947)	1.21	19.16 (451)	1.20
Occasional	12.60 (552)	0.84	15.35 (318)	1.24
Missing	0.06 (2)	0.06	0.00 (0)	0.00
Where Respondent works:	**% (n)**	**SE %**	**% (n)**	**SE %**
At home	82.34 (4140)	1.28	88.45 (1751)	1.12
Away	17.53 (839)	1.27	11.55 (224)	1.12
Missing	0.13 (4)	0.08	0.00 (0)	0.00
Partner's education level (among currently married):	**% (n)**	**SE %**	**% (n)**	**SE %**
No education	19.07 (460)	1.25	17.24 (304)	1.42
Primary	17.10 (431)	1.11	22.45 (389)	1.61
Secondary	54.58 (1765)	1.62	41.25 (881)	1.69
Higher	8.62 (335)	0.73	19.07(404)	1.34
Don't Know	0.57 (20)	0.18	0.00 (0)	0.00
Missing	0.06 (2)	0.06	0.00 (0)	0.00
Total	3013		1978	
Partner's occupation:	**% (n)**	**SE %**	**% (n)**	**SE %**
Did not work	3.04 (78)	0.47	2.47 (56)	0.43
Professional/technical/ managerial	5.74 (216)	0.59	8.07 (189)	0.81
Clerical	3.64 (151)	0.46	4.38 (108)	0.62
Sales	11.77 (404)	0.84	12.39 (247)	0.91
Agricultural	12.14 (293)	1.17	14.64 (288)	1.41
Services	5.67 (181)	0.62	3.81 (100)	0.51
Skilled and unskilled manual	57.63 (1678)	1.51	53.71 (986)	2.17
Don't Know	0.06 (2)	0.04	0.49 (11)	0.18
Missing	0.31 (10)	0.14	0.00 (0)	0.00
Total	3013		1972	

Total values were only indicated where (n) was not the same as the total reported above.

3.2 Health Care Utilization and Barriers to Care Data

3.2.1 Descriptive Statistics

Table 4 illustrates select health care utilization characteristics across the three comparison groups. More garment workers (5%) had at least one member of their household covered by health insurance in comparison to agricultural labourers, of whom only 1% had at least one member of their household covered. The two most popular forms of health insurance held among those who were covered were: a) privately purchased commercial health insurance plans and b) the Employee State Insurance Scheme (ESIS). Thirty-three percent of garment workers had at least one member of their household covered by ESIS in comparison to 13% of agricultural labourers and 28% of all women ($p=0.0126$). Privately purchased commercial health insurance was held by at least one member of 32% of garment workers' households, 41% of agricultural labourers' households and 27% of all women households. (For descriptive statistics of other forms of insurance held, consult Table A in the Appendix).

Table 4: Select health care utilization characteristics across all three comparison groups

Health Care Utilization Measures	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Health Insurance	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Member of household covered by health insurance	5.24 (287)	0.55	1.01 (152)	0.14	5.71 (1470)	0.28
The type of insurance held among those covered:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Employee State Insurance Scheme	33.04 (85)	5.49	13.34 (29)	3.69	27.73 (396)	2.07
Other privately purchased commercial health insurance	31.53 (70)	4.50	40.89 (57)	6.61	27.35 (388)	1.76
General Health Problems	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Diabetes	0.82 (48)	0.19	0.46 (51)	0.07	0.89 (248)	0.09
Goiter or other thyroid disorder	1.03 (68)	0.20	0.50 (70)	0.07	0.92 (231)	0.09
(In addition to asthma, these were the only health problems asked about)						
Source of Health Care	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**

Health Care Utilization Measures	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Govt./Municipal hospital	18.45 (1341)	1.19	10.66 (1431)	0.56	14.31 (4694)	0.42
CHC/Rural Hospital/PHC	10.46 (569)	0.88	17.33 (2428)	0.74	13.77 (2691)	0.47
Private hospital	15.35 (631)	1.24	12.75 (1222)	0.60	14.84 (3126)	0.45
Private doctor/clinic	38.59 (1781)	1.69	38.65 (4128)	0.94	38.79 (7771)	0.64
Reasons for not using Govt. Facilities	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No nearby facility	30.39 (1284)	1.57	35.44 (3681)	0.97	28.67 (5478)	0.63
Poor quality of care	33.36 (1404)	1.45	39.53 (3897)	0.91	35.81 (6392)	0.57
Matters discussed during contacts:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Family planning	12.06 (61)	2.66	6.58 (140)	0.65	8.57 (255)	0.65
Immunization	42.24 (269)	3.14	60.68 (1165)	1.66	56.67 (1542)	1.26
Disease prevention	15.93 (82)	2.98	8.24 (169)	1.12	8.84 (236)	0.95
Medical treatment for self	18.61 (99)	2.26	12.17 (268)	1.05	11.98 (376)	0.84
Health facility was clean:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Very clean	68.47 (1210)	1.82	58.10 (2032)	1.14	66.16 (5184)	0.83
Somewhat clean	30.68 (696)	1.83	40.00 (1465)	1.12	32.57 (2739)	0.81
Not clean	0.84 (28)	0.28	1.48 (56)	0.22	0.97 (96)	0.14
Quality of health care:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Health worker spoke nicely:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Nicely	82.80 (499)	2.19	70.90 (1502)	1.48	78.06 (2325)	1.09
Somewhat nicely	15.94 (84)	2.18	26.57 (513)	1.42	19.97 (538)	1.07
Not nicely	0.96 (9)	0.50	2.38 (51)	0.40	1.54 (50)	0.26
Health worker ensured Information was understood:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	3.56 (33)	0.98	11.22 (245)	0.93	7.46 (225	0.62
Yes	78.10 (456)	3.69	66.10 (1389)	1.72	77.05 (2257)	1.06
No explanation needed	18.04 (103)	3.72	22.30 (428)	1.59	15.02 (429)	0.95

The NFHS-3 asked women to report on general health problems that they experienced. The self-reported prevalence of diabetes mellitus in garment workers was 0.82%, 0.46% in agricultural labourers and 0.89% in all women, the three groups were statistically different from one another (p=0.0189). The garment workers (1%) also reported a higher prevalence of goiter or other thyroid disorders in comparison to agricultural labourers (0.50%) and all women (0.92%), the difference between the groups is statistically significant (p=0.0059) however this may not translate into clinical significance.

Women were also asked to share where members of their household generally sought treatment when they got sick. Thirty-nine percent of garment workers, agricultural labourers and all women answered that treatment was generally sought from a private doctor/clinic. After private doctors/clinic, most garment workers sought treatment from government/municipal hospitals (18%), whereas agricultural labourers sought treatment from community health centres (CHC)/rural hospitals/ primary health centres (PHCs) (17%) as their second choice and 15% of all women sought care from private hospitals, these differences are statistically significant (p<0.001). Women whose households did not generally seek care from government facilities were asked why they did not use these facilities. The most frequently cited response by 33% of garment workers, 40% of agricultural labourers and 36% of all women was the poor quality of care delivered in government facilities. The second most commonly reported reason was the lack of nearby government facilities as stated by 30% of garment workers, 35% of agricultural labourers and 29% of all women. For other reasons why households don't use government facilities consult Table A in the appendix.

Women were asked in the NFHS-3 if they had contacted grass-roots health workers such as Auxiliary Nurse Midwives (ANMs), Lady Health Visitors (LHVs), Anganwadi Workers (AWWs), Accredited Social Health Activists (ASHAs), Multipurpose Workers (MPWs) and other community health workers in the three months prior to the survey. Those women who had contacted these health personnel were asked to share all topics discussed during contacts. The most commonly reported topic was immunization, and this remained true for all three comparison groups: 42% of garment workers, 61% of agricultural workers and 57% of all women reported discussing immunization. The second most common topic was medical treatment for self as reported by 19% of garment workers, 12% of agricultural labourers and 12% of all women. The third and fourth most commonly discussed topic by 16% and 12% of garment workers was disease prevention and family planning, respectively. However, only 8% of agricultural labourers and 9% of all women discussed disease prevention and 7% of agricultural labourers and 9% of all women discussed family planning. For other matters discussed during contacts consult Table A in the appendix.

The experience of health care services differs across the three comparison groups. Women were asked to report on the cleanliness of the health facility they most recently visited. The percentage of garment workers who reported that the facility was very clean was 68%, relative to 58% of agricultural labourers and 66% of all women who reported the same. Women who had any contact with community health workers were asked for their assessments of the quality of care provided by these workers. Eighty-three percent of garment workers reported that the health worker spoke nicely, compared to only 71% of agricultural labourers and 78% of all women. A higher percentage of garment workers also reported that the health worker ensured that the information discussed was understood by them compared to only 66% of agricultural labourers and 77% of all women.

Table 5 presents the responses from all three comparison groups on their experiences of barriers they've encountered when accessing health care services. The biggest problem as reported by female garment workers (21%) was the lack of health providers, followed by the lack of adequate drugs (20%). In contrast agricultural labourers reported that their biggest problem was the distance to health care facilities (36%). The all women group was very similar to garment workers in general.

Table 5: Barriers to accessing medical advice or treatment across all three comparison groups

Barriers to accessing health care:	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
	% (n)	SE %	% (n)	SE %	% (n)	SE %
Getting permission to go for treatment :	-		-		-	
No problem	81.01 (4157)	1.02	75.19 (8580)	0.77	77.38 (17,549)	0.53
Not a big problem	12.87 (577)	0.82	17.58 (1923)	0.66	16.08 (2973)	0.47
Big problem	6.12 (249)	0.53	7.23 (937)	0.38	6.52 (1056)	0.30
Getting money for treatment:	% (n)	SE %	% (n)	SE %	% (n)	SE %
No problem	64.39 (3280)	1.34	51.60 (5720)	1.02	61.70 (13,761)	0.59
Not a big problem	20.89 (1095)	1.01	24.91 (2780)	0.78	22.22 (4587)	0.50
Big problem	14.72 (608)	1.06	23.47 (2938)	0.79	16.02 (3227)	0.43
Distance to health facility:	% (n)	SE %	% (n)	SE %	% (n)	SE %
No problem	56.86 (3038)	1.50	34.25 (3896)	0.99	51.86 (12,318)	0.64
Not a big problem	22.80 (1139)	1.04	29.99 (3224)	0.83	24.39 (4889)	0.51
Big problem	20.35 (806)	1.37	35.76 (4319)	1.01	23.71 (4367)	0.55
Having to take transport:	% (n)	SE %	% (n)	SE %	% (n)	SE %
No problem	62.67 (3298)	1.50	37.30 (4255)	1.02	55.81 (13,061)	0.65
Not a big problem	20.53 (1032)	1.00	28.88 (3089)	0.80	23.01 (4568)	0.51
Big problem	16.78 (652)	1.24	33.82 (4096)	1.01	21.15 (3946)	0.53
Not wanting to go alone:	% (n)	SE %	% (n)	SE %	% (n)	SE %
No problem	67.90 (3625)	1.39	55.40 (6292)	0.92	65.25 (14,898)	0.60
Not a big problem	22.77 (964)	1.23	27.55 (3062)	0.76	24.01 (8672)	0.51
Big problem	9.32 (393)	0.69	17.02 (2084)	0.64	10.70 (4506)	0.37
Concern that no female provider available:	% (n)	SE %	% (n)	SE %	% (n)	SE %
No problem	60.88 (3250)	1.41	51.51 (5784)	1.07	58.84 (13,498)	0.67
Not a big problem	21.46 (968)	1.05	25.33 (2777)	0.80	23.26 (4642)	0.54
Big problem	17.63 (764)	1.07	23.16 (2879)	0.86	17.86 (3436)	0.53

Barriers to accessing health care:	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Concern that no provider available :	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No problem	57.85 (3159)	1.52	48.66 (5370)	1.19	56.86 (12,990)	0.70
Not a big problem	20.67 (848)	1.08	23.91 (2517)	0.86	21.34 (4058)	0.54
Big problem	21.49 (976)	1.23	27.42 (3552)	0.95	21.77 (4527)	0.58
Concern that no drugs available :	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No problem	58.84 (3199)	1.59	48.61 (5297)	1.20	56.83 (12,914)	0.69
Not a big problem	20.70 (867)	1.10	24.33 (2640)	0.91	20.93 (3961)	0.53
Big problem	20.47 (917)	1.26	27.05 (3503)	0.94	22.20 (4701)	0.58
UHC = Urban Health Centre; UHP = Urban Health Post; UFWC = Urban Family Welfare Centre; CHC = Community Health Centre; PHC = Primary Health Centre; ICDS = Integrated Child Development Services; NGO = Nongovernmental Organization; TBA = Traditional Birth Attendant ANM = Auxiliary Nurse Midwife; LHV = Lady Health Visitor; AWW = Anganwadi Worker; ASHA = Accredited Social Health Activist; MPW = Multipurpose Worker						

3.2.2 Multivariable Logistic Regression

In the NFHS-3 women were asked to identify the problems they encountered when trying to access medical advice or treatment. Their responses were coded into No Problem, Big Problem, Not a Big Problem and Missing. For the multivariable logistic regression, the responses ‘Not a Big Problem' and ‘Big Problem' were combined and the response ‘No Problem' was left by itself to create binary outcomes. Tables 6 and 7 report the odds ratios and 95% confidence intervals for each barrier for both women in general (Table 6) and ever-married women (Table 7). Significant findings are made bold. Covariables were kept in the model if: a) variables were statistically significant ($p<0.05$) in the Wald chi-square test, b) known to be important based on a theoretical model or from the literature, or c) resulted in a significant change in the -2log likelihood (intercept and covariables) fit statistic.

Table 6 exhibits the odds ratios and 95% confidence intervals for all three comparison groups. Multivariable logistic regressions were used to model the event occurring: for example the outcome variable modeled was permission=1, modeling those women who reported that getting permission was a problem (big or small) to assessing medical advice and/or treatment.

Getting permission to seek medical advice or treatment appeared to be a) more of a problem for agricultural labourers and b) less of a problem for all women when compared with garment workers after adjusting for covariables; however this was not statistically significant. Money was more of a problem for agricultural labourers (OR: 1.20 95% CL: 1.05-1.39) compared to garment workers when trying to seek medical advice or treatment after adjusting for covariables. As well, the odds of all women was 1.02 times the odds of garment workers to report that money was a problem to accessing health care services, this finding was not statistically significant. Distance also appeared to be more of a problem after adjustment for agricultural labourers and less of a problem for all women in comparison to garment workers; however this was not statistically significant. The lack of health providers was reported by agricultural labourers to be more of a problem than it was reported by garment workers (not statistically significant). In addition, the odds of all women was 0.93 times the odds of garment workers to report that no health provider was a problem in accessing medical advice or treatment, these findings were not statistically significant.

Women who reported to have access to their own source of income were less likely to report experiencing permission (OR: 0.61 95% CL: 0.54-0.67), money (OR: 0.55 95% CL: 0.50-0.60), distance (OR: 0.88 95% CL: 0.79-0.97), or no health provider (OR: 0.82 95% CL: 0.74-0.91) as barriers to accessing health care. Women who earned cash compared to women were not paid at all were more likely (OR: 1.39 95% CL: 1.21-1.59), to report that money was a barrier to accessing health care.

Women who lived in rural areas reported these barriers more frequently compared to women who lived in urban areas (i.e. distance OR: 2.57 0. 95% CL: 2.21-2.99). An increase in the number of years of education a woman had also decreased the likelihood of her reporting that permission (OR: 0.85 95% CL: 0.80-0.90), money (OR: 0.77 95% CL: 0.73-0.81), distance (OR: 0.81 95% CL: 0.77-0.85), or no health provider (OR: 0.89 95% CL: 0.84-0.93) were barriers to accessing medical advice or treatment. Widows are more likely to report that these barriers are a problem when compared with unmarried women.

Table 6: Multivariable-adjusted odds ratios for barriers to accessing medical advice or treatment for women across all comparison groups

	Barriers to Care			
Outcomes:	**Permission[ξ] (Model 1)**	**Money[ξ] (Model 2)**	**Distance[ξ] (Model 3)**	**No health provider[ξ] (Model 4)**
N:	**23,193**	**23,190**	**23,192**	**23,192**
C statistic:	**0.695**	**0.707**	**0.733**	**0.712**
Predictor Variables (below):	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Group				
Garment Workers[ψ]	1.00	1.00	1.00	1.00
Agricultural L.	1.08 (0.91-1.29)	**1.20 (1.05-1.39)**	1.13 (0.97-1.32)	1.03 (0.88-1.21)
All Women	0.97 (0.82-1.15)	1.02 (0.89-1.17)	0.93 (0.81-1.07)	0.93 (0.80-1.08)
Age (continuous)	**0.97 (0.97-0.98)**	0.99 (0.99-1.00)	**0.99 (0.98-0.99)**	0.99 (0.99-1.00)
Education (# yrs) (ordinal variable)	**0.85 (0.80-0.90)**	**0.77 (0.73-0.81)**	**0.81 (0.77-0.85)**	**0.89 (0.84-0.93)**
Place of Residence	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Urban[ψ]	1.00	1.00	1.00	1.00
Rural	**1.46 (1.22-1.74)**	**1.39 (1.21-1.60)**	**2.57 (2.21-2.99)**	**1.51 (1.27-1.79)**
Marital Status	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Never married[ψ]	1.00	1.00	1.00	1.00
Married	0.96 (0.84-1.10)	1.05 (0.93-1.18)	**1.25 (1.11-1.42)**	1.12 (0.99-1.27)
Widowed	**0.62 (0.47-0.82)**	**1.26 (1.02-1.56)**	**1.37 (1.10-1.69)**	**1.24 (1.01-1.51)**
Divorced	0.82 (0.41-1.67)	1.02 (0.57-1.81)	**1.82 (1.03-3.20)**	1.09 (0.64-1.86)
Not living together	**0.63 (0.44-0.91)**	1.16 (0.87-1.54)	1.15 (0.86-1.55)	1.09 (0.82-1.45)
Respondent's type of earnings for work:	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Not paid[ψ]	1.00	1.00	1.00	1.00
Cash only	1.05 (0.90-1.22)	**1.39 (1.21-1.59)**	1.05 (0.91-1.22)	0.87 (0.75-1.00)
Cash and kind	1.04 (0.86-1.26)	**1.51 (1.26-1.81)**	**1.38 (1.15-1.67)**	0.99 (0.82-1.20)
In-kind only	0.91 (0.74-1.11)	0.91 (0.74-1.12)	1.12 (0.89-1.40)	**0.74 (0.57-0.96)**
Has own money	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
No[ψ]	1.00	1.00	1.00	1.00
Yes	**0.61 (0.54-0.67)**	**0.55 (0.50-0.60)**	**0.88 (0.79-0.97)**	**0.82 (0.74-0.91)**
Household has a BPL card	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
No[ψ]	1.00	1.00	1.00	1.00
Yes	0.99 (0.90-1.10)	**1.11 (1.01-1.21)**	1.02 (0.93-1.12)	1.00 (0.91-1.10)

	Barriers to Care
The variable *state of residence* was included in all of the models but is not reported here. ᵠ Indicates referent response. ξTesting for interaction between *Respondent's type of earnings for work* and *Has own money* was significant for the Wald chi-square test at p<0.0001.	

Table 7 shows the odds ratios and 95% confidence intervals for barriers to accessing medical advice or treatment for all three comparison groups, however this table presents finding specifically for ever-married women to analyze the effects of marriage.

Agricultural labourers more frequently reported that permission, money (statistically significant), distance, and no health provider were barriers compared to garment workers. The all women category more frequently reported that permission and money were barriers to accessing care compared to garment workers; however these results were not statistically significant. The odds of reporting that money was a barrier to accessing health care services for agricultural labourers was 1.21 the odds of garment workers. The odds in favour of money, distance, and no health provider being a problem decrease for each increasing year of education for ever-married women.

Women who reported to have access to their own source of money were also less likely to report that permission, money, and no health provider presented barriers. Women with cash earnings were less likely to report that no health provider was a barrier (OR: 0.78 95% CL: 0.67-0.92) but more likely to report that money was a barrier (OR: 1.28 95% CL: 1.09-1.50). An increase in the number of years husbands were educated served as a protective measure against reporting that permission, money, distance and no health provider were barriers. Women were asked to report on the number of marital control issues they perceived their partner/husband to have. Women who reported that their husband had six control issues were more likely to experience all four of the barriers to accessing health care.

Table 7: Multivariable-adjusted odds ratios for barriers to accessing medical advice or treatment for ever-married women across all comparison groups

	Barriers to Care			
Outcomes:	**Permission**	**Money[ξ]**	**Distance[ξ]**	**No health provider[ξ]**
N:	**13,530**	**13,528**	**13,529**	**13,530**
C statistic:	**0.725**	**0.726**	**0.743**	**0.716**
Predictors:	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Group				
Garment Workers[ψ]	1.00	1.00	1.00	1.00
Agricultural L.	1.07 (0.85-1.35)	**1.21 (1.01-1.45)**	1.15 (0.95-1.39)	1.07 (0.87-1.30)
All Women	1.03 (0.82-1.30)	1.03 (0.86-1.22)	0.96 (0.79-1.15)	0.96 (0.79-1.17)
Age	**0.99 (0.98-0.99)**	1.01 (0.99-1.01)	0.99 (0.99-1.01)	0.99 (0.99-1.00)
Education	0.94 (0.87-1.03)	**0.84 (0.78-0.90)**	**0.84 (0.79-0.90)**	**0.90 (0.84-0.96)**
Place of Residence	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Urban[ψ]	1.00	1.00	1.00	1.00
Rural	**1.43 (1.16-1.78)**	**1.36 (1.15-1.61)**	**2.56 (2.14-3.06)**	**1.32 (1.08-1.61)**
Marital Status	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Married[ψ]	1.00	1.00	1.00	1.00
Widowed	**0.67 (0.50-0.89)**	**1.23 (1.02-1.50)**	1.03 (0.84-1.27)	1.13 (0.94-1.36)
Divorced	0.69 (0.29-1.63)	0.82 (0.42-1.59)	1.30 (0.68-2.49)	0.84 (0.44-1.62)
Not living together	**0.52 (0.33-0.82)**	0.90 (0.65-1.24)	0.81 (0.59-1.11)	0.77 (0.55-1.07)
Respondent's type of earnings for work:	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Not paid[ψ]	1.00	1.00	1.00	1.00
Cash only	1.01 (0.84-1.22)	**1.28 (1.09-1.50)**	1.03 (0.87-1.20)	**0.78 (0.67-0.92)**
Cash and kind	0.99 (0.79-1.24)	**1.40 (1.14-1.72)**	**1.27 (1.03-1.56)**	0.90 (0.73-1.11)
In-kind only	0.94 (0.74-1.20)	0.96 (0.76-1.20)	1.16 (0.91-1.48)	**0.75 (0.58-0.98)**
Has own money	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
No[ψ]	1.00	1.00	1.00	1.00
Yes	**0.66 (0.57-0.75)**	**0.57 (0.51-0.64)**	0.94 (0.83-1.07)	**0.88 (0.79-0.99)**
Household has a BPL card	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
No[ψ]	1.00	1.00	1.00	1.00
Yes	1.01 (0.90-1.13)	1.06 (0.95-1.17)	0.98 (0.87-1.10)	0.96 (0.86-1.07)
Husband's Education	**0.88 (0.83-0.92)**	**0.88 (0.85-0.92)**	**0.92 (0.88-0.96)**	**0.95 (0.91-0.98)**
Number of control issues	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
0[ψ]	1.00	1.00	1.00	1.00
6	**3.95 (2.70-5.79)**	**3.23 (2.21-4.85)**	**2.27 (1.51-3.41)**	**2.02 (1.42-2.88)**

Outcomes:	Permission	Money[ξ]	Distance[ξ]	No health provider[ξ]
Freedom of movement:	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Respondent is allowed to go to the market:				
Not at all[Ψ]	1.00	1.00	1.00	1.00
Alone	**1.42 (1.11-1.83)**	**1.44 (1.15-1.81)**	1.14 (0.88-1.47)	1.17 (0.92-1.49)
With someone else only	**1.70 (1.35-2.15)**	**1.28 (1.03-1.59)**	1.11 (0.85-1.43)	**1.47 (1.15-1.86)**
Respondent is allowed to go to a health facility:	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Not at all[Ψ]	1.00	1.00	1.00	1.00
Alone	0.88 (0.61-1.27)	0.94 (0.66-1.34)	0.74 (0.48-1.14)	0.85 (0.57-1.26)
With someone else only	1.18 (0.83-1.68)	1.06 (0.77-1.48)	1.11 (0.73-1.69)	1.09 (0.74-1.60)
Respondent is allowed outside this community:	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**	**OR (95% CL)**
Not at all[Ψ]	1.00	1.00	1.00	1.00
Alone	**0.29 (0.21-0.39)**	**0.53 (0.39-0.71)**	1.02 (0.74-1.40)	0.93 (0.69-1.25)
With someone else only	**0.42 (0.32-0.56)**	0.83 (0.63-1.10)	1.13 (0.83-1.54)	0.91 (0.67-1.22)

The variable *state of residence* was included in all of the models but is not reported here.
[Ψ] Indicates referent response
[ξ]Interaction between *Respondent's type of earnings for work* and *Has own money* was significant for the Wald chi-square test at p<0.0001.

3.3 Women's Empowerment and Domestic Violence Data

<u>3.3.1 Descriptive Statistics</u>

The percentage of garment workers who were currently working was 89% compared to 78% of agricultural labourers and 27% of all women (Table 8). In response to whether garment workers worked seasonally or all year round, 69% of garment workers responded that they worked all year, more than agricultural labourers of whom only 42% worked all year. There are differences in where women work; 82% of garment workers worked from home compared to 6% of agricultural labourers and 20% of all women. Table 8 shows that garment workers were mostly paid in cash only (91%) with few in-kind payments, compared to agricultural labourers of whom 19% received cash and kind payments. For more detailed information on cash earnings consult Table B in the appendix.

Table 8: Select women's empowerment and domestic violence indicators

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Employment:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent worked in the last 12 months:	-	-	-	-	-	-
No	0.00 (0)	0.00	0.00 (0)	0.00	68.91 (14,809)	0.56
In the past year	10.07 (458)	0.68	21.20 (2463)	0..75	4.18 (782)	0.23
Currently working	88.96 (4445)	0.70	77.93 (8858)	0.76	26.50 (5881)	0.53
Have a job, but on leave	0.97 (80)	0.18	0.87 (120)	0.10	0.39 (107)	0.06
Missing	0.00 (0)	0.00	0.00 (0)	0.00	0.02 (4)	0.01
Respondent employed all year/seasonally:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
All year	68.97 (3482)	1.39	42.33 (4780)	1.00	67.49 (4746)	0.88
Seasonal	18.37 (947)	1.21	53.44 (6178)	1.02	27.96 (1720)	0.86
Occasional	12.60 (552)	0.84	4.17 (475)	0.33	4.44 (291)	0.36
Missing	0.06 (2)	0.06	0.06 (8)	0.02	0.10 (13)	0.05
Total	4983		11,441		6770	
Where Respondent works:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
At home	82.34 (4140)	1.28	6.01 (754)	0.48	20.05 (1315)	0.90
Away	17.53 (839)	1.27	93.83(10,670)	0.48	79.85 (5439)	0.90
Missing	0.13 (4)	0.08	0.16 (17)	0.04	0.10 (16)	0.04
Total	4983		11,441		6770	
Respondent's type of earnings for work:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Not paid	6.40 (307)	0.72	15.54 (2227)	0.93	28.45 (1754)	1.02
Cash only	91.40 (4525)	0.81	45.72 (4937)	1.11	54.39 (4068)	1.07
Cash and kind	1.44 (114)	0.28	19.45 (2169)	0.87	10.40 (575)	0.61
In-kind only	0.70 (34)	0.24	19.27 (2105)	1.24	6.70 (363)	0.54
Missing	0.69 (3)	0.06	0.02 (3)	0.01	0.05 (10)	0.02
Total	4983		11,441		6770	
Access to money and credit:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent has money for her own use:	-	-	-	-	-	-
No	41.51 (2008)	1.48	52.66 (6196)	1.05	56.59 (12,329)	0.65
Yes	58.49 (2975)	1.48	47.33 (5244)	1.05	43.36 (9246)	0.65
Missing	0.00 (0)	0.00	0.01 (1)	0.01	0.05 98)	0.02

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Respondent has a bank or savings account:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	81.51 (4100)	0.84	90.86 (10,395)	0.40	83.99 (17,540)	0.40
Yes	18.35 (875)	0.84	8.95 (1025)	0.40	15.84 (4006)	0.40
Missing	0.14 (8)	0.06	0.19 (21)	0.05	0.17 (37)	0.04
Respondent has knowledge of loan programs:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	49.30 (2490)	1.50	65.89 (7678)	0.94	60.91 (13,408)	0.66
Yes	50.70 (2493)	1.50	34.08 (3760)	0.94	39.05 (8169)	0.66
Missing	0.00 (0)	0.00	0.03 (3)	0.02	0.04 (6)	0.02
Respondent has been given a loan:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	86.06	1.21	82.20	1.02	90.37	0.50
Yes	13.93	1.21	17.58	1.01	9.50	0.50
Missing	0.01	0.00	0.22	0.09	0.13	0.05
Freedom of movement:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent is allowed to go to the market:						
Alone	57.13 (3195)	1.45	51.31 (6152)	0.91	51.44 (12,877)	0.59
With someone else only	29.53 (1423)	1.11	34.97 (3931)	0.81	36.50 (6831)	0.56
Not at all	13.33 (365)	1.10	13.68 (1354)	0.68	12.01 (1867)	0.40
Missing	0.00 (0)	0.00	0.04 (4)	0.02	0.05 (8)	0.02
Respondent is allowed to go to a health facility:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Alone	52.08 (2799)	1.36	47.45 (5622)	0.87	47.46 (11,552)	0.58
With someone else only	43.18 (2026)	1.28	47.61 (5320)	0.88	47.89 (9264)	0.59
Not at all	4.74 (158)	0.58	4.91 (497)	0.35	4.59 (759)	0.25
Missing	0.00 (0)	0.00	0.02 (2)	0.02	0.06 (8)	0.03

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Respondent is allowed to go to places outside this community:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Alone	41.76 (2333)	1.37	39.33 (4703)	0.84	37.62 (9235)	0.56
With someone else only	49.77 (2350)	1.37	53.01 (5969)	0.89	53.91 (10,858)	0.61
Not at all	8.48 (300)	0.80	7.63 (766)	0.48	8.42 (1481)	0.36
Missing	0.00 (0)	0.00	0.03 (3)	0.02	0.06 (9)	0.03
Partner's characteristic's:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Partner's education level (among currently married):	-	-	-	-	-	-
No education	19.07 (460)	1.25	45.93 (4254)	0.78	23.27 (3198)	0.55
Primary	17.10 (431)	1.11	19.53 (1929)	0.48	15.50 (2371)	0.40
Secondary	54.58 (1765)	1.62	31.11 (3173)	0.68	47.46 (8005)	0.60
Higher	8.62 (335)	0.73	2.01 (226)	0.22	12.84 (2557)	0.41
Don't Know	0.57 (20)	0.18	1.16 (118)	0.13	0.80 (128)	0.10
Missing	0.06 (2)	0.06	0.25 (27)	0.05	0.13 (28)	0.04
Total	3013		9727		16,287	
Partner's occupation:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Did not work	3.04 (78)	0.47	1.96 (196)	0.17	2.13 (355)	0.15
Professional/ technical/ managerial	5.74 (216)		0.59		1.28 (167)	
Clerical	3.64 (151)		0.46		1.05 (142)	
Sales	11.77 (404)	0.84	4.87 (451)	0.32	13.67 (2456)	0.41
Agricultural	12.14 (293)	1.17	56.85 (5392)	0.98	29.36 (3820)	0.64
Services	5.67 (181)	0.62	2.63 (291)	0.20	6.13 (1172)	0.27
Skilled and unskilled manual	57.63 (1678)	1.51	30.97 (3052)	0.82	36.03 (5824)	0.62
Don't Know	0.06 (2)	0.04	0.23 (17)	0.06	0.05 (6)	0.03
Missing	0.31 (10)	0.14	0.15 (19)	0.04	0.14 (34)	0.04
Total	3013		9727		16,287	
Domestic violence:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Perceptions of domestic violence:						

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Wife beating is justified if wife neglects the children:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	61.61 (2840)	1.25	55.64 (6146)	0.88	65.73 (14,019)	0.59
Yes	37.26 (2095)	1.23	43.17 (5153)	0.88	33.21 (7286)	0.58
Don't Know	1.13 (48)	0.24	1.19 (142)	0.12	1.03 (272)	0.09
Missing	0.00 (0)	0.00	0.00 (0)	0.00	0.03 (6)	0.02
Wife beating is justified if wife is disrespectful to in-laws:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	56.47 (2645)	1.34	49.36 (5590)	0.86	59.30 (12,954)	0.61
Yes	41.64 (2261)	1.32	48.80 (5634)	0.87	39.12 (8238)	0.60
Don't Know	1.89 (77)	0.36	1.83 (216)	0.19	1.56 (386)	0.13
Missing	0.00 (0)	0.00	0.01 (1)	0.01	0.02 (5)	0.01
Experience of domestic violence:						
Ever experience any emotional violence? (currently married women)	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	83.28 (1927)	1.10	77.94 (5732)	0.75	84.15 (10,214)	0.51
Yes	16.72 (354)	1.10	21.96 (1519)	0.75	15.80 (1648)	0.51
Missing	0.01 2)	0.01	0.10 (4)	0.07	0.06 (9)	0.02
Total	2283		7255		11,871	
Ever experience any less severe physical violence? (currently married women)	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	63.02 (1498)	1.48	52.34 (4039)	0.86	66.39 (8370)	0.66
Yes	36.97 (782)	1.48	47.56 (3212)	0.84	33.53 (3491)	0.66
Missing	0.01 (3)	0.01	0.10 (4)	0.07	0.09 (10)	0.04
Total	2283		7255		11,871	

More garment workers (58%) had access to their own money than agricultural labourers (47%) and the all women (43%) group. Also, 18% of garment workers had bank/savings accounts compared to only 9% of agricultural labourers and 16% of all women. The percentage of garment workers who knew about loan programs was 51% but only 14% of garment workers had taken out loans, compared to 34% of agricultural labourers who knew of loan programs but 18% had taken out a loan.

Freedom of movement was measured in the NFHS-3 by asking respondents if they were allowed to go places by themselves, with other people or not at all. Fifty-seven percent of garment workers reported that they could go to the market alone, 52% reported that they could go to health facilities alone and 42% reported that they could go outside their community alone, fewer agricultural labourers and all women were able to go to these places alone.

Most garment workers had completed secondary education (54%) and 55% of them were married to men who had also completed secondary education, compared to 46% of agricultural labourers who were married to men with no education. Most garment workers (58%) were married to men whose occupation was in the skilled and unskilled manual labour sector while 57% of agricultural labourers were married to men in agricultural labour. Thirty-six percent of women in the all women group were married to men in the skilled and unskilled manual labour sector.

A subsample of women were asked about their perceptions of domestic violence in the NFHS-3 survey. Several hypothetical domestic scenarios were presented to women and they were asked if wife beating was justified in those cases. The two reasons for which most garment workers thought wife beating was justified was a.) when wives disrespected in-laws (42%) and b.) when wives neglected their children and households (37%). Agricultural labourers showed similar patterns of justification and agricultural labourers thought wife-beating was justified in the other scenarios more than both garment workers and all women. Participants were also asked about their experience of emotional and/or physical violence. Seventeen percent of garment workers reported experiencing emotional violence compared to 22% of agricultural labourers. In addition, 13% of garment workers reported experiencing severe physical violence compared to

19% of agricultural labourers. For more data on domestic violence consult Table B in the appendix.

3.3.2 Multivariable Logistic Regression

In the NFHS-3 currently married women were asked about their decision making abilities. Respondents were asked: who in their household had the final say on various aspects of their life. Their responses were coded into 'Respondent Alone', 'Respondent and Husband/Partner,' 'Husband/Partner Alone', 'Someone Else', 'Other' and 'Missing'. For the multivariable logistic regression, the responses 'Respondent Alone' and 'Respondent and Husband/Partner' were grouped together and the responses 'Husband/Partner Alone', 'Someone Else', and 'Other' were grouped to create binary outcomes. Descriptive statistics for decision making abilities can be found in the appendix (Table B). Table 9 reports the odds ratios and 95% confidence intervals for each decision, significant findings are made bold. Covariables were kept in the model if they were a) statistically significant ($p<0.05$) on the Wald chi-square test, b) significant based on the literature, or c) resulted in a significant change in the -2log likelihood (intercept and covariables) fit statistic.

Table 9 illustrates that agricultural labourers (OR: 0.69 95% CL: 0.54-0.88) and all women (OR: 0.75 95% CL: 0.58-0.98) are less likely to make decisions regarding how to spend their earnings compared to garment workers. As well, agricultural labourers are less likely to make decisions regarding their own health care (OR: 0.86 95% CL: 0.75-0.99) when compared with garment workers. The odds in favour of having the final say jointly with husband/partner on own cash earnings increased an estimated 4% for each additional year of age and 38% for each increasing level of education for women. The odds of women with a BPL card to report having the final say on own cash earnings jointly with husband/partner was 0.80 times the odds of women without BPL cards to report having the final say on own cash earnings.

Women, who reported having the freedom to go to the market alone were more likely to engage in decision making on both their own earnings (OR: 1.76 95% CL: 1.33-2.33) and their own health (OR: 1.82 95% CL: 1.55-2.14). The odds of women who agreed that wife beating was justified if wife argued with partner to report having the final say on own health care jointly with husband/partner was 0.80 times the odds of women who disagreed that wife beating was justified if wife argued with partner, to report having the final say on own health care jointly with husband/partner.

Table 9: Multivariable-adjusted odds ratios for respondent alone/respondent and husband jointly making decisions for currently married women across all comparison groups

	Decision Making Abilities	
Outcomes:	**Own earnings**	**Own health**[ξ]
N:	**10,993**	**26,852**
C Statistic:	**0.747**	**0.690**
Predictors:	**OR (95% CL)**	**OR (95% CL)**
Group:		
Garment Workers [ψ]	1.00	1.00
Agricultural L.	**0.69 (0.54-0.88)**	**0.86 (0.75-0.99)**
All Women	**0.75 (0.58-0.98)**	0.88 (0.76-1.01)
Age	**1.04 (1.03-1.05)**	**1.03 (1.02-1.03)**
Education	**1.38 (1.25-1.52)**	**1.12 (1.07-1.03)**
Household has a BPL card	**OR (95% CL)**	**OR (95% CL)**
No [ψ]	1.00	1.00
Yes	**0.80 (0.69-0.92)**	**0.88 (0.81-0.96)**
Has own money	**OR (95% CL)**	**OR (95% CL)**
No [ψ]	1.00	1.00
Yes	**1.67 (1.44-1.93)**	**1.15 (1.05-1.25)**
Husband's education	1.00 (0.94-1.07)	**0.92 (0.89-0.95)**
Freedom of movement:	**OR (95% CL)**	**OR (95% CL)**
Respondent is allowed to go to the market:		
Not At all [ψ]	1.00	1.00
Alone	**1.76 (1.33-2.33)**	**1.82 (1.55-2.14)**
With someone else only	**1.32 (1.02-1.71)**	**1.38 (1.19-1.59)**
Respondent is allowed to go to a health facility:		
Not At all [ψ]	1.00	1.00
Alone	**1.64 (1.13-2.38)**	1.22 (0.97-1.54)
With someone else only	1.00 (0.71-1.42)	0.87 (0.70-1.08)

Outcomes:	Own earnings	Own health[ξ]
Perceptions of domestic violence:	**OR (95% CL)**	**OR (95% CL)**
Wife beating justified if she argues with him		
No [ψ]	1.00	1.00
Yes	1.00 (0.87-1.16)	**0.80 (0.73-0.87)**

The variables *state of residence* was included in both models but is not reported here.
[ψ] Indicates referent response
[ξ]Interaction between *Household has a BPL card* and *Has own money* was significant for the Wald chi-square test at $p<0.0001$.

CHAPTER 4: DISCUSSION

4.1 Demographics

According to the NFHS-3, 59.7% of Indian women reported having no occupation. The two most frequently reported occupations were agricultural labourers (9.2%) and garment workers (4%). As two of the largest providers of employment for Indian women, the effect of these occupations in the empowerment of women with regard to their decision - making in health and health care access was important to analyze.

Garment workers were described using data from the most recent (2005-06) National Family Health Survey (NFHS-3). Descriptive statistics suggested that garment workers deviated less from the ‘all women’ category which is representative of all women in India than the agricultural labourers. Generated frequencies portrayed garment workers as a younger demographic group, most of whom had completed secondary education and married men who were equally educated and also worked in skilled or unskilled manual labour. Fewer garment workers were married compared to both the agricultural labourers and the all women group. In our discussions with managers in garment factories from Karnataka, India, many reported that most of their employees were young, unmarried women who had just completed secondary education. This population provides the garment industry with young fresh talent to fuel its business. The managers reported that there was a high turnover rate as young women would work as garment workers until they were married, at which point they would leave to have children and then return once the children were older.

Descriptive statistics found that 82% of garment workers worked from home. Although not distinguishable in the dataset, most of these garment workers most likely worked informally as home-based tailors. The 18% of garment workers in our dataset who worked away from home may be garment workers who work in factories. In contrast 94% of agricultural labourers worked away from home. As 69% of agricultural labourers belonged to the poorest-poorer wealth index, most agricultural labourers farm on land that does not belong to them whereas the 6% of agricultural labourers that do work from home may be subsistence farmers. Occupation-specific information would be useful here for further analyses.

Results suggested that more garment workers lived in urban centers (59%) instead of rural areas. This finding may also be related to why garment workers are more educated and wealthier than agricultural labourers. This may also be due to migration of garment workers from rural areas to urban centers looking for work(48) both in factories or from operating tailoring business' that draws from the higher population density found in cities. Agricultural labourers in contrast lived more so in rural areas (93%) than in urban areas. This is not an unexpected finding, however this implies that agricultural labourers are often deprived of the amenities found in urban arenas indicating an urban bias(19).

Fewer garment workers held BPL cards (25%) compared to agricultural labourers (40%) and most reported to belong to the 'richer' wealth index (34%) whereas 38% of agricultural labourers belonged to the 'poorest' wealth index. Therefore it appears that based on employment alone garment workers have a higher SES. However, it is difficult to say whether it is the occupation – garment work or whether the fact that they are more educated, live predominantly in urban areas, and are married to more educated men that keeps garment workers in the higher wealth bracket. It is important to note however that 91% of garment workers received cash only as their method of payment compared to both agricultural labourers and all women, of whom only 46% and 54% respectively, received cash only payments. This is consistent with results from NFHS-3 reports(20). This finding does suggest that garment work as a mode of employment provides women with more access to their own source of money when compared with agricultural labourers.

Assessing crude changes in frequencies for certain demographic indicators collected over two cross-sectional time periods from the NFHS-2 to NFHS-3 shows that garment workers as a population have realized better outcomes in several areas. Results suggest that garment workers have become more educated, are younger, more urban, more work year-round and more make cash only and marry similarly educated men.

4.2 Health Care Utilization and Barriers to Care

Health insurance coverage was low amongst garment workers but was close to the national average of 5% as represented by the all women comparison group in our study and as reported in the NFHS-3 (20). However, this may be due to the fact that 80% of garment workers in this sample worked from home and were most likely informal self-employed workers without access to ESI benefits (factory working garment workers would). One percent of agricultural labourers reported having a member of their household covered by health insurance. This finding is supported by the fact that agricultural labourers tended to marry men who also worked in agricultural labour, which generally does not provide health insurance coverage. Having a member of the household covered by health insurance proved to be protective against different barriers to health, especially if women were married.

Garment workers who did report having a member in the household with insurance tended to have Employee State Insurance Scheme and private insurance as the two most popular forms of coverage and sought care primarily from private doctors followed by care from government hospitals. This is consistent with national data from the NFHS-3(20). The reason most commonly cited by garment workers for not using government facilities was the poor quality of care delivered in government facilities; this was echoed by agricultural labourers and women in general. This finding is also shown in the national data from the NFHS-3(20).

Our hypothesis based on our theoretical framework was that garment workers would report facing fewer barriers to accessing health care due to their access to more cash earnings. This assumption proved to be true, however after controlling for a number of covariables in our regression models, this assumption was only statistically significant for money as a barrier (although the trend was similar for all other barriers as well). Garment workers reported that money was less of a problem to accessing health care than it was for agricultural labourers.

The regression models for all barriers: permission, money, distance and no health provider all showed that women with access to their own money reported fewer barriers to accessing medical advice or treatment. This speaks to the importance of employment, more specifically garment work as an income source which helps to reduce poverty and inequality resulting in improved living standards for garment workers and their families. This is shown by 91% of garment workers receiving cash as their method of payment unlike both agricultural labourers and all women, of whom only 46% and 54% respectively, received cash as payments. Therefore our hypothesis that fewer garment workers would report facing barriers such as permission, money, distance and no health provider because they had access to their own cash earnings was reflected in the results from the regression models.

As garment workers tended to be mostly populated in urban centers, fewer of them used the services of grass roots health personnel like ASHA's, AWW's and LHV's who are mostly in rural areas. Whereas 93% of agricultural labourers lived in rural India and often used their services compared to garment workers who sought most of their care from physicians who are rare in rural areas. This may explain why no health provider appears to be a bigger problem for agricultural labourers than it is for garment workers, but it was not a statistically significant finding.

Ever-married women, particularly widows reflected an interesting relationship with the barriers. Widows were less likely to report that permission was a barrier to accessing health care when compared with married women, but were also more likely than married women to report that money was a barrier to accessing health care. These are interesting findings as they speak to the independence of widows and their freedom of movement, however as they may be the only income earners, money might be spread thin and accessing medical advice might prove to be too expensive.

Married women’s experience of barriers to health care is heavily influenced by their husband’s education levels, his control issues and her freedom of movement. The odds in favour of reporting permission, money, distance and no health provider as barriers to care decreased for each additional year of husband's education. As well, when respondents reported that their husband had six control issues compared to none the odds of them reporting that permission, money, distance and no health provider were barriers increased substantially. This indicates the large role that husband's play in women's access to health care services. Therefore, this speaks to the importance of women having their own income to assist them with overcoming barriers to health care services.

Several barriers such as permission, money, distance and no health provider to accessing medical advice or treatment were assessed for garment workers, agricultural labourers and women in general in India. In general, enabling factors for low self-reported barriers were age, higher education levels, access to their own money and living in urban areas. Women who were married were also affected by their husband's education level, his number of control issues as well as her freedom of movement. Women who reported cash earnings were more likely to report that money was a barrier to accessing health care, even though women who had their own money reported that money was not a barrier. However, there was a significant interaction between the variables *respondent's type of earnings* and women *having their own money* at $p<0.0001$.

4.3 Women's Empowerment and Domestic Violence

More garment workers were employed all year (69%) compared to agricultural labourers who were mostly seasonal workers (53%). Since garment workers worked year round and had dependable employment they also had more money for their own use compared to agricultural workers. Also, 91% of garment workers received cash payments compared to agricultural labourers and all women who received no payment, cash and kind, and rarely only cash. This resulted in less hard cash for these two comparison groups. In contrast, 99% of currently married men aged 15-49 in the NFHS-3 were employed, of which 92% earned cash for their work(20). Therefore "not only are currently married women less than half as likely as currently married men to be employed, but when employed, they are only 70% as likely as men to be paid only in cash and five times as likely as men to not receive any earnings at all"(20).

According to our hypothesis based off our theoretical model, having a source of income provides women with increased decision-making abilities thereby acting as an empowering tool. This was demonstrated in all of the regression models by women with access to their own source of money reporting less barriers to health care and having more decision making abilities. According to the NFHS-3, "The proportion of women who themselves mainly decide the disposition of their own earnings increases with age, education and wealth, whereas the proportion for whom the husband mainly decides, decreases with age, education and wealth"(20). As previously mentioned, according to the World Bank, when women play larger roles in deciding how household money is spent, a larger share gets spent on child and welfare expenditures(20).

The results from this study show that employment with cash earnings increases the likelihood of women participating in decision making (20). Women with access to their own source of money had more say in the decisions that were measured. They had a final say either alone or jointly with their partners on how their cash earnings were spent, how their partner's cash earnings were spent, on their own health care, purchasing daily needs and visiting family. As 58% of garment workers had money for their own use compared to 47% of agricultural workers and 43% of women in general, garment workers were more likely to have negotiating powers at home. The regression models for empowerment showed that agricultural labourers and all women were less able to have decision making powers regarding their own earnings and health compared to garment workers. The importance of this finding lies in how garment work as an income source is a tool in improving daily living conditions which address the social determinants of health. Women who work as garment workers are given more opportunities to improve their welfare as well as their families.

Living in urban areas and more years of education are also enabling factors for decision making capabilities which is consistent with national level data(20). Women who were older, had the freedom to go to the market or health facilities alone, and had their own money had more decision making abilities. In India "45 percent of all women aged 15-49 say that they have some money that they can use; 15 percent have a bank or savings account that they themselves use; 39 percent know of a programme that gives money to women to start or expand a business of their own; and only 4 percent of all women have ever taken a loan from such a programme”(20). These indicators increased for women who were employed for cash. More garment workers were allowed to go to the market, health facilities and outside of their community on their own than women in either of the other groups. Women, whose household held a BPL card, were less likely to make decisions regarding their own earnings or their own health. This once again illustrates the need for the social determinants of health to be addressed. The finding that poorer women are less able to make decisions regarding their health and earnings is an issue that affects not only the woman herself, but her family and her society.

A normative behaviour that is commonly accepted in India is the ‘right’ of husbands to have power over their wives’ behavior and bodies through whatever means necessary(20). Women who believed that husbands’ should control their wives may be perceived to be less empowered and their acceptance of these norms need to be addressed(20). Perceptions of domestic violence play an important role in women’s empowerment. Women who believed that wife beating was justified if she argued with husband were less likely to make decisions regarding her own health. Garment workers were all less likely to agree with wife beating which may have increased their likelihood of making decisions and facing fewer barriers. For married women, the odds in favour of making decisions regarding their own health increased for every year of husband’s education.

The theoretical framework for this study highlighted the importance of garment work as an important source of income for Indian women. The access to cash earnings provided by garment work were expected to increase their cash earnings thereby increasing their decision making abilities resulting in empowerment. This theory was backed up by the results from this study which found that garment workers were more likely to have the final say on decisions regarding their own cash earnings and their own health.

4.4 LIMITATIONS

The limitations to this study stem primarily from the fact that the NFHS uses self-report data. This has many advantages but is also associated with several biases. One of the biases that may play a role is volunteer bias by women who decided to participate being inherently different from women who declined to take care part of the survey. There might also be some recall bias, over reporting of positive health care indicators like the number of health facility visits and the under reporting of the prevalence of domestic violence. There are also other biases based on respondent's misinterpretation of questions, such as the possible under reporting of general health problems due to lack of knowledge of disease pathology. The survey design, large sample size and data collection through the use of multilingual well trained interviewers helped to reduce sources of bias, however findings may be subject to confounders and interactions which were not addressed. As well, as multiple women were interviewed from the same household the data might have an unknown degree of clustering. This results in a lack of independence among individuals in the same cluster which can lead to complicated methodological challenges in both design and analyses.

Other limitations to the study are found in the data analyses, such as the grouping of various similar but different occupations (spinners, weavers, knitters, dyers, tailors, dress-makers, sewers, upholsterers and related workers) into one umbrella *garment worker* occupation category. As well, as 80% of garment workers reported working from home, it was not known whether these women owned their own tailoring business at home, worked on assignment, worked under an employer/family business, or self-employed it was difficult to describe the group given a lack of specificity. Also, when respondents were asked about their occupation if they reported to be a general labourer working in the garment industry, they would have been coded simply as a labourer and would not have been captured.

As well when variables were dichotomized for the multivariable logistic regression some information was lost. As the NFHS is a health survey for the entire population of India, the type of garment workers we pooled are representative of the garment workers in

India. However, the results would have been much richer if a survey particularly designed for garment workers could have been employed. This would have provided data specific to garment workers and would have enlightened us on whether these garment workers worked for the export or domestic market, whether they moved to their current address from somewhere else, where they left their children when they go to work and other occupation specific questions.

4.5 Future Studies

As the present study was mainly descriptive, it would be beneficial in future studies to test for interactions amongst the different explanatory variables to detect at which levels interactions were taking place to tease out exact relationships. As well, a deeper analysis on confounder variables should be undertaken. The next step would be to conduct primary data collection from garment workers in both formal and informal employment in India to compare against our data. Comparing the similarities between this subsample's characteristics to the nationally representative sample provided by the NFHS-3 may provide more accurate results.

4.6 Summary

Access to fair and consistent employment will reduce poverty and inequalities and improve the daily living conditions of women and their families. The focus of this paper was to test the hypothesis that garment work as a source of income for women would provide more cash earnings resulting in decreased barriers to accessing health care services and increased decision making abilities. Female garment workers were compared to both women in agricultural labour (the largest source of employment for Indian women) and women in general in India to see how they compared. This study used descriptive statistics and multivariable logistic regression analyses to model whether women's empowerment indicators such as decision making, access to resources, domestic violence, and gender role attitudes differed between these groups.

This study is the first to specifically report on Indian female garment workers using the NFHS. We compared the effects of their occupation on their health behaviours and measures of empowerment. We found that, in general, garment workers are younger, more educated and more are unmarried, more urban, belong to a higher wealth index, earn more cash and have more access and control over their own source of wealth compared to agricultural labourers and women in general in India. Fewer garment workers than agricultural or all women agreed that wife beating should be justified. On average garment workers were married to men with more education and to men who also worked in skilled and unskilled labour. These enabling factors resulted in garment workers having more decision making powers on control over their own earnings and control over their own health care.

These findings support hypotheses that access to income empowers women by allowing them to take part in more decision making and reduces barriers to accessing health care services. However, it is important to recognize the presence of more complex social interactions. Garment work is an important source of income for women in India, resulting in increased women's empowerment. Therefore these data suggest that efforts to ensure regular employment as well as healthy and safe working conditions would result in broad public health benefits for women and their families.

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APPENDIX

Table A: Health Care Utilization Measures Across Comparison Groups

Health Care Utilization Measures	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Use of Tobacco	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Smokes cigarettes or bidis	0.67 (37)	0.17	2.80 (284)	0.23	1.18 (311)	0.12
Smokes cigars or pipe	0.07 (7)	0.06	0.23 (29)	0.06	0.15 (26)	0.04
Smokes paan masala	1.36 (172)	0.23	1.58 (215)	0.15	2.04 (803)	0.14
Smokes ghutka	1.59 (101)	0.26	2.12 (246)	0.21	1.79 (376)	0.14
Smokes other chewing tobacco	3.52 (312)	0.47	9.73 (1146)	0.45	5.25 (1396)	0.26
Uses snuff	0.33 (10)	0.12	1.27 (144)	0.16	0.81 (133)	0.10
Other	0.44 (27)	0.13	1.41 (215)	0.21	0.43 (98)	0.06
Does not use tobacco	92.83 (4387)	0.59	82.66 (9397)	0.57	89.72 (18,845)	0.34
All that applies >100%						
Use of Alcohol	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Drinks alcohol	0.96 (56)	0.25	4.48 (603)	0.43	1.91 (537)	0.16
Frequency of alcohol use among those who drink alcohol:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Almost every day	17.27 (6)	8.14	14.80 (85)	2.64	17.27 (73)	2.56
About once a week	19.86 (10)	8.56	46.82 (272)	3.26	45.16 (197)	3.18
Less often	62.69 (39)	12.77	37.47 (242)	3.36	36.47 (265)	3.12
Missing	0.19 (1)	0.19	0.91 (4)	0.47	1.10 (2)	0.78
Health Insurance	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Member of household covered by health insurance	5.24 (287)	0.55	1.01 (152)	0.14	5.71 (1470)	0.28
The type of insurance held among those covered:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Employee State Insurance Scheme	33.04 (85)	5.49	13.34 (29)	3.69	27.73 (396)	2.07

Health Care Utilization Measures	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Central Government Health Scheme	6.74 (29)	1.99	17.14 (21)	5.07	20.32 (285)	1.87
Community Health Insurance Programme	7.43 (17)	2.22	11.07 (15)	3.09	4.96 (56)	0.84
Other health insurance through employer	5.58 (14)	1.96	3.18 (5)	1.50	6.60 (109)	1.04
Medical reimbursement from employer	10.94 (54)	3.25	7.20 (13)	3.33	10.12 (199)	1.23
Other privately purchased commercial health insurance	31.53 (70)	4.50	40.89 (57)	6.61	27.35 (388)	1.76
Other	3.66 (16)	1.50	6.08 (10)	2.89	4.15 (70)	0.78
General Health Problems	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Diabetes	0.82 (48)	0.19	0.46 (51)	0.07	0.89 (248)	0.09
Asthma	2.27 (90)	0.31	1.81 (181)	0.16	1.80 (384)	0.12
Goiter or other thyroid disorder	1.03 (68)	0.20	0.50 (70)	0.07	0.92 (231)	0.09
Source of Health Care	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Govt./Municipal hospital	18.45 (1341)	1.19	10.66 (1431)	0.56	14.31 (4694)	0.42
Govt. dispensary	1.62 (133)	0.27	0.97 (157)	0.16	1.63 (513)	0.14
UHC/UHP/UFWC	0.56 (27)	0.15	0.12 (28)	0.03	0.33 (76)	0.07
CHC/Rural Hospital/PHC	10.46 (569)	0.88	17.33 (2428)	0.74	13.77 (2691)	0.47
Sub-centre	0.51 (31)	0.15	1.41 (193)	0.18	1.35 (322)	0.15
Anganwadi/ICDS Centre	0.00 (0)	0.00	0.02 (3)	0.01	0.07 (12)	0.03
Govt. mobile clinic	0.00 (0)	0.00	0.01 (1)	0.01	0.01 (3)	0.01
Other public health facility	0.35 (13)	0.14	0.08 (12)	0.03	0.45 (116)	0.09
NGO or trust hospital/clinic	0.42 (23)	0.14	0.49 (66)	0.13	0.22 (65)	0.05
Private hospital	15.35 (631)	1.24	12.75 (1222)	0.60	14.84 (3126)	0.45
Private doctor/clinic	38.59 (1781)	1.69	38.65 (4128)	0.94	38.79 (7771)	0.64
Private paramedic	0.55 (37)	0.12	1.16 (168)	0.18	0.79 (167)	0.09
Vaidya/Hakim/Homeopath	0.76 (20)	0.28	0.30 (34)	0.07	0.47 (89)	0.07

Health Care Utilization Measures	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Traditional healer	0.05 (1)	0.05	0.35 (43)	0.11	0.12 (20)	0.05
Pharmacy/drugstore	0.84 (65)	0.25	0.72 (121)	0.16	0.81 (209)	0.09
DAI (TBA)	0.00 (0)	0.00	0.00 (1)	0.00	0.00 (3)	0.00
Other private health facility	7.66 (161)	1.41	10.93 (950)	0.71	5.78 (597)	0.36
Shop	0.03 (1)	0.03	0.00 (0)	0.00	0.01 (2)	0.01
Home treatment	0.20 (8)	0.09	0.15 (17)	0.06	0.11 (49)	0.03
Other	0.21 (8)	0.09	0.18 (23)	0.05	0.16(40)	0.04
Not de jure resident	3.38 (132)	0.40	3.72 (413)	0.22	5.97 (1013)	0.22
Missing	0.00 (1)	0.00	0.00 (2)	0.00	0.01 (5)	0.01
Reasons for not using Govt. Facilities	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Households that do not generally use govt. health facilities:						
No nearby facility	30.39 (1284)	1.57	35.44 (3681)	0.97	28.67 (5478)	0.63
Facility timing inconvenient	10.85 (454)	0.90	6.49 (684)	0.38	8.45 (1816)	0.31
Health personnel often absent	5.13 (201)	0.53	6.63 (664)	0.48	5.79 (972)	0.27
Waiting time too long	20.75 (874)	1.18	12.02 (1228)	0.53	16.01 (3458)	0.41
Poor quality of care	33.36 (1404)	1.45	39.53 (3897)	0.91	35.81 (6392)	0.57
Other reason	2.91 (135)	0.44	1.97 (232)	0.18	2.29 (537)	0.16
All that apply >100%						
Contacts with health personnel in the past 3 months	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
ANM/LHV	11.45 (374)	0.90	12.87 (1345)	0.54	11.80 (1918)	0.38
AWW	8.05 (299)	0.84	11.45 (1258)	0.53	9.57 (1631)	0.34
ASHA	0.07 (2)	0.06	0.15 (14)	0.06	0.04 (15)	0.04
MPW	1.21 (29)	0.43	0.45 (48)	0.09	0.72 (102)	0.13
Other	0.34 (35)	0.12	0.27 (36)	0.09	0.27 (92)	0.06
All that apply >100%						

Health Care Utilization Measures	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Matters discussed during contacts:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Family planning	12.06 (61)	2.66	6.58 (140)	0.65	8.57 (255)	0.65
Immunization	42.24 (269)	3.14	60.68 (1165)	1.66	56.67 (1542)	1.26
Antenatal care	6.93 (44)	1.32	6.58 (148)	0.60	8.93 (265)	0.66
Delivery care	1.67 (11)	0.67	2.05 (47)	0.33	3.09 (91)	0.37
Delivery preparedness	0.16 (4)	0.13	0.47 (11)	0.16	0.96 (27)	0.22
Postnatal care	1.08 (9)	0.59	1.12 (26)	0.25	1.48 (49)	0.26
Disease prevention	15.93 (82)	2.98	8.24 (169)	1.12	8.84 (236)	0.95
Medical treatment for self	18.61 (99)	2.26	12.17 (268)	1.05	11.98 (376)	0.84
Treatment for sick child	4.60 (26)	1.22	4.75 (108)	0.50	4.89 (165)	0.48
Treatment for other person	0.89 (7)	0.60	2.29 (48)	0.37	2.34 (71)	0.35
Malaria control	5.95 (24)	2.36	3.28 (72)	0.54	3.75 (93)	0.37
Supplementary food	5.75 (36)	1.30	10.95 (270)	0.88	7.51 (267)	0.60
Growth monitoring for children	6.37 (27)	1.31	5.70 (120)	0.66	5.99 (177)	0.53
Early childhood care	2.47 (15)	0.79	2.09 (53)	0.35	2.64 (79)	0.40
Pre-school education	7.04 (38)	1.61	5.62 (110)	0.70	4.60 (143)	0.52
Nutrition or health education	5.97 (34)	1.21	5.30 (116)	0.68	5.07 (161)	0.50
Family life education	5.13 (25)	1.17	2.00 (56)	0.32	3.07 (109)	0.38
Menstrual hygiene	3.84 (18)	1.45	1.24 (33)	0.23	1.23 (40)	0.26
Other	3.94 (29)	0.96	1.37 (36)	0.27	2.71 (92)	0.37
all that apply >100%						
Among women who visited a health facility or camp:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Type of facility visited:						
Government/ municipal hospital	18.33 (420)	1.46	12.71 (499)	0.78	14.89 (1610)	0.57
Government dispensary	1.50 (48)	0.31	0.82 (46)	0.16	1.68 (205)	0.18

Health Care Utilization Measures	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
UNC/ UHP/ UFWC	0.11 (12)	0.06	0.22 (11)	0.09	0.27 20)	0.07
CHC/ Rural hospital/ PHC	6.70 (129)	0.83	15.31 (651)	0.86	11.23 (749)	0.59
Sub-centre/ ANM	3.48 (30)	0.71	4.48 (146)	0.48	3.39 (198)	0.32
Govt mobile clinic	0.00 (0)	0.00	0.08 (4)	0.05	0.03 (6)	0.02
Camp	0.85 (19)	0.28	0.75 (30)	0.15	0.58 (46)	0.14
Anganwadi/ ICDS Centre	0.55 (13)	0.21	2.64 (101)	0.29	1.84 (129)	0.20
Other public medical sector	1.24 (16)	0.82	0.32 (12)	0.11	0.53 (51)	0.10
Private hospital	54.42 (1051)	2.09	49.96 (1677)	1.14	56.64 (4426)	0.82
Private mobile clinic	2.62 (48)	0.57	2.11 (71)	0.30	2.07 (177)	0.23
Pharmacy/ Drugstore	1.93 (48)	0.41	1.83 (75)	0.31	1.27 (103)	0.17
Other private medical	6.37 (71)	1.22	7.54 (199)	0.70	3.75 (178)	0.36
NGO or trust hosp/ clinic	0.79 (14)	0.30	0.45 (20)	0.12	0.71 (59)	0.13
Other	1.04 (14)	0.33	0.52 (15)	0.16	1.05 (69)	0.17
Missing	0.05 (3)	0.05	0.28 (11)	0.11	0.09 (10)	0.04
Service sought:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Family planning	1.51 (23)	0.38	1.39 (50)	0.23	1.12 (88)	0.16
immunization	4.41 (95)	0.64	5.97 (215)	0.48	8.17 (616)	0.42
Antenatal care	2.96 (80)	0.54	4.50 (185)	0.39	5.60 (492)	0.35
Delivery care	0.49 (19)	0.19	1.56 (60)	0.22	2.54 (208)	0.23
Postnatal care	0.10 (7)	0.08	0.38 (11)	0.12	0.68 (59)	0.12
Disease prevention	1.42 (26)	0.42	1.04 (34)	0.20	1.02 (85)	0.14
Medical treatment for self	60.38 (1183)	1.68	55.22 (2013)	1.03	56.59 (4429)	0.79
Treatment for sick child	29.65 (516)	1.47	32.80 (1101)	0.96	30.42 (2409)	0.72
Treatment for other person	4.18 (69)	0.66	3.64 (110)	0.41	2.91 (236)	0.25
Growth monitoring for children	1.69 (25)	0.44	1.57 (49)	0.25	1.30 (106)	0.20
Health check-up	7.57 (177)	1.02	7.37 (266)	0.69	7.73 (682)	0.46
Other	0.16 (2)	0.12	0.16 (7)	0.07	0.08 (7)	0.03
	Median (Min-Max)		**Median (Min-Max)**		**Median (Min-Max)**	
Median time waited for Service (min.):	27.81 (1.00-90.00)		28.79 (1.00-108.00)		29.40 (1.00-120.00)	

Health Care Utilization Measures	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
	% (n)	SE %	% (n)	SE %	% (n)	SE %
Health worker was responsive to need:	96.15 (1841)	0.60	95.15 (3365)	0.41	96.46 (7750)	0.29
Health worker respected Privacy:						
Yes	53.67 (1080)	1.94	54.69 (1932)	1.30	59.51 (5041)	0.92
Says privacy not needed	35.45 (652)	1.85	34.11 (1237)	1.28	33.03 (2427)	0.90
Health facility was clean:						
Very clean	68.47 (1210)	1.82	58.10 (2032)	1.14	66.16 (5184)	0.83
Somewhat clean	30.68 (696)	1.83	40.00 (1465)	1.12	32.57 (2739)	0.81
Not clean	0.84 (28)	0.28	1.48 (56)	0.22	0.97 (96)	0.14
Missing	0.01 (2)	0.01	0.42 (15)	0.13	0.30 (17)	0.09
Quality of health care:	% (n)	SE %	% (n)	SE %	% (n)	SE %
Most Recent Contact:						
ANM	54.30 (278)	3.24	51.99 (1016)	1.69	50.54 (1352)	1.34
LHV	3.43 (23)	0.94	1.43 (37)	0.36	3.85 (139)	0.48
AWW	34.84 (234)	3.37	43.58 (947)	1.63	40.82 (1244)	1.31
ASHA	0.00 (0)	0.00	0.44 (5)	0.33	0.18 (9)	0.11
MPW	6.02 (26)	1.51	1.62 (32)	0.36	2.85 (71)	0.55
Other	1.10 (31)	0.50	0.78 (29)	0.22	1.32 (97)	0.31
Missing	0.31 (3)	0.25	0.15 (4)	0.09	0.44 (14)	0.16
Total	595		2070		2926	
Health worker spoke nicely:	% (n)	SE %	% (n)	SE %	% (n)	SE %
Nicely	82.80 (499)	2.19	70.90 (1502)	1.48	78.06 (2325)	1.09
Somewhat nicely	15.94 (84)	2.18	26.57 (513)	1.42	19.97 (538)	1.07
Not nicely	0.96 (9)	0.50	2.38 (51)	0.40	1.54 (50)	0.26
Missing	0.31 (3)	0.25	0.15 (4)	0.09	0.43 (13)	0.16
Total	595		2070		2926	
Health worker ensured Information was understood:	% (n)	SE %	% (n)	SE %	% (n)	SE %
No	3.56 (33)	0.98	11.22 (245)	0.93	7.46 (225	0.62
Yes	78.10 (456)	3.69	66.10 (1389)	1.72	77.05 (2257)	1.06
No explanation needed	18.04 (103)	3.72	22.30 (428)	1.59	15.02 (429)	0.95
Missing	0.31 (3)	0.25	0.38 (8)	0.15	0.48 (15)	0.17

Health Care Utilization Measures	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Barriers to accessing health care:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Getting permission to go for treatment :	-		-		-	
No problem	81.01 (4157)	1.02	75.19 (8580)	0.77	77.38 (17,549)	0.53
Big problem	6.12 (249)	0.53	7.23 (937)	0.38	6.52 (1056)	0.30
Not a big problem	12.87 (577)	0.82	17.58 (1923)	0.66	16.08 (2973)	0.47
Missing	0.00 (0)	0.00	0.00 (1)	0.00	0.02 (5)	0.01
Getting money for treatment:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No problem	64.39 (3280)	1.34	51.60 (5720)	1.02	61.70 (13,761)	0.59
Big problem	14.72 (608)	1.06	23.47 (2938)	0.79	16.02 (3227)	0.43
Not a big problem	20.89 (1095)	1.01	24.91 (2780)	0.78	22.22 (4587)	0.50
Missing	0.00 (0)	0.00	0.02 (3)	0.01	0.05 (8)	0.02
Distance to health facility:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No problem	56.86 (3038)	1.50	34.25 (3896)	0.99	51.86 (12,318)	0.64
Big problem	20.35 (806)	1.37	35.76 (4319)	1.01	23.71 (4367)	0.55
Not a big problem	22.80 (1139)	1.04	29.99 (3224)	0.83	24.39 (4889)	0.51
Missing	0.00 (0)	0.00	0.02 (2)	0.01	0.04 (9)	0.01
Having to take transport:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No problem	62.67 (3298)	1.50	37.30 (4255)	1.02	55.81 (13,061)	0.65
Big problem	16.78 (652)	1.24	33.82 (4096)	1.01	21.15 (3946)	0.53
Not a big problem	20.53 (1032)	1.00	28.88 (3089)	0.80	23.01 (4568)	0.51
Missing	0.02 (1)	0.02	0.00 (1)	0.00	0.04 (8)	0.01
Not wanting to go alone:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No problem	67.90 (3625)	1.39	55.40 (6292)	0.92	65.25 (14,898)	0.60
Big problem	9.32 (393)	0.69	17.02 (2084)	0.64	10.70 (4506)	0.37
Not a big problem	22.77 (964)	1.23	27.55 (3062)	0.76	24.01 (8672)	0.51
Missing	0.01 (1)	0.01	0.02 (3)	0.01	0.04 (14)	0.02
Concern that no female provider available:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No problem	60.88 (3250)	1.41	51.51 (5784)	1.07	58.84 (13,498)	0.67

Health Care Utilization Measures	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Big problem	17.63 (764)	1.07	23.16 (2879)	0.86	17.86 (3436)	0.53
Not a big problem	21.46 (968)	1.05	25.33 (2777)	0.80	23.26 (4642)	0.54
Missing	0.02 (1)	0.02	0.04 (1)	0.00	0.04 (7)	0.02
Concern that no provider available :	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No problem	57.85 (3159)	1.52	48.66 (5370)	1.19	56.86 (12,990)	0.70
Big problem	21.49 (976)	1.23	27.42 (3552)	0.95	21.77 (4527)	0.58
Not a big problem	20.67 (848)	1.08	23.91 (2517)	0.86	21.34 (4058)	0.54
Missing	0.00 (0)	0.00	0.01 (2)	0.01	0.04 (8)	0.02
Concern that no drugs available :	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No problem	58.84 (3199)	1.59	48.61 (5297)	1.20	56.83 (12,914)	0.69
Big problem	20.47 (917)	1.26	27.05 (3503)	0.94	22.20 (4701)	0.58
Not a big problem	20.70 (867)	1.10	24.33 (2640)	0.91	20.93 (3961)	0.53
Missing	0.00 (0)	0.00	0.00 (1)	0.00	0.04 (7)	0.02

UHC = Urban Health Centre; UHP = Urban Health Post; UFWC = Urban Family Welfare Centre; CHC = Community Health Centre; PHC = Primary Health Centre; ICDS = Integrated Child Development Services; NGO = Nongovernmental Organization; TBA = Traditional Birth Attendant ANM = Auxiliary Nurse Midwife; LHV = Lady Health Visitor; AWW = Anganwadi Worker; ASHA = Accredited Social Health Activist; MPW = Multipurpose Worker

Table B: Women's Empowerment and Domestic Violence Indicators

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Employment:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent worked in the last 12 months:	-	-	-	-	-	-
No	0.00 (0)	0.00	0.00 (0)	0.00	68.91 (14,809)	0.56
In the past year	10.07 (458)	0.68	21.20 (2463)	0..75	4.18 (782)	0.23
Currently working	88.96 (4445)	0.70	77.93 (8858)	0.76	26.50 (5881)	0.53
Have a job, but on leave	0.97 (80)	0.18	0.87 (120)	0.10	0.39 (107)	0.06
Missing	0.00 (0)	0.00	0.00 (0)	0.00	0.02 (4)	0.01
Respondent employed all year/seasonally:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
All year	68.97 (3482)	1.39	42.33 (4780)	1.00	67.49 (4746)	0.88
Seasonal	18.37 (947)	1.21	53.44 (6178)	1.02	27.96 (1720)	0.86
Occasional	12.60 (552)	0.84	4.17 (475)	0.33	4.44 (291)	0.36
Missing	0.06 (2)	0.06	0.06 (8)	0.02	0.10 (13)	0.05
Total	4983		11,441		6770	
Where Respondent works:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
At home	82.34 (4140)	1.28	6.01 (754)	0.48	20.05 (1315)	0.90
Away	17.53 (839)	1.27	93.83(10,670)	0.48	79.85 (5439)	0.90
Missing	0.13 (4)	0.08	0.16 (17)	0.04	0.10 (16)	0.04
Total	4983		11,441		6770	
Respondent's type of earnings for work:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Not paid	6.40 (307)	0.72	15.54 (2227)	0.93	28.45 (1754)	1.02
Cash only	91.40 (4525)	0.81	45.72 (4937)	1.11	54.39 (4068)	1.07
Cash and kind	1.44 (114)	0.28	19.45 (2169)	0.87	10.40 (575)	0.61
In-kind only	0.70 (34)	0.24	19.27 (2105)	1.24	6.70 (363)	0.54
Missing	0.69 (3)	0.06	0.02 (3)	0.01	0.05 (10)	0.02
Total	4983		11,441		6770	
Among married women, cash earnings as compared to husband:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
More than him	6.34 (187)	0.71	8.64 (487)	0.58	11.56 (398)	0.87
Less than him	82.02 (2085)	1.21	76.62 (4237)	0.90	69.67 (2079)	1.28
About the same	7.28 (173)	0.92	8.32 (474)	0.51	12.64 (401)	0.86

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Partner doesn't bring in money	2.00 (48)	0.35	1.95 (117)	0.21	3.14 (90)	0.44
Decision Making (currently married) :	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
How women's cash earnings are used:	-	-	-	-	-	-
Respondent alone	38.82 (1004)	1.65	19.71 (1075)	0.77	24.97 (814)	1.10
Respondent and husband/partner	48.77 (1298)	1.54	57.70 (3263)	1.03	58.48 (1840)	1.32
Husband/partner alone	8.25 (169)	0.81	18.00 (949)	0.82	13.26 (309)	0.94
Someone else	2.95 (52)	0.64	2.97 (167)	0.28	2.18 (53)	0.43
Missing	1.20 (35)	0.30	1.61 (79)	0.21	1.11 (35)	0.25
Total	2558		5533		3051	
How men's cash earnings are used:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent alone	8.25 (211)	0.77	7.12 (590)	0.37	6.14 (917)	0.30
Respondent and husband/partner	64.23 (1847)	1.51	62.98 (5584)	0.84	60.20 (9725)	0.67
Husband/partner alone	21.32 (503)	1.21	22.47 (1888)	0.73	24.82 (3457)	0.55
Other	5.48 (115)	0.77	6.12 (542)	0.37	7.24 (867)	0.32
Husband/partner has no earnings	0.71 (11)	0.23	1.15 (108)	0.15	1.53 (220)	0.15
Missing	0.02 (1)	0.02	0.17 (14)	0.05	0.08 (15)	0.03
Total	2688		8726		15,201	
Who has the final say on own health care:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent alone	30.74 (802)	1.54	26.24 (2255)	0.80	27.44 (4324)	0.58
Respondent and husband/partner	37.60 (1176)	1.46	35.63 (3165)	0.90	35.64 (6056)	0.65
Husband/partner alone	26.48 (652)	1.20	30.55 (2795)	0.78	29.67 (4064)	0.60
Someone else	4.14 (82)	0.88	6.57 (534)	0.47	5.86 (685)	0.32
Other	1.04 (24)	0.32	0.92 (86)	0.13	1.33 (152)	0.15
Missing	0.00 (0)	0.00	0.08 (8)	0.04	0.06 (10)	0.02
Total	2736		8843		15,291	

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Who has the final say on making large household purchases:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent alone	10.71 (277)	1.01	9.97 (874)	0.43	8.36 (1359)	0.32
Respondent and husband/partner	47.43 (1486)	1.55	44.96 (4088)	0.88	44.79 (7699)	0.65
Husband/partner alone	30.88 (692)	1.39	32.51 (2784)	0.83	31.53 (4296)	0.59
Someone else	8.28 (69)	0.96	10.75 (914)	0.59	12.22 (1550)	0.43
Other	2.70 (0)	0.43	1.72 (174)	0.22	3.03 (375)	0.24
Missing	0.00 (0)	0.00	0.09 (9)	0.04	0.07 (12)	0.02
Total	2736		8843		15,291	
Who has the final say on making household purchases for daily needs:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent alone	42.92 (1225)	1.73	33.91 (3075)	0.83	31.60 (5502)	0.60
Respondent and husband/partner	26.11 (759)	1.36	28.45 (2524)	0.82	28.33 (4489)	0.60
Husband/partner alone	19.91 (456)	1.20	25.05 (2148)	0.75	24.66 (3324)	0.51
Someone else	8.22 (220)	0.95	10.67 (907)	0.59	12.46 (1596)	0.44
Other	2.83 (76)	0.49	1.82 (180)	0.22	2.90 (370)	0.22
Missing	0.00 (0)	0.00	0.09 (9)	0.04	0.06 (10)	0.02
Total	2736		8843		15,291	
Who has the final say on visits to family or relatives:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent alone	13.59 (387)	1.05	11.78 (1077)	0.55	10.62 (1873)	0.37
Respondent and husband/partner	51.56 91542)	1.66	50.04 (4481)	0.93	50.66 (8417)	0.69
Husband/partner alone	25.83 (595)	1.35	27.07 (2341)	0.80	25.92 (3447)	0.58
Someone else	6.89 9159)	0.91	9.48 (782)	0.60	10.14 (1230)	0.40
Other	2.13 (53)	0.42	1.54 (154)	0.22	2.61 (314)	0.21
Missing	0.00 (0)	0.00	0.08 (8)	0.04	0.06 (10)	0.02
Total	2736		8843		15,291	

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Access to money and credit:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent has money for her own use:	-	-	-	-	-	-
No	41.51 (2008)	1.48	52.66 (6196)	1.05	56.59 (12,329)	0.65
Yes	58.49 (2975)	1.48	47.33 (5244)	1.05	43.36 (9246)	0.65
Missing	0.00 (0)	0.00	0.01 (1)	0.01	0.05 98)	0.02
Respondent has a bank or savings account:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	81.51 (4100)	0.84	90.86 (10,395)	0.40	83.99 (17,540)	0.40
Yes	18.35 (875)	0.84	8.95 (1025)	0.40	15.84 (4006)	0.40
Missing	0.14 (8)	0.06	0.19 (21)	0.05	0.17 (37)	0.04
Respondent has knowledge of loan programs:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	49.30 (2490)	1.50	65.89 (7678)	0.94	60.91 (13,408)	0.66
Yes	50.70 (2493)	1.50	34.08 (3760)	0.94	39.05 (8169)	0.66
Missing	0.00 (0)	0.00	0.03 (3)	0.02	0.04 (6)	0.02
Respondent has been given a loan:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	86.06	1.21	82.20	1.02	90.37	0.50
Yes	13.93	1.21	17.58	1.01	9.50	0.50
Missing	0.01	0.00	0.22	0.09	0.13	0.05
Freedom of movement:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Respondent is allowed to go to the market:						
Alone	57.13 (3195)	1.45	51.31 (6152)	0.91	51.44 (12,877)	0.59
With someone else only	29.53 (1423)	1.11	34.97 (3931)	0.81	36.50 (6831)	0.56
Not at all	13.33 (365)	1.10	13.68 (1354)	0.68	12.01 (1867)	0.40
Missing	0.00 (0)	0.00	0.04 (4)	0.02	0.05 (8)	0.02
Respondent is allowed to go to a health facility:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Alone	52.08 (2799)	1.36	47.45 (5622)	0.87	47.46 (11,552)	0.58
With someone else only	43.18 (2026)	1.28	47.61 (5320)	0.88	47.89 (9264)	0.59

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Not at all	4.74 (158)	0.58	4.91 (497)	0.35	4.59 (759)	0.25
Missing	0.00 (0)	0.00	0.02 (2)	0.02	0.06 (8)	0.03
Respondent is allowed to go to places outside this community:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Alone	41.76 (2333)	1.37	39.33 (4703)	0.84	37.62 (9235)	0.56
With someone else only	49.77 (2350)	1.37	53.01 (5969)	0.89	53.91 (10,858)	0.61
Not at all	8.48 (300)	0.80	7.63 (766)	0.48	8.42 (1481)	0.36
Missing	0.00 (0)	0.00	0.03 (3)	0.02	0.06 (9)	0.03
Partner's characteristic's:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Partner's education level (among currently married):	-	-	-	-	-	-
No education	19.07 (460)	1.25	45.93 (4254)	0.78	23.27 (3198)	0.55
Primary	17.10 (431)	1.11	19.53 (1929)	0.48	15.50 (2371)	0.40
Secondary	54.58 (1765)	1.62	31.11 (3173)	0.68	47.46 (8005)	0.60
Higher	8.62 (335)	0.73	2.01 (226)	0.22	12.84 (2557)	0.41
Don't Know	0.57 (20)	0.18	1.16 (118)	0.13	0.80 (128)	0.10
Missing	0.06 (2)	0.06	0.25 (27)	0.05	0.13 (28)	0.04
Total	3013		9727		16,287	
Partner's occupation:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Did not work	3.04 (78)	0.47	1.96 (196)	0.17	2.13 (355)	0.15
Professional/ technical/ managerial	5.74 (216)		0.59		1.28 (167)	
Clerical	3.64 (151)		0.46		1.05 (142)	
Sales	11.77 (404)	0.84	4.87 (451)	0.32	13.67 (2456)	0.41
Agricultural	12.14 (293)	1.17	56.85 (5392)	0.98	29.36 (3820)	0.64
Services	5.67 (181)	0.62	2.63 (291)	0.20	6.13 (1172)	0.27
Skilled and unskilled manual	57.63 (1678)	1.51	30.97 (3052)	0.82	36.03 (5824)	0.62
Don't Know	0.06 (2)	0.04	0.23 (17)	0.06	0.05 (6)	0.03
Missing	0.31 (10)	0.14	0.15 (19)	0.04	0.14 (34)	0.04
Total	3013		9727		16,287	
Domestic violence:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
Perceptions of domestic violence:						

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Wife beating is justified if wife goes out without telling husband:	-	-	-	-	-	-
No	69.61 (3324)	1.22	60.18 (6767)	0.88	71.49 (15,709)	0.55
Yes	28.93 (1599)	1.22	38.45 (4505)	0.87	27.41 (5578)	0.55
Don't Know	1.46 (60)	0.25	1.38 (169)	0.13	1.08 (291)	0.09
Missing	0.00 (0)	0.00	0.00 (0)	0.00	0.02 (5)	0.01
Wife beating is justified if wife neglects the children:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	61.61 (2840)	1.25	55.64 (6146)	0.88	65.73 (14,019)	0.59
Yes	37.26 (2095)	1.23	43.17 (5153)	0.88	33.21 (7286)	0.58
Don't Know	1.13 (48)	0.24	1.19 (142)	0.12	1.03 (272)	0.09
Missing	0.00 (0)	0.00	0.00 (0)	0.00	0.03 (6)	0.02
Wife beating is justified if wife argues with husband:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	68.42 (3442)	1.19	58.43 (6656)	0.88	70.52 (15,655)	0.55
Yes	29.65 (1438)	1.14	39.91 (4576)	0.87	27.97 (5514)	0.54
Don't Know	1.93 (103)	0.32	1.63 (207)	0.15	1.48 (407)	0.11
Missing	0.00 (0)	0.00	0.02 (2)	0.02	0.03 (7)	0.02
Wife beating is justified if wife burns food:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	79.05 (4017)	0.99	70.10 (8051)	0.77	79.95 (17,710)	0.48
Yes	19.84 (913)	0.96	28.38 (3214)	0.77	18.90 (3579)	0.47
Don't Know	1.10 (53)	0.22	1.49 (174)	0.17	1.13 (288)	0.10
Missing	0.00 (0)	0.00	0.03 (2)	0.02	0.03 (6)	0.02
Wife beating is justified if wife is unfaithful:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	74.73 (3619)	1.06	62.93 (7039)	0.82	74.22 (16,040)	0.54
Yes	22.71 (1251)	1.02	34.47 (4098)	0.81	23.40 (4997)	0.52
Don't Know	2.50 (111)	0.37	2.55 (301)	0.22	2.33 (537)	0.16
Missing	0.05 (2)	0.04	0.04 (3)	0.03	0.05 (9)	0.02
Wife beating is justified if wife is disrespectful to in-laws:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	56.47 (2645)	1.34	49.36 (5590)	0.86	59.30 (12,954)	0.61

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Yes	41.64 (2261)	1.32	48.80 (5634)	0.87	39.12 (8238)	0.60
Don't Know	1.89 (77)	0.36	1.83 (216)	0.19	1.56 (386)	0.13
Missing	0.00 (0)	0.00	0.01 (1)	0.01	0.02 (5)	0.01
Experience of domestic violence:						
Ever experience any emotional violence? (currently married women)	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	83.28 (1927)	1.10	77.94 (5732)	0.75	84.15 (10,214)	0.51
Yes	16.72 (354)	1.10	21.96 (1519)	0.75	15.80 (1648)	0.51
Missing	0.01 2)	0.01	0.10 (4)	0.07	0.06 (9)	0.02
Total	2283		7255		11,871	
Ever experience any less severe physical violence? (currently married women)	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	63.02 (1498)	1.48	52.34 (4039)	0.86	66.39 (8370)	0.66
Yes	36.97 (782)	1.48	47.56 (3212)	0.84	33.53 (3491)	0.66
Missing	0.01 (3)	0.01	0.10 (4)	0.07	0.09 (10)	0.04
Total	2283		7255		11,871	
Ever experience any severe physical violence? (currently married women)	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	87.37 (2051)	1.08	80.81 (5975)	0.63	89.20 (10,765)	89.20
Yes	12.63 (230)	1.08	19.09 (1276)	0.62	19.09 (1095)	10.73
Missing	0.01 (2)	0.01	0.10 (4)	0.07	0.10 (11)	0.08
Total	2283					
Ever physically hurt by mother /step-mother?	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	95.48 (2973)	0.55	95.79 (7772)	0.29	95.79 (13,782)	0.22
Yes	4.52 (147)	0.55	4.17 (320)	0.29	4.14 (610)	0.22
Missing	0.00 (2)	0.00	0.04 (3)	0.02	0.07 (9)	0.03
Total	3122		8095		14,401	

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Ever physically hurt by father /step-father?	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	97.64 (3040)	0.37	98.12 (7921)	0.18	97.85 (14,070)	0.16
Yes	2.35 (80)	0.37	1.84 (171)	0.18	2.08 (322)	0.16
Missing	0.00 (2)	0.00	0.04 (3)	0.02	0.07 (9)	0.03
Total	3122		8095		14,401	
Ever physically hurt by mother-in-law?	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	99.58 (3108)	0.16	99.11 (8037)	0.13	99.31 (14,329)	0.10
Yes	0.41 (12)	0.16	0.85 (55)	0.13	0.62 (63)	0.10
Missing	0.00 (2)	0.00	0.04 (3)	0.02	0.07 (9)	0.03
Total	3122		8095		14,401	
Ever physically hurt by father-in-law?	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	99.89 (3116)	0.07	99.54 (8060)	0.09	99.70 (14,368)	0.06
Yes	0.11 (4)	0.07	0.42 (32)	0.08	0.23 (24)	0.06
Missing	0.00 (2)	0.00	0.04 (3)	0.02	0.07 (9)	0.03
Sought help:						
Sought help from someone	24.64 (264)	1.90	28.23 (1060)	0.94	23.31 (1012)	0.88
No help was sought	72.92 (735)	1.95	69.71 (2526)	0.94	74.25 (3349)	0.91
Missing	2.44 (30)	0.64	2.06 (74)	0.28	2.44 (115)	0.33
Total	1029		3660		4476	
Marital Control:						
Husband jealous if respondent talks with other men:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	74.35 (1723)	1.38	67.65 (4965)	0.82	74.06 (9194)	0.60
Yes	25.38 (550)	1.38	31.73 (2250)	0.81	25.37 (2603)	0.59
Don't Know	0.27 (9)	0.11	0.62 (40)	0.14	0.53 (68)	0.09
Missing	0.00 (1)	0.00	0.00 (0)	0.00	0.05 (6)	0.02
Total	2283		7255		11,871	
Husband accuses respondent of unfaithfulness:	**% (n)**	**SE %**	**(68)% (n)**	**SE %**	**% (n)**	**SE %**
No	90.79 (2094)	0.90	88.80 (6470)	0.49	91.49 (10,958)	0.36

Women's Empowerment Indicators	Garment Workers (4,983)		Agricultural Labourers (11,441)		All Women (21,583)	
Yes	9.12 (187)	0.90	10.83 (763)	0.48	8.30 (885)	0.36
Don't Know	0.09 (1)	0.09	0.37 (22)	0.13	0.16 (21)	0.05
Missing	0.00 (1)	0.00	0.00 (0)	0.00	0.05 (7)	0.02
Total	2283		7255		11,871	
Husband does not permit respondent to meet her girlfriends:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	81.60 (1912)	1.49	83.28 (6008)	0.70	84.13 (10,144)	0.55
Yes	18.40 (370)	1.49	16.39 (1228)	0.70	15.55 (1697)	0.54
Don't Know	0.00 (0)	0.00	0.33 (19)	0.11	0.25 (23)	0.07
Missing	0.00 (1)	0.00	0.00 (0)	0.00	0.06 (7)	0.03
Total	2283		7255		11,871	
Husband tries to limit respondent's contact with family:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	87.08 (2015)	1.22	87.27 (6316)	0.56	90.30 (10,854)	0.42
Yes	12.83 (265)	1.22	12.31 (915)	0.55	9.46 (990)	0.41
Don't Know	0.09 (2)	0.09	0.42 (24)	0.13	0.17 (19)	0.05
Missing	0.00 (1)	0.00	0.00 (0)	0.00	0.07 (8)	0.03
Total	2283		7255		11,871	
Husband insists on knowing where respondent is:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	86.43 (1933)	1.02	85.58 (6151)	0.63	88.04 (10,393)	0.43
Yes	13.46 (344)	1.01	13.82 (1070)	0.62	11.60 (1432)	0.42
Don't Know	0.11 (5)	0.09	0.58 (33)	0.15	0.29 (39)	0.08
Missing	0.00 (1)	0.00	0.02 (1)	0.02	0.08 (7)	0.04
Total	2283		7255		11,871	
Husband doesn't trust respondent with money:	**% (n)**	**SE %**	**% (n)**	**SE %**	**% (n)**	**SE %**
No	80.50 (1880)	1.66	81.30 (5918)	0.75	81.35 (9883)	0.63
Yes	19.23 (396)	1.66	18.14 (1304)	0.73	18.23 (1940)	0.62
Don't Know	0.27 (6)	0.15	0.54 (32)	0.14	0.36 (40)	0.09
Missing	0.00 (1)	0.00	0.02 (1)	0.02	0.06 (8)	0.02
Total	2283		7255		11,871	