Published in final edited form as:

Cult Health Sex. ; : 1–15. doi:10.1080/13691058.2018.1491060.

Sexual intimacy and marital relationships in a low-income urban community in India

Stephen L. Schensul^{*,a}, Marie A. Brault^{1,b}, Priti Prabhugate^c, Shweta Bankar^d, Toan Ha^a, and Deborah Foster^a

^aDepartment of Community Medicine and Health Care, University of Connecticut Health Center, Farmington, CT, USA;

^bDepartment of Anthropology, University of Connecticut, Storrs, CT, USA;

^cInternational Center for Research on Women, Mumbai, India;

^dInternational Center for Research on Women, Mumbai, India

Abstract

Data from a six-year study of married women's sexual health in a low-income community in Mumbai indicated that almost half the sample of 1125 women reported that they had a negative view of sex with their husbands. Qualitative interviews and quantitative survey data identified several factors that contributed to this diminished interest including: a lack of foreplay; forced sex; the difficulty of achieving privacy in crowded dwellings; poor marital relationships and communication; a lack of facilities for post-sex ablation and a strong desire to avoid conception. Women's coping strategies to avoid husband's demands for sex included refusal based on poor health, the presence of family members in the home and non-verbal communication. Factors that contributed to a satisfactory to pleasurable sexual relationship included greater relational equity, willingness on the part of the husband to not have sex if it is not wanted, a more "loving" (*pyaar karna*) approach, women able to initiate a desire for sex and greater communication about sexual and non-sexual issues. This paper examines the ecological, cultural, couple and individual dynamics of intimacy and sexual satisfaction as a basis for the development of effective interventions for risk reduction among married women.

Keywords

Married women; low income; marital sexuality; urban; India

Introduction

The literature that describes married life for women in low-income communities in India focuses on the intersection of structural, cultural, economic and gender inequities that result in women entering marriage at a young age, with little education or preparation for marriage and little or no property or wealth of their own (Weitzman 2014). Women entering their

*Corresponding Author: Stephen L. Schensul schensul@uchc.edu.

¹Marie Brault is now at Yale Center for Interdisciplinary Research on AIDS, Yale School of Public Health, New Haven, CT, USA

husband's household are in a subservient position, leaving them at the bottom of social and age hierarchies in their new households (Fernandez 1997; Silverman et al. 2016). In these hierarchies, there is little room for women to make decisions, work outside the home, communicate freely with individuals inside or outside the household, or develop an intimate relationship with their husband.

In this characterisation of low-income women's marital and familial relationships, it would follow that sexual intimacy between spouses replicates the same patriarchal structure. In fact, the literature concerning marital sexuality in India has largely focused on the negative aspects of the marital sexual relationship related to HIV/STI transmission, physical and/or sexual violence, and alcohol use and unprotected sex (Saggurti, Schensul, and Singh 2010; Silverman et al. 2008; Solomon et al. 2009; Verma and Collumbien 2003). For married women, the risks include women's lack of knowledge or preparation for sex (Khan et al. 2005), forced or coerced sex, norms that support husbands' domination and control of women's bodies and sexual violence as a component of intimate partner violence (Acharya, Sabarwal, and Jejeebhoy 2012; Chibber et al. 2012).

The presence of pleasurable intimate relationships between a portion of husbands and wives and concomitantly greater equity in these marriages in low-income urban communities is described in a much smaller number of publications (Mehrotra et al. 2015; Bojko et al. 2010; Sandhya 2009; Maitra and Schensul 2002). This paper seeks to move beyond the negative stereotypes common in the literature to present the ecological, cultural, spousal and individual dynamics of intimacy and sexual satisfaction among married women living in a majority Muslim, low-income community of 600,000 in Mumbai, India. It focuses on the following research questions:

1. What is the distribution of relatively positive and negative sexual relationships in a low-income community in Mumbai?
2. What are the factors in the non-sexual relationship between wife and husband that create a positive or negative context for marital sexuality?
3. What are the sexual behaviours and responses of wife and husband that are associated with relative sexual satisfaction or dissatisfaction?

Methods

The data described in this paper come from the NIMH project, "The Prevention of HIV/STI among Married Women in Urban India ("Married Women's Project;" RO1 MH075678; S. Schensul, PI)." This project, conducted from 2009 to 2013 (see Schensul, et al. 2009), was part of an ongoing Indo-US research collaboration *Research and Intervention in Sexual Health: Theory to Action* (RISHTA, meaning "relationship" in Hindi and Urdu).

The study community consists primarily of Muslims (80%) and Hindus (14%). Most were migrants from rural parts of Uttar Pradesh and Bihar in the North, Tamil Nadu in the South and Maharashtra in the West of India. Men are primarily engaged in daily wage work such as driving auto rickshaws and trucks, masonry and carpentry work, working in the local *zari* (piece goods) industries and selling items, fruits and vegetables on community lanes. An

increasing number of women (28%) worked for cash income both in (63%) and outside (37%) the home. The average monthly family income was INR 5900 per month (approximately US\$100).

The RISHTA Married Women's Project implemented multilevel interventions, focused on generating greater gender equity and the organisation of a "women's health clinic" providing both gynaecological and psychological care at the community's municipal Urban Health Center. For more details, see (Schensul, Verma, et al. 2009).

The data for this paper are derived from both exploratory and explanatory mixed methods in the formative research phase. Exploratory methods included participant observation, mapping of community resources, key informant interviews of government officials, service providers, community organisation and religious leaders and in-depth interviews with married women (N = 43) that informed the development of a baseline survey, the "Women's Structured Survey" (Women's Structured Survey) (N = 1125). In-depth interviewing and survey administration in Hindi or Marathi, depended on the participant's language preference. Female research investigators with extensive experience and advanced training at the Master's or PhD levels conducted the interviews and administered the surveys. The qualitative data provided explanations of the results of analysis of the survey data. Both the qualitative and the quantitative analysis contributed to the design of the interventions and to assessing impact. The key inclusion criterion for both the in-depth interview and the survey samples involved married women having any of six gynaecological symptoms (vaginal discharge, genital itching, burning micturition, lower abdominal pain, genital ulcers and inguinal swelling).

Data Analysis

A coding system consistent with the theoretical model and the design of the study utilised a tree diagram method (Schensul 1993). Qualitative interview data were translated into English, entered into Atlas.ti (Muhur 2013), coded and analysed to assess the issues that impacted on women's sexual health. All coders independently coded the same segments of narrative text and then compared their application of the coding scheme. The process of coding and comparison continued until an 85% level of agreement was achieved.

The Women's Structured Survey consisted of demographic data and a series of scales that measured spousal communication, marital conflict, emotional status, women's empowerment, gender equitable norms, women's health problems and other variables. Descriptive statistics were computed to assess the characteristics of the sample and the subgroups defined by age, age at marriage, education, religion, family structure and household composition and prevalence of gender (in)equity, sex quality and forced sex. Logistic regression was used to examine the association between the independent variable (forced sex) and outcome variable (sex quality), controlling for demographic factors.

All women were fully briefed about the nature of the study and written consent was obtained. Women who were ineligible for the study or did not consent to participation received standard care at the Women's Health Clinic of the Urban Health Center. The project

received IRB approval from all participating institutions (see acknowledgements for a list) and the Indian Council for Medical Research.

Results

Socio-demographic characteristics

The mean completed age of the women who responded to the Women's Structured Survey was 28.6 years old, with a mean age at marriage of 17.7 years (46% married below the legal age of 18). The sample consisted mostly of Muslim women (91.6%), with 8.1% Hindu and 0.4% Buddhist. The mean level of education was 5 years. More than half (57%) of participants had migrated to Mumbai, with 71.2% living in nuclear families and a mean of 2.6 living children.

The Challenges of Economic Marginality

Living in an urban poor community means an ongoing set of challenges due to limited economic, political and social resources. Streets are crowded, flies congregate over fruit and vegetable sellers' displays, houses and business structures are dilapidated, dust floats in the air in dry periods, mud and standing water abound during monsoons, and piles of garbage lie along roads and in disintegrating drainage systems all year round.

The low-skilled jobs that brought migrants from impoverished areas of India have been reduced in favour of high-tech positions, leaving the inconsistencies of income derived from daily wage labour, auto-rickshaw driving and piecework. Politicians pay attention to the community during election time but rarely deliver promised infrastructural needs such as improved roads, sanitation systems, recreational facilities, upgraded schools and adequate water and toilets. Families have perpetual anxiety concerning residential stability and income for food, school fees, housing costs, expenses associated with the marriage of daughters, and other daily expenses.

The frustrations of economic marginality place a high degree of stress on marital relationships. The traditional gender roles call for men to be providers and women to maintain the household. Economic marginality means that wives must cope with their husband's inadequate income in maintaining the household, undermining both their roles. For those relationships in which there is good spousal communication, marital partnerships can be an effective adaptive strategy in facing adversity. However, in relationships with limited communication, increased financial anxiety leads to arguments, harsh words and abuse affecting the marital and sexual relationship.

[My] husband is sitting at home and not working. There is no money since last few months. I have been running my house by borrowing money from others...There are quarrels in the house on this issue. I told him to find some work and earn as we cannot live just on borrowed money. He got angry. He beat me and told me to leave the home.

(32-year-old woman, with 3 children)

Our income is not much but we are happy, and I save money from our monthly income. I am at peace (sukun). Only my health is not good...My husband prepared the tea for us. He helps me in household works when I am ill.

(27-year-old woman, with two children)

The Ecology of Marital Sexuality

Housing in the study community ranges from durable concrete and brick materials (*puccha*) in the better off areas, to those who have used found materials such as tin sheets and burlap (*kattcha*) in the peripheral areas where the poorest families live, to those with a mix of materials (semi-*puccha*) scattered throughout the community. Limited available land means that houses and rooms in multi-residence buildings (*chawals*) are crowded together with little outdoor space and a lack of privacy from one unit to another. The great majority (80%) of housing consists of a single room, where cooking, eating, washing and sleeping must occur in the same floor space. When the family retires at night, floor mats are spread for sleeping. Families may consist of spouses and children only, or extended families that may include in-laws and husband's siblings and their families. With a mean of six people per household, the typical single room floor space is fully used. In these circumstances, sex between spouses must take place when the other residents of the household are sleeping or out, and must be quiet, to avoid awakening household members or being heard by neighbours.

All the family lives together in one room and as a result we don't have any privacy at home. I can't even talk with my husband in this family. We have sex once in a month, thinking that what if someone might awake or heard our voices while having sex. So, we avoid having sex.

(27-year-old woman with 1 child)

In this small house, where all of us sleep together in the same room how can we both have sex? We have a young son who sleeps with us. My mother-in-law sleeps in the same room. So, it really gets difficult.

(22-year-old woman with one child)

To compound the situation, the availability of both water and toilets in the community is a major problem, particularly in relation to washing and ablution before and after sex. There are 75–80 public toilets facilities in the community with 10 seats for each gender and an estimated 50 more, built by the World Bank and various NGOs and maintained by local people. About half the toilets are older, maintained by the municipality and in poor condition. Women report difficulty using these toilets post-coitus since going out late at night announces to neighbours that they have had sex. Visiting the toilets late at night requires walking down dark lanes with men and boys hanging around the toilets, raising safety concerns. Taking a bath prior to sex and doing ablutions post-coitus is difficult due to a shortage of available water. Earlier there were water taps at selected intervals in the community; now most households have piped in water. However, water is frequently unavailable by evening time due to limitations placed on slum communities by the municipality.

Women's Interest in sex

In response to the question on the baseline Women's Structured Survey (N=1125), "Have you experienced a lack of interest in sexual activity," 476 (42.3) indicated yes, currently; 56 (5.0%), yes, in the past; and 593 (52.7%) no, never. In response to the question of "What parts of your marital relationship would you like to improve," 432 (28.4%) respondents indicated that they would like to improve marital sex. These results indicate that a majority of the women have a positive interest in marital sexuality with a substantial minority reporting a lack of interest. Several factors are associated with women's positive and negative reactions to marital sex as described below.

Consent and readiness for sex

The leading factor for women's lack of interest in sex as described in the qualitative interviews was the issue of forceful or coercive sex. The baseline Women's Structured Survey probed several elements of forceful sex. In Table 1, the frequencies of these variables are shown and their relationship to women's interest in sex.

Women made clear in the qualitative interviews that force was counter to their desire and pleasure. As a result of constant forcing, a 25-year-old woman with three children stated that, "My each feeling had died towards my husband (Har feelings mar gai hai).

Women who described positive sexual experiences said that their favourite part of sex was foreplay. Women reported that foreplay provides a sense of love and intimacy as their husbands kissed them and caressed their bodies. Women talking about sexual pleasure described vaginal lubrication (*gilla hona*), happiness (*khushi*) and emission of water to indicate orgasm (*paani girna*). Women reporting sexual pleasure also described it as making love (*pyaar karna*). The baseline Women's Structured Survey asked four questions related to women's perception of the quality of their sexual experience as indicated by their readiness for penetration or lubrication (described as getting "wet"), arousal, pain and orgasm (expressed as "releasing water"). The results are presented in Table 2.

There was a close association of these four variables, allowing the development of a scale of markers of sex quality (Cronback's Alpha = .941). Of the sample (N=1125), 602 (53.6%) reported no issues and 523 (46.4%) reported experiencing at least one or more of these issues. Logistic regression analysis was conducted to examine the relationship between forced sex and sex quality adjusting for age, education, marriage and age at marriage. It was found that those who reported forced sex were 1.6 times more likely to experience a lack of sexual satisfaction than those women who did not report forced sex (OR=1.6, 95% CI: 1.36–1.89).

[My husband and I] speak to each other about all concerns of the day. When he is in the mood, he asks me to sleep at his side and not in the middle between the two sons. He puts his hand on my tummy and crosses his leg on me. Then he slowly moves his one hand to my breasts and presses them gently and with the other hand he opens my salwar [pants]. Till the time I get wet, he moves his hand on my breast and kisses my lips. When he realises that I am wet, he does it

(26-year-old woman with 1 child)

I like the whole act of sex with my husband. The most I like is when he undresses me and starts playing with my breasts. Then I like when inserts his penis into my vagina and after some time we both release water [have an orgasm] together.

(23-year-old woman with 2 children)

Insufficient foreplay, particularly associated with forced sex, meant a lack of vaginal lubrication, leading to pain and resulted in limited sexual interest and pleasure for the woman.

I like when he touches me or kisses me. My whole body turns hard and I too feel this should go on but once he removes my cloths and inserts his penis into my vagina it don't like it... because my vagina is not wet. It takes a long time for my vagina to get wet.

(28-year-old woman with 2 children)

I don't like it when he forces me to have sex and I am not feeling like it... Whenever I am prepared ["wet"] to have sex I am happy. Otherwise I do not enjoy anything

(30-year-old woman with 5 children)

Most of the time he does sex when I am not wet. It pains a lot. (24-year-old woman with 1 child)

Husband's alcohol use

A subset of women who experienced forced sex attributed it to their husband's alcohol consumption. In the Women's Structured Survey, 109 (9.7%) of the sample reported that their husbands drank alcohol and 49 (45%) of this group indicated that the alcohol promoted sexual abuse. Women who experienced forced sex after their husbands have been drinking may try to refuse sex, but frequently these requests were ignored.

My husband is alcoholic, and daily he is drinking, and he is having forceful sexual act with me. It's too much pain for me, most of the times I had complained to my mother-in-law but how she will help me?

(25-year-old woman with 2 children)

Now even I don't want my husband to come near me. In the nights when he comes home drunk, I don't want him to touch me. But many a times I cannot do anything. I am in my husband's clutches. If I don't then he starts beating and screaming at me. Everyone in the house and around wake-up and it's such a shame.

(29-year-old with 4 children)

Pornography and sexual acts.

Pornographic films and videos are available in "video parlours" and cyber cafes and with the advent of cable television and smartphones, at home and on personal devices (Verma 2012). These movies and videos depict sexual performances involving compliant women, multiple positions, anal and oral sex, sexual abuse and herculean male performance. For unmarried and married men, pornographic content affects expectations and provides a skewed view of

sexual performance. Our qualitative interviews indicate that the positions and acts depicted in these videos are generally received negatively by women.

Till marriage, I was not much aware of sex. My husband told me everything. He has shown me movies, which explain sex...it shows men and women together doing sex in standing, sitting and sleeping positions and different sexual practices like vaginal, oral and anal sex. After seeing these videos, my husband insists me to do with him.

(18-year-old woman with one child).

Sometimes late night they show pictures on cable. One night my husband was watching the movie and asks me to watch. I told him I found it dirty and that I did not want to watch it. Still I watched a bit. After watching my husband forced me to do anal sex. It was very painful for me and I started crying.

(28-year-old woman with 4 children)

Fear of conception

Many women are concerned about conception because they have met or exceeded their ideal family size or seek a longer interval between pregnancies. These birth control concerns contribute to anxiety related to unwanted conception that reduces their interest in and the quality of marital sex. Difficulty in accessing contraception, misconceptions regarding the effectiveness and side effects of contraceptives, or husband's objections to contraception are limiting factors in contraceptive use. In the face of husband's refusal, some women reported secretly using intrauterine devices (IUDs) such as the Copper T).

I have a good sexual relationship with my husband. He listens to me whenever I deny for sex. However, he does not use condom. I am worried due to pregnancy. So, I am not able to enjoy at the time of sex.

(30-year-old woman with 3 children)

He says if he uses condom then he loses the erection easily. He insists that he will not ejaculate inside me, but I don't allow to do this because twice he failed to withdraw. I took the emergency pill next morning and by God's grace, I didn't conceive. So now I just don't trust him and I'm on pill from last 3 months.

(26-year-old woman with one child)

Sexual communication norms

In traditional patriarchal norms, women are not to be too knowledgeable about sex, they should not communicate with their husbands about sex, they should not indicate their desire for sex, they should always be ready for sex when their husbands want it, and their objective in sex is to meet the needs of their husbands. In the baseline Women's Structured Survey, we asked women about these norms (see Table 3).

The results presented in Table 3 indicate considerable variance in adherence to norms concerning sexual communication. For couples who have more open sexual communication (e.g. wife feels comfortable asking for/initiating sex), women are more content with their

sexual relationship. For couples who are relatively less communicative, the responsibility lies with women to always be available and to respond positively to husbands' demands for sex with negative consequences for refusal. As one woman of 25 with three children put it, "The men never ask, they just do."

Prevalence of sex (in)equity in the study community

To quantitatively characterise the nature of the sexual relationship reported by women in this sample, a composite scale was developed of the Women's Structured Survey items indicating sexual equity and inequity that included initiation of sex (with force, inability to refuse husbands demands) and the impact of the sex act on women (not achieving orgasm, lubrication, arousal and experiencing pain). The resultant scale with 7 items has a Cronbach's alpha of 0.825. Of women in the sample, 317 (28.2%) report having none of these issues, 285 (25.3%) one of the 7 issues and 525 (46.5%) with two or more.

Strategies to reduce risk

Whether women participated in sex of their own volition or were forced, whether they lacked interest or took pleasure in the process and outcome, marital sex was a contested domain in which optimisation required mutual interest, acceptable behaviours and pleasurable outcomes for each partner and each sexual encounter. The analysis of the qualitative data indicated that even in the most positive sexual relationships, some degree of coercion, acceding reluctantly to husband's demands, having sex demanded/requested too frequently and accepting husband's requests for unwanted sexual acts may occur. In this section, we review the multiple strategies that women took to reduce the risks associated with unwanted sex. What is not in this list is divorce or permanent separation. Women in urban poor communities, particularly those in arranged marriages would be unlikely to get support for such a step from family and would have no financial resources for living independently with or without their children. Therefore, the strategies employed need to be understood in light of the need to maintain the marital relationship. These strategies include:

Meeting husband's demands for sex—One approach that reduced conflict and decreased the potential for violence and strain on the marital relationship was to always give in to the husband's demand for sex, no matter the desires of the woman.

To me having sex is very dirty and I hate it but at the same time I realised that because I made my husband happy whenever he desired, he is always happy with me. This is the life of women.

(33-year-old woman with 3 children)

I allow him to have sex whenever he wants to. Sometimes I don't feel like having sex, but I don't say no to him. One never knows, if I refuse he can always go to other women

(30-year-old woman, with 5 children).

Non-verbal refusal—The direct, verbal communication by a woman that she will not have sex despite her husband's demands could have negative consequences that included

arguments and violence. However, the need to avoid disruption in the cramped household lent itself to non-verbal refusal with less complications.

So, I ignore him whenever he calls me at night [for sex], then he gets what I mean. He gets very irritated on me but what to do? I don't have any other option.

(30-year-old woman with 4 children)

I don't feel like having sex when I am tensed. When I don't feel like having sex I turn my face away from my husband or don't turn my face towards him when he hugs me. So, he understands and goes to sleep quietly.

(22-year-old woman with one child)

Visiting the natal home—Temporary escape from a negative sexual relationship was available for women who had opportunities to visit their natal home. Returning to the natal family was particularly helpful when women needed respite from an abusive situation.

Along with my children I went to my mother's place, though he requested me not to go but I didn't listen to him. Why to listen that liar [about husband's extramarital sex], from the starting of the day he is lying to me, but I never said anything because I trusted him ... I don't know why he needed another female when I was there?

(32-year-old woman with 3 children)

I visited last 15 days back to my native place, to talk with my mother and get mental peace. My husband is drinking every day, and he is having forcefully sexual act with me. It is very painful.

(25-year-old woman with 2 children)

Women's health problems—Sex was a causal factor in some women's health problems or exacerbated existing problems. Since the eligibility criteria for the sample required women have at least one of six gynaecological-related symptoms, these symptoms were prominent in women's descriptions of marital sex. Women emphasised white discharge (*safed pani*, see Kostick et al. (2010), pain/burning sensation during sex, back pain, burning micturition, and abdominal and other pains associated with menstruation and pregnancy. These issues frequently decreased women's interest and were used by women as a reason to avoid unwanted sex.

My husband listens to me whenever I deny for sex. Due to my health problem, I do not feel for having sex frequently. I avoid sex, but he never tries to force me for sex.

(28-year-old woman with 2 children)

At the time of menses or during the problem of heavy flow of white discharge and I say no for sex, my husband listens to me. For that matter I truly respect my husband.

(23 year-woman with no children)

In addition, there was a cultural norm followed by many couples that during a woman's menstrual period she was considered "unclean" and should not participate in cooking, cleaning, religious activities, or other activities including sex. While there were no clear-cut prohibitions regarding sex during pregnancy or after delivery, women reported considerable discomfort and frequently preferred to not have sex during these periods.

When I am menstruating that time, I refuse to have sex and he also doesn't like to have sex during menstruation.

(24-year-old woman with 3 children)

My husband does not understand and never listens to me. He beats up regularly and forces me for sex during my menstrual period. From the initial years of marriage, he is always like this; he always forced me for sex and never listened to what I want.

(27-year-old women with 3 children)

I don't like to have sex when I am pregnant. But he wants to have sex even then. In the last few months of pregnancy when my stomach became very big, it gets very difficult to have sex in the usual position so then he demanded anal sex. I don't like that, it pains a lot... So, what can I do? I have to give in.

(29-year-old woman with 4 children)

For those couples in which there was forceful sex, these concerns were seen as excuses. Men who do not force sex are more inclined to wait until the symptom or condition is resolved.

Now he just gets on my nerves, I get irritated when he starts touching me, I feel if man cannot take care of his wife when she is in pain why to sleep with him ...he stopped giving money for household, I was not feeling well he didn't bother to take me to the hospital or get me medicines.

(25-year-old woman with 1 child).

My husband feels that I giving false reasons about my health to avoid having sex.

(28-year-old woman with 4 children).

Ageing out of sex—The age when sexual frequency reduces or no longer happens was based on a combination of factors that included older children in the household who were becoming aware of sex, cultural norms that considered sexuality untoward after completing procreation and a loss of libido. For women with a poor sexual relationship, reaching a more advanced age provided relief from husbands' sexual demands. Those women with a more positive relationship continued to enjoy sex, but at a reduced frequency. Some women stated that their husbands' libido also decreased with age, making it easier to reduce or eliminate sexual encounters.

But now after so many years I don't feel like doing it anymore. The children are growing up and they have started understanding so many things. It should not give them a wrong impression about their mother.

(30-year-old woman with 5 children)

My husband is 48 and, in this age, he does not feel like having more sex, also my health is also not good, so the less we are involved in sex. These days, due to space problem and large family, we feel awkward to have sex.

(38-year-old woman with one child)

Discussion

This paper began with a critique of the negative portrayal of sexuality among low-income married couples in India and argued for a greater emphasis on the range of variation in marital and sexual relationships in these communities. The data in this paper provide support for more variation than is typically reported in the literature. Nonetheless, establishing the prevalence of relatively “positive” versus relatively “negative” sexual relationships is not an easy task. First, the baseline Women’s Structured Survey sample is not a random sample of the study community, but women, 18–40, coming to the Urban Health Center seeking treatment for a gynaecological-related health problem. Second, the baseline Women’s Structured Survey sample is 93% Muslim, while the community is approximately 80% Muslim. This overrepresentation is due to the fact that the Muslim majority in the study community includes the poorest households; the Urban Health Center is very low cost, while private care is expensive. With these provisos, there are several variables to choose from in estimating the quality of the sexual relationship. More than 50% of women in the baseline Women’s Structured Survey sample reported that they never lacked interest in sex; more than half indicated that they never had a problem with lack of lubrication, arousal, pain during sex or orgasm and over 60% indicated that marital sex did not need to be improved. While response bias cannot be discounted (e.g. the tendency to report a more positive relationship so that a woman feels she is meeting cultural norms), the fact that all of the women in the sample have a gynaecological symptom may have had a counter, dampening effect. The evidence from these data suggest that approximately 50% of married women have a more successful sexual relationship in their marriage.

It is a testament to the 50% of couples that a satisfactory sexual relationship can be maintained in an environment of limited privacy, lacking many basic facilities of comfort and support. The ability to achieve this intimacy requires recognition of appropriate moments, mutuality of interest, consensus concerning acceptable acts and achievement of mutual satisfaction. For the other 50%, when sex is controlled by the husband, it must be furtive and quick, leading to one-sided male satisfaction.

The dynamics of the overall marital relationship is a determining force in sexual intimacy. The in-depth interview data illustrates the role of good spousal communication both about life and sex issues, the economic problems that affect household maintenance and children’s futures, the ability or inability of the couple to work together to solve major life challenges, relationships with the extended family and attitudes concerning gender equity and women’s empowerment. In a previous paper (Mehrotra et al 2015), the Women’s Structured Survey data was utilised to develop a scale of “sexual health” based on the World Health Organization’s (2002) call for understanding sexual intimacy that included perspectives on “pleasure” as well as “risk.” In a linear regression conducted with this Sexual Health Scale those women that had a poorer marital relationship, more limited empowerment within the

marriage, more inequitable gender norms, greater domestic violence, lower social support and greater food insecurity (a marker for economic status) and poorer health were significantly more likely to have poorer sexual health. These results suggest that women's sexual relationships are impacted by emotional intimacy and support within the marital dyad, as well as factors external to the couple (Sandhya 2009).

With divorce and separation out of the question for women with either positive or negative sexual relationships, women in this community must take initiatives with regards to sex that maintains spousal relationships while meeting their own physical, emotional and sexual needs. These behavioural strategies included satisfying the sexual needs of husbands to keep the peace and maintain the relationship despite unwanted sex, saying no to unwanted sex either verbally or non-verbally in ways that the husband will accept, taking the initiative for sex, asking for specific sexual acts or extended foreplay, making husbands aware of readiness for penetration, sleeping with children to avoid sex, reducing the number of sexual encounters due to children's awareness and couple's age, and requesting that sex not happen due to health problems. These behaviours, whether to placate their husbands or to enhance the mutual sexual experience, indicate that most women in this sample assess their objectives and develop strategies and accommodations to sex that maintain the marital relationship. Women with more negative relationships, must cope with the relative unpleasantness of sex with little support or external assistance. Women with more positive relationships must address issues such as sexual requests from husbands that are too frequent, unwanted sexual acts, and times when health problems limit their sexual interest. In either case, women are not passive and powerless, but able to develop their own approaches to avoid risk or enhance sexual intimacy.

This study has utilised a mixed methods approach in which quantitative data generated by the baseline Women's Structured Survey maximises reliability, representativeness and statistical hypothesis testing, while the qualitative data drawn from in-depth interviews allows discovery, generates narratives and assists in explaining the statistical results (Schensul, Verma, and Nastasi 2004). However, no matter what the methods, the need for explicit details on sexual behaviour is vital to achieve a nuanced understanding of women's sexual experiences. In addition, the content presented in this paper refutes the frequently heard statement that "a specific group" (e.g. low-income women in urban India) "will not talk about sex." Under the right circumstances (Women's Structured Survey and in-depth interviews were conducted in a private room at the Urban Health Center) and confidentiality, the project found that women were anxious to communicate, particularly those women dealing with problematic relationships.

There have been a wide variety of approaches to the reduction of risky sexual behaviour and prevention of HIV/STI transmission, but rarely those that focus on the relational, emotional and sexual dynamics of the marital unit. The results described in this paper indicate that a substantial number of couples find it possible to have a relatively satisfying sexual relationship despite the challenges of a low-income urban community. At the same time, an equally large number find sex to be contentious with a negative impact on the marital relationship. The RISHTA project has demonstrated the feasibility of implementing individual counselling (see (Maitra et al. 2015)) and group couples' intervention (Maitra et

al. 2017) that provided women with an opportunity to share their concerns about sexuality and related issues with counsellors and peers and community interventions to promote gender equity (see (Schensul et al. 2015)). Services such as those developed in the RISTA project have been shown to have a positive effect on both the marital and sexual relationship. Rather than the bleak picture painted by most of the literature, there is sufficient frequency of positive relationships to support evolving cultural norms concerning gender equity and sexual intimacy in marriage. Whether through externally provided services or changing norms and values, it is clear that a focus on the marital dyad can be a vital component in the efforts to prevent HIV/STI transmission, unwanted conception, intimate partner violence and forced sex.

Acknowledgements

We would like to thank the research investigators and the intervention staff of the RISHTA Women's Project for their commitment, hard work under difficult conditions and service to the study community. Special thanks to the other principal investigators: Ravi Verma of the Asia Regional Office of ICRW, Niranjana Saggurti at the India Country Office of Population Council; Shubhada Maitra of the Tata Institute of Social Sciences, Jean J. Schensul at the Institute for Community Research, Hartford, CT and Bonnie K. Nastasi at Tulane University for their contributions to design, methodology, intervention and dissemination of research results. We thank the women in the community for their hospitality, openness and ability to voice their perspectives. This work was supported by the National Institute for Mental Health [RO1 MH075678] of the US National Institutes of Health.

References

- Acharya Rajib, Sabarwal Shagun, and Jejeebhoy Shireen J.. 2012 "Women's Empowerment and Forced Sex within Marriage in Rural India." *Economic & Political Weekly* 47 (2): 65–9.
- Bojko Martha J., Schensul Stephen L., Singh Rajendra, Burleson Joseph A., Moonzwe Lwendo S., and Saggurti Niranjana. 2010 "Sexual Health, Marital Sex and Sexual Risk in Urban Poor Communities in India." *Asia-Pacific Journal of Public Health* 22 (3 suppl): 144S–50S. [PubMed: 20566547]
- Chibber Karuna S., Krupp Karl, Padian Nancy, and Madhivanan Purnima. 2012 "Examining the Determinants of Sexual Violence among Young, Married Women in Southern India." *Journal of Interpersonal Violence* 27 (12): 2465–83. [PubMed: 22279129]
- Fernandez Marilyn. 1997 "Domestic Violence by Extended Family Members in India: Interplay of Gender and Generation." *Journal of Interpersonal Violence* 12 (3): 433–55.
- Khan ME, Barge Sandhya, Sadhwani Hemlata, and Kale Giteshwari. 2005 "Knowledge, Attitude and Experience of Marriage and Sexuality among Newly-Married Women in Gujarat, India: An Exploratory Study." *International Quarterly of Community Health Education* 23 (3): 215–51.
- Kostick Kristin M., Schensul Stephen L., Jadhav Kalpita, Singh Rajendra, Bavadekar Amruta, and Saggurti Niranjana. 2010 "Treatment Seeking, Vaginal Discharge and Psychosocial Distress Among Women in Urban Mumbai." *Culture, Medicine and Psychiatry* 34 (3): 529–47.
- Maitra Shubhada, Schensul Stephen L., Hallowell Benjamin D., Brault Marie A., and Nastasi Bonnie K.. 2017 "Group Couples' Intervention to Improve Sexual Health Among Married Women in a Low-Income Community in Mumbai, India." *Journal of Marital and Family Therapy* 44(1): 73–89 [PubMed: 28683159]
- Maitra Shubhada, Brault Marie A., Schensul Stephen L., Schensul Jean J., Nastasi Bonnie K., Verma Ravi K., and Burleson Joseph A.. 2015 "An Approach to Mental Health in Low- And Middle-Income Countries: A Case Example from Urban India." *International Journal of Mental Health* 44 (3): 215–30. [PubMed: 26834278]
- Maitra Shubhada, and Schensul Stephen L. 2002 "Reflecting Diversity and Complexity in Marital Sexual Relationships in a Low-Income Community in Mumbai." *Culture, Health & Sexuality* 4 (2): 133–51.

- Mehrotra Purnima, Schensul Stephen L., Saggurti Niranjana, Burleson Joseph A., and Maitra Shubhada. 2015 "The WHO Concept of Sexual Health Applied to An Urban Poor Community in Mumbai, India." *International Journal of Sexual Health* 27 (1): 57–68.
- Muhr T 2013 "Atlas. Ti: Qualitative Data Analysis, Version 7." Berlin, Germany.
- Saggurti Niranjana, Schensul Stephen L, and Singh Rajendra. 2010 "Alcohol Use, Sexual Risk Behavior and STI Among Married Men in Mumbai, India." *AIDS and Behavior* 14 (1): 40–7.
- Sandhya Shaifali. 2009 "The Social Context of Marital Happiness in Urban Indian Couples: Interplay of Intimacy and Conflict." *Review of. Journal of Marital and Family Therapy* 35 (1): 74–96.
- Schensul SL 1993 "Using Ethnograph to Build a Survey Instrument." *Field Methods* 5 (2): 9-9
- Schensul Stephen L., Saggurti Niranjana, Singh Rajendra, Verma Ravi K., Nastasi Bonnie K., and Mazumder Papiya Guha. 2009 "Multilevel Perspectives on Community Intervention: An Example from an Indo-US HIV Prevention Project in Mumbai, India." *American Journal of Community Psychology* 43 (3-4): 277–91. [PubMed: 19357946]
- Schensul Stephen L., Singh Rajendra, Schensul Jean J., Verma Ravi K., Burleson Joseph A., and Nastasi Bonnie K.. 2015 "Community Gender Norms Change as a Part of a Multilevel Approach to Sexual Health among Married Women in Mumbai, India." *American Journal of Community Psychology* 56 (1-2): 57–68. [PubMed: 26136202]
- Schensul Stephen L., Verma Ravi K., and Nastasi Bonnie K.. 2004 "Responding to Men's Sexual Concerns: Research and Intervention in Slum Communities in Mumbai, India." *International Journal of Men's Health* 3 (3): 197.
- Schensul Stephen L., Verma Ravi K., Nastasi Bonnie K., Saggurti Niranjana, and Mekki-Berrada Abdelwahed. 2009 "Sexual Risk Reduction among Married Women and Men in Urban India: An Anthropological Intervention" In. *Anthropology and Public Health: Bridging Differences in Culture and Society*, eds. Hahn RA and Inhorn MC, 362–94. Oxford University Press, USA.
- Silverman JG, Balaiah D, Ritter J, Dasgupta A, Boyce SC, Decker MR, Naik DD, Nair S, Saggurti N, and Raj A. 2016 "Maternal Morbidity Associated with Violence and Maltreatment from Husbands And In-Laws: Findings From Indian Slum Communities." *Reproductive Health* 13 (1): 109. doi: 10.1186/s12978-016-0223-z. [PubMed: 27608805]
- Silverman Jay G., Decker Michele R., Saggurti Niranjana, Balaiah Donta, and Raj Anita. 2008 "Intimate Partner Violence and HIV Infection Among Married Indian Women." *Journal of the American Medical Association* 300 (6): 703–10. [PubMed: 18698068]
- Solomon Suniti, Subbaraman Ramnath, Solomon Sunil S., Srikrishnan Aylur K., Johnson Sethulakshmi C., Vasudevan CK, Anand Santhanam, Ganesh Aylur K., and Celentano David D.. 2009 "Domestic Violence and Forced Sex among the Urban Poor in South India: Implications for HIV Prevention." *Violence Against Women* 15 (7): 753–73. [PubMed: 19448166]
- Verma Amita. 2012 "Cyber Pornography in India and its Implication on Cyber Cafe Operators." *Computer Law & Security Review* 28 (1): 69–76.
- Verma Ravi K., and Collumbien Martine. 2003 "Wife Beating and the Link with Poor Sexual Health and Risk Behavior among Men in Urban Slums in India." *Journal of Comparative Family Studies* 34 (1): 61–74.
- Weitzman Abigail. 2014 "Women's and Men's Relative Status and Intimate Partner Violence in India." *Population and Development Review* 40 (1): 55–75.
- World Health Organization (WHO). 2002 "Defining Sexual Health: Report of a Technical Consultation on Sexual Health, January 28–31, 2002." In. Geneva, Switzerland: World Health Organization.

Table 1:

Forceful sex and women's interest in sex

Variable	Frequency (%)	Association with women's interest in marital sex
Husband physically forces you to have sex when you do not want to	233 (20.7)	More force, less interest $X^2(2,1125)= 37.2, p <.001, DF = 1$
Husband forces you to perform sexual acts you do not want to do	160 (14.2)	Forced for unwanted sexual acts, less interest $X^2 (2,1125)= 36.3, p <.001, DF = 1$
Inability to refuse if your husband demand's sex and you do not want it?	241 (21.4)	Less able to refuse, less interest $X^2 (2,1125)= 33.6, p <.001, DF = 1$

Table 2:

Indicators of sexual satisfaction (N = 1125)

Variable	Frequency (%)
A lack of lubrication	378 (33.6)
Long time for arousal	394 (35.0)
Pain during sex	476 (42.3)
Difficulty in achieving orgasm	361 (32.1)

Table 3:

Norms about sexual communication (N = 1125)

Variable	Frequency (%)
Can you refuse your husband's demands for sex if you do not want it	No = 241 (21.4)
Can you initiate sex?	No = 240 (21.3)
A woman should always be ready whenever her husband wants sex	Strongly agree or Agree = 751 (66.8)
Engagement in sex is only for men's satisfaction	Strongly agree or Agree = 646 (57.4)
Does your husband discuss sex freely with you?	Never = 402 (35.7)
Do you discuss sex freely with him?	Never = 331 (29.4)