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Knowledge about Reproductive Tract Infections and Sex Work among Female Textile Workers in Surat, India

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Abstract

In this qualitative study, we investigated knowledge about reproductive tract infections (RTIs) and commercial sex work among female textile workers of Surat, India. We analyzed data from three focus groups conducted with 18 women using content analysis. Participants had some knowledge about the symptoms of RTIs; however, they had limited knowledge about RTI prevention, transmission, and treatment. None used condoms consistently for RTI prevention. The women attributed economic hardship as one of the main reasons for engaging in commercial sex work. Our study is one of the first to evaluate sexual and reproductive health among female textile workers in India.

Keywords

India; sexually transmitted infection (STI); human immunodeficiency virus (HIV); female textile workers; focus groups

Reproductive tract infections (RTIs), which include sexually transmitted infections (STIs), such as Human Immunodeficiency Virus (HIV), are a serious global health problem.

Authors Disclosure

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Globally, women with lower socioeconomic status are vulnerable to engaging in commercial sex work for economic reasons. Thus, women working in lower-wage positions, such as in the textile industry in India, are vulnerable to RTIs. Understanding the factors that increase women's risk of RTIs in India can help public health officials create educational messages, information, and health-promotion activities for women in similar cultures globally as well as for women who work in similar low wage industries globally. In this qualitative study, we investigated knowledge about reproductive tract infections (RTIs) and commercial sex work among female textile workers of Surat, India. We analyzed data from three focus groups conducted with 18 women using content analysis.

RTIs are a serious public health problem in India. Epidemiologically, the number of people living with HIV worldwide is dominated by India (Joint United Nations Programme on HIV/AIDS, 2013). Currently, there are an estimated 2.1 million people living with HIV in India, and a majority of HIV infections in India are acquired through sexual intercourse (Department of AIDS Control, Ministry of Health & Family Welfare 2013). Heterosexual sexual intercourse is the primary mode of transmission of HIV to the general population in India. The HIV epidemic is said to be truncated and largely driven and maintained through contact between high-risk populations (sex workers and men who have sex with men) and a bridge population (clients). This bridge population then transmits the infection to their monogamous sexual partners, but these partners do not engage in sexual intercourse with another partner, and therefore stop the spread of the virus further (Department of AIDS Control, Ministry of Health & Family Welfare 2013).

As of 2012, India's HIV epidemic was mainly concentrated in four states that account for 55% of all HIV infections in the country (The World Bank, 2012): Andhra Pradesh-500,000 people with HIV; Maharashtra-420,000 people with HIV; Karnataka-250,000 people with HIV; and Tamil Nadu-150,000 people with HIV. Not only is HIV widespread in these states, but there is great risk of acquiring STIs and RTIs. Among women experiencing vaginal discharge in Karnataka, 23.0% and 22.5% tested positive for herpes simplex virus (HSV)-2 and *Trichomonas vaginalis* respectively; moreover, 10.7% of women tested positive for both HIV and HSV-2, indicating the high prevalence of STIs and HIV found in the region (Becker et al., 2010). When looking at the prevalence of STIs in Chennai, India, the capital of Tamil Nadu, 50% and 11% of high-risk HIV-negative women tested positive for HSV-2 and syphilis, respectively. Despite 46.2% of women reporting having only one primary male sexual partner, women had equal or higher prevalence of all STIs measured compared to men, indicating women may have been infected by their primary male sexual partner's high-risk activities (Kumarasamy et al., 2008) or may be more likely than men to observe symptoms of STIs, such as the symptoms of gonorrhea.

In 2012, the Indian states of Gujarat, West Bengal, Bihar, and Uttar Pradesh each had approximately 100,000 people living with HIV or acquired immunodeficiency syndrome (AIDS; The World Bank, 2012). In Gujarat, sex work (87% heterosexual and 2% same-sex) constitutes 89% of total HIV transmission, followed by parent to child transmission at 5% (Gujarat State AIDS Control Society, Department of Health & Family Welfare, 2014). Surat, the second largest city in Gujarat, significantly contributes to India's commercial exports, especially diamonds and textile products (Gujarat State AIDS Control Society, Department

of Health & Family Welfare, 2014). In 2011, Surat saw the highest population growth rate (44.9%) in the state of Gujarat, primarily owing to the textile industry that provides enormous employment opportunities to people coming from rural areas (Government of Gujarat, 2011). Moreover, HIV prevalence among the population of inter-state migrant workers is substantially higher than the general population and is considered a high-risk bridge population for HIV transmission (Department of AIDS Control, 2012).

There is some indication that people who work in the textile industry in Surat may be at increased risk for HIV. In a study conducted in Surat, it was found that male migrant workers from lower socioeconomic backgrounds were more likely to engage in risky sexual behavior than non-migrant workers (Gupta & Singh, 2002). In another study conducted to assess the health practices of male textile workers in Surat, Bansal and colleagues (2008) conducted interviews with 100 men and found that more than half of the study participants reported visiting commercial sex workers at least once. However, the majority of the participants self-reported regularly using a condom when seeking services of sex workers. Furthermore, low levels of socioeconomic and educational backgrounds and limited opportunities to meet emotional and physical requirements may cause socially marginalized members of the rural-to-urban migrant population to engage in commercial sex work, as reported in Vietnam (Elmer, 2001) and in the People's Republic of China (Settle, 2003). Also, in a study designed to assess HIV risk at workplaces in the Indian state of Karnataka, it was reported that semi-skilled workers from mining, textile, and sugar industries had insufficient knowledge about HIV/AIDS, did not consistently use condoms during sexual intercourse, and frequently visited female sex workers (Halli et al., 2009).

Previous research on commercial sex work among women has demonstrated that, across all countries, women enter sex work for a variety of reasons, such as: 1) lack of economic development in rural areas (Wawer, Podhisita, Kanungsukkasem, Pramualratana, & McNamara, 1996); 2) economic necessities of the family and economic survival (Bucardo, Semple, Fraga-Vallejo, Davila, & Patterson, 2004; Hong & Li, 2008); and 3) coercion or deception that forces them into the sex trade (Basu et al., 2004; Busza & Baker, 2004; Silverman et al., 2006). A few researchers have analyzed the reasons that women start engaging in sex work in the Indian context and have identified trafficking, destitution (Blanchard et al., 2005; Dandona et al., 2006), and industrialization (Blanchard et al., 2005) as the primary reasons. Moreover, most female sex workers have no or low literacy, belong to lower caste groups, or face poor economic conditions back at home (Blanchard et al., 2005; Chattopadhyay & McKaig, 2004; Dandona et al., 2006; Ramesh et al., 2010).

In light of these findings, it is important for researchers to study populations from lower socioeconomic backgrounds that may make them vulnerable to STIs and increase their risk of HIV infection. Furthermore, understanding the factors that increase women's risk of infections can then help tailor educational messages, information, and health-promotion activities specific to the audience. While most of the existing research has focused on male migrant populations and female sex workers (Gupta & Singh, 2002; Bansal et al., 2008), it is also important to evaluate knowledge of RTIs among vulnerable women employed in semi-skilled manual labor. Our study is the first known pilot study assessing knowledge and perceptions about high-risk sexual behavior, attitudes towards risk prevention, and treatment

seeking behavior among female textile workers from very low socioeconomic backgrounds in Surat, India.

We used a qualitative research approach to understand the STI risk behavior among Surat female textile workers. Specifically, we aimed to: 1) identify female textile workers' knowledge of RTIs and their treatment seeking behavior; 2) identify female textile workers' perceptions of commercial sex work within the textile industry of Surat; and 3) identify the sexual network of Surat female textile workers who engage in sex work.

Method

Study Setting

We conducted this study in the textile markets of Surat City between 2008 and 2009. Surat is a coastal industrial city with a high standard of living, located in the southern part of Gujarat state on the Gulf of Bombay. The population of Surat City is 4.84 million people, as per the census. The textile market area has a highly dense population and is located two kilometers from 'Sahara Darwaja,' an area of Surat where textile markets are located. The Surat textile markets are located in a warehouse district of Surat and are defined as places where people work to press and pack clothes produced in Surat for shipping and distribution throughout India. Most women who work in the textile industry are employed in semi-skilled manual labor and are paid daily wages through contracts and subcontracts. Prior to initiation of data collection, the project team contacted and met with the managers and supervisors of more than 100 textile markets. During these meetings, members of the research team explained the study to the managers and supervisors who all provided their oral consent for the study team to approach the female textile workers for participation in the study. From the textile market sites that agreed to be a part of the study, we randomly selected three market sites in which to conduct the focus group discussions (FGDs).

We included in the study adult female workers age 18 to 49 years and employed at a Surat textile market. This age group represents the most common age group of women participating in commercial sex work. We required that participants also speak the languages of Hindi or Gujarati in order to participate in the study.

Procedure

Prior to starting the study, two investigators developed a semi-structured FGD guide. The guide included both open-ended and closed-ended questions with follow-up probes drawn from Social Ecological Model constructs (Best et al., 2003) (see Table 1). In particular, we wrote the questions to focus on the women's sexual health status and sexual behaviors. In our study, we focused on high-risk sexual behaviors, which we operationally defined as: multi-partner sexual behavior for money, gifts, or favors.

We collected the data by conducting three FGDs at three different textile markets that we randomly selected from a list of markets that agreed to participate in this study. A research team of six members familiar with the textile markets approached interested female textile workers during the day at each textile market. We invited participants to attend one of three

FGDs held at varying times and days. Each FGD was made up of women from a single textile market. We recruited six to eight women for each FGD.

To maintain confidentiality of the participants, we carried out each FGD at a quiet place at or near the market area. Participants were seated in a circle to foster discussion among them. On the day of the FGD, a counselor from the study team explained the study procedures to all the participants and obtained written informed consent from each participant. A total of six women participated in each FGD, which was moderated by a trained faculty member from the Preventive and Social Medicine Department of the Government Medical College, Surat. Trusted non-profit organization (NGO) staff who had experience with working with this population assisted the study researchers. During each FGD, the moderator prepared a sociogram. Each sociogram was a diagram that enabled the research team to visualize the responses of the participants to one another. FGDs were conducted in Hindi (national language) and Gujarati (regional language). The FGDs lasted between 45 and 60 minutes while two trained members of the research team observed and recorded field notes.

We audio taped and transcribed verbatim each FGD. We prepared a summary for each FGD based on observations of the FGD moderators. Two study investigators met several times to review the data. These two investigators prepared a list of codes based on questions in the focus group guide. The two investigators reviewed the focus group transcripts together and discussed the coding until consensus was reached. In some cases, the investigators listened to the recordings of the FGDs and consulted the sociogram to review the context of the data. The two investigators described ideas that were repeated and considered salient in the FGD transcripts as themes for the analysis. After performing the coding, we organized the data using tables representing a particular theme.

Results

Participants' median age was 35.9 years (standard deviation [SD]: 6.3 years; range: 22–45 years). Participants' employment in a textile market ranged from 1 year to more than 15 years. Of the 18 people in the FGD, only one was unmarried. Participants' median monthly income was 1,300 Indian rupees (equivalent to US\$21; SD: 252 Indian rupees; range: 1,200–1,500 Indian rupees). This indicates that all of the women in our study were living well below the poverty line set by the World Bank (poverty line was set at below \$1.25/day from 2008 to 2015 and updated to \$1.90 as of October 2015; World Bank, 2015). Hence, all participants in our study were living in financially destitute conditions. All participants were employed as sweepers in the textile markets and were responsible for sweeping and cleaning their designated areas.

Knowledge of Reproductive Tract Infections (RTIs) and Treatment Seeking Behavior

Overall Perceptions of RTIs.—When focus group moderators asked participants about their knowledge regarding RTIs, including STIs, most remained silent; only a few replied. A few participants said that they heard these terms for the first time during the FGD. One participant reported that these infections usually occur in those who have extramarital sexual relations. Another participant answered that these infections happen to women many times

during their life, especially at the time of pregnancy. One participant asked the moderator to provide information regarding RTIs.

Symptoms of RTIs.—When focus group moderators asked participants about symptoms of RTIs, including STIs, the women reported that vaginal discharge, ulcers, weakness, backache, infertility, and cancer of the uterus were symptoms of RTIs.

Treatment Seeking Behavior.—Following the discussion of perceptions and symptoms of RTIs, focus group moderators informed FGD participants about the symptoms of RTIs, including STIs, to learn about their treatment seeking behavior in the past five years if they had experienced a symptom of a RTI. The most commonly mentioned RTI symptom that participants reported was vaginal discharge. In total, three participants reported experiencing vaginal discharge. One participant reported that she had experienced vaginal discharge before marriage. At that time, she used “*ispaghula*” (i.e., a home remedy consisting of edible fiber) for treatment. Shortly after she was married, the vaginal discharge symptom resolved. Another participant reported that she had vaginal discharge in the past and had obtained treatment for it; however, her partner was not treated at that time. One participant answered that she had experienced vaginal discharge three to four days prior to the FGD. At the time of the FGD, the participant had obtained treatment for it from a private health clinic. She had no information regarding whether or not her partner had similar complaints, and her partner had not been treated. One participant said that RTIs are common among women, particularly at the times of menstruation and childbirth; therefore, there was no need to get treatment for the symptoms. The rest of the participants said that they had not experienced any of these symptoms in the past.

Knowledge Regarding HIV and AIDS.—Focus group moderators asked about FGD participants’ knowledge regarding HIV/AIDS and modes of transmission of HIV/AIDS. In response, some of the participants remained silent, some answered “no” by nodding their heads (indicating they had no knowledge regarding HIV/AIDS), while the rest of the participants replied verbally. Among the participants who replied verbally to the query, only a few answered correctly about modes of HIV transmission by stating that HIV was transmitted through exposure to blood, injections, and sexual relations with someone other than the spouse. A few participants reported that they had heard the phrase “HIV/AIDS,” but they did not have any other information. The remaining participants reported methods of HIV/AIDS transmission that were not accurate, including eating stale foods, sitting with persons infected with HIV, and exposure to dust. Participants reported that newspapers, signboards, or friends were the sources of their information regarding HIV/AIDS. Some of the participants stated that they did not have enough information regarding HIV/AIDS because they did not have enough time to get the information due to their busy work schedule of sweeping in the markets, which started early in the morning and ended in the late evening.

HIV/AIDS Prevention.—When focus group moderators asked about modes of prevention of the transmission of HIV/AIDS, only some participants engaged in the discussion, while others remained silent. Those who did provide a response mentioned that keeping clean,

keeping a safe distance from an HIV-infected person, blood testing, avoiding sex with multiple partners, using condoms, and convincing an HIV-infected person not to touch anybody could prevent transmission of HIV/AIDS. Again, some participants reported that they did not have time to learn about this “new” disease. When focus group moderators asked FGD participants about the role of television as a source of information for textile workers to learn about preventive measures against HIV/AIDS, a few participants reported that they did not have money to buy a television. Even though most participants lacked resources, the majority of them agreed that television was a good way to receive information about HIV/AIDS. The majority of the participants did not participate in the discussion when asked these questions.

Knowledge Regarding Condoms and Use of Condoms.—When focus group moderators asked FGD participants about their knowledge of condoms, almost half of the participants reported that they had seen one previously. Most participants stated they had seen a condom, but had never used one. When focus group moderators asked FGD participants about how condoms may be accessed, participants listed *anganwadi* (health workers), a medical store, and a hospital. A few participants mentioned that they lacked knowledge of where condoms were distributed due to the fact that they were female. When focus group moderators asked FGD participants about the reasons for condom use, only a few participants said that condoms are used to prevent pregnancy. None of the participants mentioned the use of condoms for the prevention of STIs.

Perceptions of Commercial Sex Work within the Textile Industry in Surat, India

Sexual Behavior and Sexual Network.—Following a discussion regarding FGD participants’ knowledge of RTIs, including STIs and HIV/AIDS, focus group moderators asked FGD participants about sexual behavior and the sexual network among female workers in textile markets in Surat. Initially FGD participants remained silent, but after focus group moderators provided FGD participants with examples of high-risk sexual behaviors (e.g. Are you aware of anyone indulging in a sexual relationship in the market area in exchange for money or goods?), some participants began talking about this issue within the group. A few FGD participants said that they did not have any information on this topic. One participant replied, “We are engaged in labor work here, and I am not involved in it (sex work).” A few FGD participants said that since they were very busy with their routine work in the textile markets, they did not have time to talk to people about others’ behavior. In addition, these participants reported that in their market, they are respected, and so these topics are not discussed. The rest of the participants agreed that these high-risk sexual activities were taking place in the markets. One female stated that “We know only about our market, not about other markets, many are engaging in high-risk sexual activities, but no one wants to accept it,” meaning that she had heard of high-risk sexual activities taking place in the markets, but nobody had admitted to participating in these activities. A few participants said that some women in the markets had sexual partners other than their husbands. One participant replied that “I have heard about it, from my husband, but I haven’t seen any such female with my eyes.” One participant was reluctant to provide specific information, and said, “I know someone involved in these kinds of activities, but if I tell her name, I may have

a fight with her.” A few participants agreed that they had heard about high-risk sexual activities previously from many people in the markets.

When focus group moderators asked FGD participants about what could be the possible reasons for involvement of these females in high-risk sexual activities, the majority of participants reported that some women engaged in high-risk sexual behavior because they lacked economic resources. The participants stated that the families of the women who engaged in high-risk sexual activities lacked money, and the women were responsible for children. Often, women engaged in high-risk sexual activity following changes in the family related to their husbands. For instance, a woman might engage in sex work if her husband was not working, if the woman was separated from her husband, or if her husband had died. Participants reported that some women suffered harassment from their husbands, such that they felt that they might have to indulge in high-risk sexual activity to address their economic needs, such as to pay the house rent and to meet the needs of their children. One participant stated that “If you are female, you have to see many things; sometimes [your] husband leaves you, and you have small children, you do not have your own house so you have to pay rent and you get 1,500 rupees (US\$25) only from the market and rent is 700–800 (US\$11-US\$12) rupees and you have a responsibility of two to three children, so sometimes they are doing this type of work.” The other participant stated “If [a woman] does not have support, she can get money by doing this.”

When focus group moderators asked FGD participants about the profile of females involved in high-risk sexual activities, some participants said that the women involved in high-risk sexual activities were 30 years of age or older, mainly because the majority of the women employed in the textile markets were in this age group. A few participants reported that females in the markets who engage in high-risk sexual behaviors might be sweepers, box makers, saree (a type of Indian garment) cutters, or employed in shops. Participants reported that women whose native states were Gujarat and Maharashtra were involved in high-risk sexual activities. Some of them were married, while some were unmarried.

Regarding the profile of the sexual partners of the women involved in sexual activities, a few participants said that their partners were from the market, as well as from outside the market area. Some participants reported they did not know much information about the clients, as they did not know about the women involved in high-risk sexual activities. No one in the FGD responded when asked about the profession of clients of female textile workers who engaged in commercial sex work. Some FGD participants reported that sexual partners of the women involved in high risk sexual activities were usually 30 years or older. When focus group moderators asked FGD participants where the high-risk sexual activities involving female textile workers took place, most participants reported they had no knowledge of the location. A few participants stated that female textile workers and their clients might have met during lunch hours.

When focus group moderators asked FGD participants to estimate how many females working in the textile markets were involved in high-risk sexual activities, there was a range of responses. When asked the number of women who engaged in high-risk sexual activities out of 10 females that they knew, one participant said one or two out of ten, while three

participants responded three out of ten, and five participants said four to five out of ten women in the textile market were involved in this work. The remaining nine participants said that none of the women they knew was involved in sex work. One participant mentioned, "If one, two women are engaging in this kind of work, and you say that all are doing same thing. But not all women are the same, just like each finger of our hand is unique."

Discussion

Our objectives for this qualitative study were to: 1) identify female textile workers' knowledge of RTIs and their treatment seeking behavior; 2) identify female textile workers' perceptions of commercial sex work within the textile industry of Surat; and 3) identify the sexual network of Surat female textile workers who engage in sex work. In general, women in the study had good knowledge of the symptom of RTIs, but similar to another study of textile workers, women who work in the Surat textile industry have little knowledge about RTI prevention, transmission, and treatment. While a few participants correctly described modes of HIV transmission and HIV prevention, there was a wide range of misconceptions reported by the women, including that HIV can be transmitted through eating rotten food, sitting with a person infected with HIV, and exposure to dust; and that people infected with HIV should stay away from and avoid touching other people. Some of these misconceptions may fuel HIV-related stigma and discrimination (Steward et al., 2008). Few study participants regularly used condoms during sexual intercourse, and none knew that condoms could prevent the transmission of HIV or other STIs. Some women did know where to access condoms, but others did not believe they needed to know where to find condoms and attributed this lack of knowledge to being female. In general, participants indicated that friends, signboards, and newspapers were their sources of information regarding HIV and AIDS, but it was difficult for them to seek information because of their long working hours.

Although none of the women in the current study reported engaging in high-risk sexual activities, the results suggest that other women working in the Surat textile industry may engage in high-risk sexual activities due to economic reasons, but these activities were taboo. Overall, women in our study seemed highly empathic with female sex workers, understanding the diverse rationales or legitimacy of their participating in sex work. Similar to previous research in India and in other countries, the main reason that female textile workers were reported to have engaged in sex work was economic (Blanchard et al., 2005; Bucardo et al., 2004; Dandona et al., 2006; Hong & Li, 2008). The FGD participants indicated that women who were unmarried, lost financial support from a spouse, or who had to support a child or children may be particularly vulnerable to turning to sex work to pay for basic necessities like housing. Our specific study finding adds to other research indicating that women in developing countries are at higher risk of being infected with HIV due to their economic vulnerability (Piot, Greener, & Russell, 2007). Participants in the study had reported limited information about high-risk sexual activities and sexual networking of other women in the textile markets and about the clients of women working in the textile markets who might engage in sex work.

Our overall study results suggest several directions to empower female textile workers to avoid RTIs and STIs, including HIV. First, there is a great need for intensive STI, RTI, and

HIV prevention programs in this hidden population, particularly for young adults who are not covered under India's National AIDS Control Program III (NACP III; National AIDS Control Organization, 2011). However, as per NACP III, a female textile worker is not considered to be a female sex worker, and therefore, would not be eligible for any kind of NACP intervention for the prevention of HIV. Improved condom programming can increase condom supply and use and prevent the spread of HIV. People can use male and female condoms to prevent pregnancy as well as STIs. Second, programs that economically support female textile workers in Surat may be necessary to prevent these women from having to turn to sex work in order to maintain basic standards of living, such as adequate housing. Third, public health workers should design additional health communication interventions to reduce misconceptions regarding the transmission and prevention of HIV. These health communication interventions may be able to reduce HIV-related stigma and discrimination. The FGD participants suggested some possible channels of communication and education including signboards, newspapers, and peers.

In the future, researchers should investigate Indian female textile workers' knowledge of HIV/AIDS, as well as factors influencing their sexual behavior to prevent HIV and other STIs. These studies would enable researchers to identify the women most at risk for HIV/AIDS, other STIs and RTIs, and to design interventions to reduce their vulnerability to these preventable infections. Researchers should design a future large-scale study using a relevant health behavior theory to identify the workers engaging in high-risk sexual activity that increases the likelihood they will contract an STI. Although none of the women in the study admitted to engaging in sex work, female textile workers in Surat, India, may be at risk for STIs due to their economic vulnerability.

Our study has a number of strengths. This is one of the first studies of sexual and reproductive health among female textile workers in India, a middle-income country. This population has low socioeconomic status, including limited literacy, and has very rarely been studied; however, it is similar to other international populations where the women are vulnerable to engaging in commercial sex work due to financial insecurity. Engagement of this vulnerable population is an important first step for promoting recommended health practices. In addition, our study has some limitations. First, it is a qualitative study conducted in textile markets in Surat, an urban area of India. The study had a small population and sample size and may be considered similar in scope to a pilot study. Although population is small, it has been neglected in research and in public health efforts. We also recruited women vulnerable to RTIs for the study. Nevertheless, the study findings may not generalize to populations outside of these particular textile markets in India. Second, it was difficult for us to enroll participants in the study, especially those who were willing to discuss their own engagement in sex work. In addition, the sensitive nature of this topic may have limited the responsiveness of the FGD participants. Participants may not have disclosed their engagement in high-risk sexual behaviors because of the presence of other textile workers in the FGD or because the FGD moderators were physicians and government employees. Third, we only used focus groups to collect data, and the focus group guide included both open-ended and closed-ended questions. However, we were limited in our ability to describe the number of participants who provided responses to open-

ended FGD queries. Researchers should design studies that are larger in scale, use in-depth interviews or mixed methods to obtain additional data, and use peer interviewers.

In conclusion, the results of our study indicate that female textile workers in Surat, India, had limited knowledge regarding RTIs, including STIs such as HIV, and did not consistently use condoms. The female textile workers acknowledged that other women in their community might engage in high-risk sexual activities to meet their basic financial needs. Researchers should conduct future large scale studies to identify women at most risk for RTIs, including STIs, and to design appropriate interventions to reduce their exposure to these diseases.

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Table 1.

Key Questions and Probes from the Focus Group Discussion Guide.

Phase 1: Introduction and Knowledge of STIs and RTIs	
Introductory Questions: Please introduce yourself and tell us your age, marital status, the length of time that you have been in Surat, the type of work that you do in the market, and the amount of income that you receive in the market.	
Question 1: Can you tell me about how HIV is transmitted from one person to another? How is HIV not transmitted?	PROBE: What do you do to prevent HIV/AIDS transmission?
Question 2: What do you know about sexually transmitted infections and reproductive tract infections?	PROBES: Can you tell me about the symptoms of sexually transmitted infections? What are the reasons that a person gets a sexually transmitted infection?
Question 3: Did you have a sexually transmitted infection or reproductive tract infection in the past five years?	PROBES: If you had it, what did you do for treatment? If you had treatment, was the disease cured? Did your partner have treatment?
Phase 2: Experience with High Risk Sexual Behaviors	
Question 4: We have learned from different sources that high risk sexual activities are going on in these markets. Do you have any information about it?	
Question 5: Can you tell any story or incident of any woman in the textile markets who has been involved in high risk sexual activities?	PROBES: In your opinion, what is the likely reason behind their involvement in these activities? With whom they are doing these activities? What do the women get in return for these activities? Where are these women from? Which language they speak? What is their age? What type of work are they doing in the markets? Do they take part in high risk sexual activities only if they do not find work in the textile markets? At what time and at what place do they do these activities? In your opinion, how many women are involved in these activities out of 10 females? Where do these women reside?
Question 6: Describe the partners of women who engage in high risk sexual activities.	PROBES: What is their approximate age? What is their marital status? Where do they reside? What language do they speak? Do the partners come from the textile markets? If so, what type of work are they doing in the textile markets?
Phase 3: Condom Use	
Question 7: What do you know about condoms?	
Question 8: Can you tell the name of places from where you get condoms?	