# Experiences and Perceptions of Marital Sexual Relationships among Rural Women in Gujarat, India

*Multipronged, carefully formulated and timely interventions are needed to educate young girls about sexual matters*

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Sexual behaviour is one of the most central, yet mysterious aspects of human life. For many people, it is virtually taboo to discuss such matters in traditional Indian settings, where attitudes remain, by and large, conservative (Bang and others, 1989). Research into sexual behaviour in India has been

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almost entirely confined to urban populations, particularly among groups of people thought to be at high risk of HIV infection (Pachauri, 1992; National AIDS Control Organization, 1994). Little is known about the sexual behaviour of people in rural areas, who comprise nearly 70 per cent of the country's population. An understanding of sexuality and gender-based power relations is important to issues of reproductive health because they underlie many relevant behaviours and conditions. Family planning policies and programmes should address a broader spectrum of sexual behaviour and consider questions of sexual enjoyment and risks, and confront ideologies of male entitlement that threaten women's sexual and reproductive rights and health (Dixon-Muller, 1993).

Traditionally, the dominant value system in India implies strong disapproval of premarital sexual relationships among both men and women (Nag, 1996). Female sexuality is seen as a powerful, unruly and dangerous trait, which should be channelled into marriage at an early age (George and Jaswal, 1995). Many people, including some policy makers, believe that there is universal marital fidelity, premarital chastity and a near total absence of homosexuality in India (Nag, 1996). Whether or not this characterization was ever valid, social taboos and sanctions against sex outside marriage have weakened under the influence of mass media, increased mobility and later age at marriage (Nag 1996; Khan and Patel, 1996; Savara and Shridhar, 1996).

Much of the available literature on marital sexual relationships in India and other developing countries has emphasized men's sexual dominance (Nayar and Chawla, 1996; Knodel and others, 1996), lack of communication between spouses (George and Jaswal, 1995), and domestic violence linked to sexual relations (Khan and others, 1992; Sharma and others, 1998). There is little doubt that, in many sections of Indian society (as in other cultures), some men assert their dominance in family life through insistence on their right to sexual intercourse "on demand", regardless of the attitude and responsiveness of their wives. Some studies imply that the overwhelming majority of women are therefore unwilling participants in sexual intercourse, and have little negotiating power over its timing or situation, or over matters such as the use of condoms (Elias and Heise, 1993). Such interpretations, which portray a negative image of women's sexual lives, should be viewed with caution because many are based on single-contact interviews, which may tend to project a stereotypical picture of women being reluctantly coerced into sex or, at best, being passive participants.

A few studies have countered these stereotypes and have hinted at ways in which women express their desire for sex. One such study describes how rural Egyptian women associate sex with love and tenderness. They enjoy their sexual life and are happy and proud of the love expressed by sex with their husbands (Khattab, 1996). In rural Rajasthan, older women and women of higher social status have reported positive sexual experiences with their husband (Oomman, 1996). In rural Maharashtra, even young wives were able to communicate their desire for sex to their husband (Apte, 1997).

One of the few studies on marital sex in a low-income country to have used repeated interviews, conducted in Nairobi, Kenya, revealed the ways in which coitus is initiated and negotiated by couples in stable marital relationships (Balmer and others, 1995). Women in this study believed coitus to be a male prerogative and therefore submitted to their husband's demands. They felt unable to verbalize their need for sex or suggest a particular position during sexual intercourse. This reluctance reflected the local belief that women who talked about their sexual needs had gained their knowledge through extramarital affairs. However, subsequent repeated in-depth interviews revealed that couples used various non-verbal strategies to initiate coitus. Those adopted by women included cooking a favourite meal, putting the children to bed early, kissing, caressing, hugging and so on.

Similar in-depth studies on inter-spousal communication and sexual interaction are almost entirely absent in India. Suitable methods to elicit valid data on sexual behaviour in India's conservative rural communities are yet to be established. This article represents a step in that direction. It explores Indian rural women's attitudes towards sex; their ability to initiate and communicate their desire for sex; and aspects of their premarital, marital and extramarital sexual experiences. It also addresses the methodological approaches necessary to elicit such sensitive information about the sexual conduct of rural women.

## Methods

### The setting

The study was conducted in two *taluka* (subdistricts), namely Padra and Vadodara, in the Vadodara district of rural Gujarat. Eight small villages about 20-25 km from Baroda were selected. The researchers' familiarity with the community and lack of urban influence were two major criteria for selecting these villages. The average village population is around 1,000; the majority of the villagers are Hindu (87 per cent), with approximately two fifths of them

being upper caste Hindus. A wide socio-economic disparity exists between the various caste groups, and strongly held religious beliefs have occasionally led to communal violence.

Agriculture is the principal occupation, although just over half of the households are landless. Most men and women work as agricultural or casual labourers. Television and regular work-seeking migration of the inhabitants to the United Kingdom of Great Britain and Northern Ireland and United States of America as well as countries in the Persian Gulf area provide exposure to Western mass media and lifestyles.

The villages have electricity, public transportation and other basic amenities, but most of the houses are *kutcha* (mud and thatch) or of mixed construction (brick walls and tin or tiled roofs). Government and private health facilities are available within each village or at close proximity. For certain conditions, such as measles, jaundice and infertility, villagers prefer traditional remedies provided by faith healers to modern allopathic medicines.

**The sample**

Initially, houses were listed in eight villages and married women reporting reproductive illnesses were identified. The researchers used a check-list that included local terms for related problems such as white discharge, menstrual problems, problems with pregnancy and childbirth, lower abdominal aches and pains, and other symptoms occurring in the urine-genital area. Out of 1,067 married women contacted during house-listing, 262 (25 per cent) reported a current reproductive health problem. Many women (58 per cent) reported multiple problems. The problems were broadly grouped into five categories: vaginal discharge (53 per cent), urine-genital problems (48 per cent), menstrual problems (24 per cent), infertility (4 per cent) and uterine prolapse (2 per cent).

Women with reproductive health problems were purposely selected in order to explore their perception of symptoms of sexually transmitted diseases and the relationship of these to their sexual behaviour. This approach also provided a strong rationale for probing into their sexual experiences. A non-participation level of about 30-40 per cent was originally anticipated, so 120 women reporting a current reproductive health problem were initially selected for the interviews. The sample was proportionately distributed across the five categories of reproductive health problems. Subsequently, with the help of 11 key informants, for example, school-teachers and *panchayat* (village council)

members, social maps were prepared to identify socio-economic clusters in the villages. The sample was selected from different clusters (called *falia*) based on community-mapping to ensure broad socio-economic representation. The final sample of 69 women comprised those with whom rapport was well established, who agreed to participate in the study and who could be contacted during repeated visits. Because of the selective nature of the sample, the findings cannot be generalized as representative of all rural Gujarati women. However, the socio-economic profiles of the women and households in this study are broadly similar to many of the agricultural communities in the state.

**Training**

A group of five researchers and five field assistants received a month-long training course in order to desensitize them on topics related to sexual behaviour. They were also trained to conduct in-depth interviews using appropriate vocabulary and subtle approaches. This was followed by trial interviews in a village 15 km from Baroda.

**Interviews**

An average of five in-depth interviews were conducted with each woman. During the pilot study, it was observed that the women were relatively uninhibited in discussing their reproductive health problems and treatment. It was, therefore, decided to initiate the discussions on these topics. Gradually, as rapport was established during the second and third interviews, women started talking about their sexual experiences with their husband. Women had no hesitation in talking about their "wedding night", on which occasion various customary practices and games were followed in different communities. It was only at the third interview that discussions about their first experience of sex were broached. Topics in the discussion guidelines also included negative issues such as sexual coercion and violence prompted by reproductive health problems (particularly in relation to menstruation, when rural women observe isolation and avoid sexual contact) and alcohol consumption, as well as premarital and extramarital relationships.

The interviews were conducted in Gujarati and were usually held in private to ensure confidentiality. However, some interviews were conducted with women in the presence of their husband (11 women) or friends (6 women). Paired interviews were allowed in order to dispel any doubt or apprehension among the respondents, and to help them to feel comfortable about the research topics, but they were limited to an initial two or three visits,

until the woman felt comfortable and her husband or friend no longer wished to attend subsequent interviews. During the study period of more than four months (April-July 1996), about 350 in-depth interviews were conducted with the 69 women. Extensive notes were taken during each interview and these were expanded as soon as possible after the completion of the interview.

### Focus group discussions

The in-depth interviews were followed by focus group discussions with other married women in the community. Information was obtained on their attitudes and beliefs regarding knowledge and awareness of women's reproductive health problems, treatment-seeking behaviour, contraceptive use and their understanding of factors causing reproductive and sexual health problems. Women for these discussions were selected from various socio-economic clusters in the villages, excluding those who were selected for in-depth interviews. In each village, at least two groups were conducted, one each among high- and low-income groups. All focus group discussions were tape-recorded, transcribed and then translated into English.

### Analysis

Textual information from interviews and focus group discussions was systematically analysed using the dtSearch software and was also manually scanned as part of the content analysis.

## Results

### Respondents' profile

Most of the women selected for the interviews were aged in their 20s and 30s, with only a few aged 40 or more (table 1). The majority were Hindus and lived in nuclear families. Only 11 women were educated to middle grade or above, and more than two fifths had no formal education. Most of them were employed outside the home, mainly as agricultural or casual labourers.

Half of the women had begun menstruating by 14 years of age, but nearly half (29) married before attaining puberty, although consummation was postponed until puberty. Age at first conception was 18 years old or younger for most women (48). Forty-two women out of the 69 had undergone sterilization, and only six respondents said they were currently using birth-spacing methods.

**Table 1. Socio-demographic profile of rural women interviewed in depth in Gujarat**

| Characteristics | Number of women (n = 89) |
|---|---|
| **Age (years)** | |
| 20-29 | 28 |
| 30-39 | 31 |
| 40+ | 10 |
| **Marital status** | |
| Married | 68 |
| Separated | 1 |
| **Number of children** | |
| None | 7 |
| 1-2 | 22 |
| >2 | 40 |
| **Type of family** | |
| Nuclear | 45 |
| Joint | 24 |
| **Religion** | |
| Hindu | 56 |
| Muslim | 13 |
| **Occupation** | |
| Agricultural/casual labourer | 29 |
| Housewife | 24 |
| Cultivator | 9 |
| Other (small business etc.) | 7 |
| **Education** | |
| No formal schooling | 31 |
| Primary level | 27 |
| Middle grade and above | 11 |

## Views on early marriage

Most respondents felt that girls should marry as soon as they attain puberty. Fear of premarital relationships that could jeopardize the family reputation, avoidance of love marriages (outside the caste) and the need to start a family were some of the reasons cited by women for their preference for early marriage. The following quotes from the in-depth interviews illustrate the views expressed by the respondents.

> "In villages, when a girl is 10-11 years old, the parents are on the look-out for a suitable match for her. Once she attains puberty, it is very risky. Nowadays, we hear so many cases of abortion. Once the daughter gets *badnam* (defamed) then she will remain single forever".

> "If my daughter elopes with someone, ultimately I will be blamed. People would say: 'her mother is like that' (meaning of loose character)".

**Awareness of sex and sexuality**

Illiteracy, dropping out of school early (especially after the onset of menstruation), restricted exposure to mass media, the burden of domestic chores, and limited ability to communicate on issues related to sex and sexuality are some of the well-documented reasons for ignorance about sex among adolescents in India (Jejeebhoy, 1998). In this study, more than half of the women had no knowledge of menstruation before menarche. The immediate reaction to their first period was usually described negatively in words such as "shocking" and "puzzling". Most of them approached sisters, sisters-in-law, or friends for advice.

Similarly, before their marriage, rural women had little information on the nature of the sex act and sexual relations in marriage. The majority of the women (43 out of 69) said that they had been totally unaware of sex prior to marriage. Others had only the vaguest idea. They cited various reasons for their ignorance such as restricted mobility, early marriage and lack of exposure to media or other potential sources of information.

> "I married at the tender age of 12. What would a girl know about it at that age? I had no brains at that time. I used to think that after marriage a boy and a girl stay together and the girl has to cook — nothing beyond that".

> "I used to think that even if a girl's foot touches a man's foot she would get pregnant. I had no idea about all this (intercourse)".

Only 10 women reported that they knew about the nature of the sexual relationships between men and women. They were aware of the meaning of the term "intercourse" (locally termed as *dhando*, *sambandh* or *sansar kare*) and that it was necessary for procreation.

**Finding out about sex**

The main sources of information were older female relatives such as sisters-in-law and sisters (21), friends (17) and neighbours (15). Most of the women (43) were told about sex in the time between marriage and *gauna*, which is a ceremony held when a married girl is sent to her husband's house. It

takes place only after she attains puberty or is considered by the parents to have matured enough to share conjugal life with her husband. Some women spoke of writing letters to their husband (2), going to the cinema with him (3) and getting the opportunity to talk to him or get physically close to him (4) during the period between marriage and *gauna.* This was also considered an appropriate time to tell newly married girls about sexual relationships. The task was usually performed by female relatives and friends, but it generally involved circumlocutions and metaphors instead of direct explanations about the sex act. They were advised to yield or submit to their husband and to adjust well to other family members in the house.

> "The day before my wedding, my sister-in-law explained everything to me. She said: 'Never deny anything to your husband. Listen to whatever he says. Satisfy all his demands. If he will not get satisfaction (from sex), he will seek it elsewhere ' ".

**Sexual debut**

Just four respondents learned about sex as a result of physical intimacy with their husband between the time of engagement and marriage. Most women understood what sexual intercourse actually was only when their marriages were consummated. Around one quarter (19) said that they found their first sexual experience pleasant (though painful), and that their husband was patient, considerate and gentle on their wedding night. However, the majority of the women (37 out of 69) were either scared and shocked (24), or resisted and avoided (13) the sexual advances made by their husband.

> "When it happened for the first time, I started bleeding as though I was menstruating. I felt as though something had hurt me. After that I had problems while urinating; it used to burn a lot. Yet my husband insisted on doing it every day. I did not enjoy it at all. I used to pray that the night would not come. I developed a fear of sex...I would cry and tell him that it was painful...still he would continue. This continued until I had to consult a doctor for bleeding. The bleeding did not stop for 15 days. After this, I developed a fear of sex".

These young women had very inadequate information about sex before they married, and as a result the first sexual encounter for most of them was a negative experience. However, as discussed below, marital sex improved for many women.

**Sexual interaction and communication**

It is generally believed that in conservative Indian society sexual interaction is always initiated by the husband and that women remain passive partners during sexual intercourse. This study indicates that several strategies were used by rural women to communicate their desire for sex to their husband. Many of them (28 women) used physical signals to convey such messages. These were described as playful hits or winks, or they would fondle, caress him, hug or kiss him and so on. Some women (15) were able to verbalize their desire for sex using circuitous terms such as "I want to do it (*mane karvanu che*)", or "I am in the mood", or simply by using the word "Come (*chal*)". Other non-verbal initiating signals (13 women) were described in various ways: "It clicks through eye contact (*aakh madi jai*)", or "I go and sleep very close to him and he understands (*pase jai ne sui jau*)".

Seven women refrained from answering the question directly by saying that the issue did not arise as their husband wanted sex all the time, or said that they were shy and felt hesitant about expressing their desire for sex, for example, "I never indicate my desire. But I never refuse him. After all he is a man. Where will he go?"

Two women felt awkward discussing the subject at all, and four women said that they did not express their desire for sex because they "did not like sex" or felt it was "dirty".

**Current attitudes towards sex**

During repeated in-depth interviews, it was observed that initially women tended to give passive or non-committal replies concerning their sexual desires and experiences. With subsequent probing, and as rapport increased, a different picture emerged. It appears that sexual contacts were perceived by many women as positive and pleasurable, rather than a negative and unpleasant task forced upon them by their husband. In order to quantify this impression, a content analysis of the in-depth interviews was performed. The informants were sorted into three categories according to whether their views on sex were broadly positive, negative or neutral.

Analysis of the in-depth interviews revealed that sex with their husband was experienced by many women (29) as positive and pleasurable, and they willingly participated in sexual intercourse. Typical of their attitudes is the following:

"Both of us enjoy sex. What's wrong in it? I do not consider it to be dirty (*gandu nathi manti*). Also, children are born because of intercourse. Then how can we say it's dirty?"

Another large group of women (24) felt that sex was an important and necessary part of their relationship with their husband. This group tended to emphasize their duty to fulfil their husband's sexual desire rather than their own pleasure. Even so, they expressed no sense of endurance or tolerance that might indicate negative attitudes towards sex, e.g. "It brings us close; we can share all our joys and sorrows. It also increases the understanding between a couple".

Sixteen of the women interviewed in depth did express negative attitudes towards sex. They reported varying degrees of forceful and coercive sexual interactions with the husband who, according to wives, became angry, threatened them, subjected them to verbal abuse and forced them to have sex, even though they did not want to. In such situations, the women tried to accommodate their husband's sexual needs in order to prevent the man from seeking alternative outlets that could threaten the security of their marital lives. Some of them expressed their feelings as follows:

"To keep him at home, I allow him to have sex whenever he desires, otherwise he will go to a prostitute *(randi)*. He loses his temper. Now I have less desire for sex, but my husband forces me to have sex. I am helpless".

"Whenever we have intercourse, it pains me a lot in the abdomen and all the sides of my stomach. When my husband puts pressure on me, I cannot bear it. He knows that it hurts me, but he does not leave me alone. I try to make him understand, but he does not listen. I cannot say no to him. He forces me and fights with me whenever I say no".

The interviews suggest that several, complex interrelated causes may account for women's negative attitudes towards sex. One of the main reasons was the fear that sex would aggravate current reproductive health problems due to heat *(garmi)*, pain and white discharge. Eleven women attributed their current reproductive health problems to sex with their husband because of the transfer of man's heat *(garmi)* or because of his extramarital relationships. Of these, eight women said that they did not willingly participate in sex with their

husbands. They developed negative attitudes towards sex when they were forced by their husband to have sexual intercourse despite their physical discomfort.

In some instances other factors were responsible. For seven women, what were felt to be excessive sexual demands from their husband ("he wants to have sex daily") and the fear of losing their husband to other women if they refused to have sex marred their interest and participation in sexual intercourse. Two women attributed their negative attitudes to the fact that they were forced to marry their husband against their wishes (as they were in love with some other person). Two others simply disliked sex without giving any particular reason for their dislike. Another two were sexually dissatisfied with their husband.

Most of the 16 women who had negative attitudes towards sex were concerned about marital stability. Yet in Gujarat, unlike some other states, widows and divorcees are not ostracized. They do have the opportunity to marry again. In this sample, nine of the interviewees had been divorced and had remarried. Reasons for the earlier divorce were given variously as alcohol abuse, violence and sexual coercion by the husband (4), husband's mental impairment (1), sexual dissatisfaction (1), infertility (1), incompatibility with a husband who was old (1) and for other unspecified reason (1). The fact that such women could marry again indicates that under certain circumstances there are options available for rural women who are unhappy in their marital lives.

The women in this study were able to some extent to articulate their likes and dislikes for sex and were quite verbose if they did not like sex. They did not necessarily project a blissful picture of their married lives, but few reported physical abuse and violence despite being asked specific questions on these subjects.

**Premarital and extramarital relationships**

Only four women interviewees reported premarital sexual relationships. On the contrary, focus group discussions and the 11 key-informant interviews revealed that inter- and intra-household premarital and extramarital relationships were not uncommon in these villages. A plausible reason for under-reporting of premarital relationships by married women was reported by a key informant:

> "No woman who is happily married would reveal to an outsider about her past (premarital sexual experience) for fear of jeopardizing her current married life. Such relationships are very common in the villages".

Similarly, although 45 women interviewed in depth said that extramarital relationships were quite common in their communities, only four out of the 69 women interviewed admitted to having such relationships. Of these, three had had premarital relationships with men with whom they were in love, which continued even after their marriages. ln one case, it had resulted in marital breakdown; in another case, the woman had a relationship with her ex-husband, who had been compelled by his family to divorce her because she was infertile. Although she remarried, she remains physically and emotionally attached to her ex-husband and has sex with him whenever they meet.

Some women suggested that the extent of extramarital relationships in these rural communities may well be higher than was admitted by the respondents:

> "These activities (extramarital relationships) are rampant (*dham dhokar*) in our village". **(From a low-income focus group discussion)**

> "Sexual relationships among relatives within joint families are quite common in our village — like a married man having a relationship with a sister-in-law and women with a younger brother-in-law". **(From a high-income focus group discussion)**

**Determinants of positive sexual experiences**

The main object of this study has been to present a qualitative, descriptive picture of rural women's sexual experiences in marriage. The information was also analysed to see which, if any, background variables were linked to the range of differences among the women's responses. We compared women reporting more positive sexual experiences with those whose responses were neutral and negative, using the chi-squared statistic. The analysis revealed that age at marriage, education, religion or caste were significantly associated with positive sexual experiences (table 2).

Family characteristics, on the other hand, showed strong relationships to the women's reports of positive sexual experiences. Both family size and type

**Table 2. Statistical association between background characteristics and whether marital sexual experiences were positive or not in rural women from Gujarat**

| Characteristics | Chi squared | Probability |
|---|---|---|
| Age at marriage | 1.22 | .54 |
| Education | 7.1 | .31 |
| Caste | 3.66 | .72 |
| Religion (Hindu/Muslim) | .06 | .97 |
| Family size (df = 3) | 13.78 | <.01 |
| Type of family (df = 3) | 18.90 | <.001 |

of family (nuclear versus joint or extended family) were significantly associated with the women's marital sexual experiences. Women in nuclear families reported more positive sexual relationships with their husband than did women living in extended/joint families. Similarly, women in small families felt more positively about the sexual side of their marriage than did women in larger families.

## Discussion and conclusions

This study portrays a range of information about the sexuality of rural women, in contrast to most other recent reports, which delineate a uniformly negative view of Indian women's sexual relationships with their husband. These women appear to be more articulate and communicative about sex than the women observed, for example, in rural Uttar Pradesh and urban Mumbai and Delhi (George and Jaswal, 1995; Nayar and Chawla, 1996; Savara and Shridhar, 1996). Despite the fact that the large majority of these women experienced unpleasant, coercive sex initially in marriage, many of them reported their current sexual relationships with their husband to be positive. The fact that a number of the women spoke of strategies for initiating sexual activity with their husband adds to the credibility of these findings.

The negative stereotypes of Indian women's sex lives may derive in part from the research methodologies usually employed in such studies, namely, one-shot interviews or group discussions. This study, on the other hand, adopted the method of repeated conversational sessions with the women in the sample. The experience suggests that there is a stereotyped "expected norm", or ideal cultural pattern of female sexual experience, in which Indian women

are expected to be uninterested in or negative towards sex. They are not therefore likely to admit that they might sometimes initiate sexual contacts with their husband. During the first and second interviews many of the women in this study produced just such stereotypical, somewhat negative responses. Getting closer to the underlying reality is akin to peeling away the layers of initial reserve. At first only the outer "expected" picture presents itself. The second and third sessions reveal more detail, and some of the women admitted that they had given a somewhat misleading picture in their first interviews. Women revealed the positive side of their sexual experiences only after greater rapport had been built up with them through repeated visits.

Of course, it is impossible to know how far these results can be generalized. The respondents were drawn from one district in Gujarat. In view of the huge size of the country and its cultural diversity, it would be unjustified to claim that similar findings would apply elsewhere. Moreover, the women were selected based on the criterion that they reported a current health problem. This method of selection also raises questions about the representivity of results even for the study district. However, this feature of the study design strengthens rather than undermines the central conclusions. Some evidence exists in India that reporting of symptoms of reproductive ill-health may be more an expression of underlying depression and psychosocial distress rather than any biomedical infection (Patel and Oomman, 1999; Trollope-Kumar, 1999). To the extent that this is true, it is likely that the sex lives and marital relationships of the 69 subjects are "worse" than those of other women. In other words, a more positive impression might have been gained by a representative sample of all married women.

The results also suggest that focus group discussions, as a methodology to elicit information on sexual behaviour, may produce a generalized and, at times, exaggerated view. For example, the focus group discussions in this study depict extensive premarital and extramarital relationships in these rural communities, whereas only four out of the total sample of 69 women acknowledged their involvement in such relationships during repeated in-depth interviews. Perhaps the truth lies somewhere between the two extremes. However, data obtained through repeated in-depth interviews provide information on actual experiences and knowledge and, therefore, may be more reliable than the generalized views obtained through focus group discussions. Similariy, a study of sexual behaviour of African women reported that "in-depth, one-on-one intelviews were necessary for eliciting good data on actual knowledge and experience" (Helitzer-Allen and others, 1994).

One of the intriguing results from this study suggests that women's sexual experiences may be conditioned by family size and type of family. This link may reflect the ways in which the traditional large extended families submerge and obstruct communications between wives and husbands of the younger generation. In traditional families, any intimacy between wife and husband must be covert, and the husband is usually expected to be aloof and distant from his wife in the presence of the older generation. However, the study does not provide extensive documentation in support of these findings. More research is needed to explore the implications of the data, but the apparent effects of these family factors suggest that intervention strategies with regard to reproductive and sexual health issues in families should pay heed to the special dynamics of extended/joint families as compared with nuclear family structures.

One striking result from the study is the lack of preparedness for marriage and the ensuing trauma of sexual debut. Preparing young girls for marriage, especially those who are not in school, is difficult. Even if they attend school, introducing topics related to reproductive and sexual health into the school curriculum is not enough. Often these topics are skipped as teachers are not specially trained and are unskilled in dealing with them. The responsibility to educate young girls in these matters should be shared by health-providers, teachers, parents and community gate-keepers. To do such would require multi-pronged, carefully formulated and timely interventions.

In conclusion, the study found that, contrary to the belief that sex is virtually a taboo subject for research in Indian communities, these women respondents were quite candid about their sexual interaction and communication with their husbands.

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