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GROUP COUPLES' INTERVENTION TO IMPROVE SEXUAL HEALTH AMONG MARRIED WOMEN IN A LOW-INCOME COMMUNITY IN MUMBAI, INDIA

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This article describes the design and implementation of a group couples' intervention focused on improving women's sexual health as a component of a multilevel community, clinical, and counseling intervention project conducted in association with a gynecological service in a municipal urban health center in a low-income community in Mumbai, India. The group couples' intervention involved four single-gender and two mixed-gender sessions designed to address the dynamics of the marital relationship and establish a more equitable spousal relationship as a means to improve women's sexual and marital health. Involvement of men presented a major challenge to couple's participation. For those couples that did participate, qualitative findings revealed significant changes in couple and family relations, sexual health knowledge, and emotional well-being.

INTRODUCTION

The nature and form of marriage is rapidly changing in Asia (The Economist, 2011), as an increasing number of middle- and upper-class women are delaying marriage, choosing to stay single or even divorcing. The average age at marriage in India has risen by two and a half years between 1970 and 2000 (Jones, 2010), with large regional differences. Women marry relatively later in the more affluent southern states, particularly Kerala, and relatively earlier in the lower income

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states of the north, particularly Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh (Visaria, 2004:62). Yet, for low-income sections of Indian society, marriage and the continuity of the marital dyad is a near universal phenomenon (Jones, 2010).

Despite the stereotypes portrayed in the literature, marriages in low-income rural and urban communities show a range of variation in compatibility, communication, and gender equity (Maitra & Schensul, 2002). There are, however, a subset of relationships that suffer from a number of challenges. Although the average age at marriage is increasing, 50% of women, primarily from low-income or marginalized communities, marry below the legal age of 18 (International Institute for Population Sciences and Macro International, 2008). Most marriages continue to be arranged by parents or other relatives, and in the most conservative families, the man and woman may not meet prior to their wedding. This lack of premarital contact coupled with men's and women's limited knowledge and experience with sex often results in unpleasant "first night" experiences that set the tone for the subsequent sexual relationship.

Marital communication presents another difficulty for some couples. Many newly married couples move in with the husband's family where the young wife assumes a junior position, and may have limited opportunities to communicate with her husband. The tensions between the new wife and her in-laws and poor communication with her husband place women at risk for intimate partner violence (Maitra & Schensul, 2002). Neolocal residence does not seem to solve these problems if the wife and husband have not established effective modes of communication and gender equity. In a context of inflation and the rising cost of living, financial stress in low-income communities also create frustrations in the marital relationship, as husbands have difficulty in meeting the traditional role of provider and women as a result have difficulty in their culturally prescribed role of maintaining the household.

Global evidence indicates that sexual intercourse within marriage or with a permanent partner puts women at risk for HIV infection, most commonly from their partners' extramarital liaisons (Joint United Nations Programme on HIV/AIDS & World Health Organization, 2007). In India, men's engagement in unprotected sexual relationships, both commercial and noncommercial, outside marriage, put wives at increased risk of acquiring HIV/STI infection. Women are most often infected through sex with their husbands, despite their perception that their own monogamy is protective (Santhya & Jeejebhoy, 2007). As a result, researchers and interventionists need to move beyond a focus on the individual to address the issues of sexual health and gender equity within the marital unit.

This article describes an intervention conducted with the marital dyad to reduce women's sexual risk and improve women's sexual health in a low-income, officially designated "slum" community in Mumbai, India. The intervention was part of a larger multilevel community, clinical and individual counseling intervention program conducted in association with a gynecological service in a municipal urban health center. The couples' intervention was designed and implemented to enable men and women to address the dynamics of the marital relationship and establish a more equitable and egalitarian relationship to improve women's sexual and marital health (World Health Organization, 2010).

The couples' intervention was informed by the feminist perspective that inequity within marriage should be challenged and addressed. Feminists have long criticized the institution of marriage as inherently unequal, inequitable, and hierarchical in terms of the power differential of the "husband" and "wife" roles with women in traditional marriages as subordinate, economically dependent, and deferent (Johnson, 1988). In most if not all countries, women continue to have the major responsibility for household and caring duties (Van Every, 1995). In terms of economics, women are still expected to provide unpaid labor in the family (Delphy & Leonard, 1992) and are disadvantaged both within their marriages (Pahl, 1989) and in paid employment (Witz, 1993). Feminist discourse has engaged with concepts of patriarchy, power, gender relations, sexuality, and masculinity to explain these inequities.

This domination–subordination dynamic is displayed in a significant number of marital relationships in India (Maitra & Schensul, 2002). Feminists and their allies have argued for working with men and masculinities in order to address violence against women and bring about a change in women's lives (Verma et al., 2006). Engaging men in interventions that facilitate reflection and challenge the dominant notions of gender relations within marriage are critical, particularly in a

context where women's health, well-being, and safety are compromised (Barker, Nascimento, & Ricardo, 2007; Dworkin, Treves-Kagan, & Lippman, 2013; Jewkes, Flood, & Lang, 2015; Jewkes & Morrell, 2010; Pulerwitz, Michaelis, Verma, & Weiss, 2010). This approach is supported by the cultural norm that husbands are responsible for the protection and well-being of the family. Thus, the couples' intervention described here sought a shift to a more gender equitable relationship that would increase the capacity of the marital unit to deal with the challenges of an urban poor community and protect the health and well-being of family members.

Couples' Interventions

Couples' interventions represent a major step forward in HIV prevention efforts (El-Bassel et al., 2003). Traditional intervention efforts that do not address the partner dynamic have often failed to demonstrate improved barrier use among women in intimate relationships, because they neglect the crucial role partners play in sexual behavior (Burton, Darbes, & Operario, 2010; El-Bassel et al., 1995; Ickovics & Yoshikawa, 1998; Misovich, Fisher, & Fisher, 1997; O'Leary, 1999, 2000). Bringing couples together and improving their communication skills in a safe, culturally sensitive (Ahmad & Reid, 2016) environment permits the discussion of a wide range of difficult issues (El-Bassel, Gilbert, et al., 2010), and enables couples to more realistically appraise their sexual risk (El-Bassel et al., 2003; Remien, 1997).

However, couples' approaches to sexual risk reduction remain rare. A review of the literature has only identified three couples' interventions that worked to reduce HIV/STI risk behavior and/or prevent transmission among serodiscordant couples conducted in the United States (El-Bassel et al., 2003; El-Bassel, Jemmott, et al., 2010; Koniak-Griffin et al., 2008), one in Zambia (Jones, Ross, Weiss, Bhat, & Chitalu, 2005), one in Kazakhstan (El-Bassel et al., 2014), and one in South Africa (Pettifor et al., 2014). While other studies were identified that provided interventions at the couple's level (Allen et al., 1992; Chomba et al., 2008; Coates, 2000; Kamenga et al., 1991; McKenna et al., 1997; Musaba, Morrison, Sunkutu, & Wong, 1998), these studies did not address the interactional and dynamic forces within the couple that contribute to sexual risk.

In couples' interventions, researchers work to address the interactional and dynamic forces that contribute to sexual risk, including martial communication, gender roles, gender equity, pregnancy intentions, and other relationship issues (Burton, et al. 2010). Couple-focused interventions have been employed at the individual level (El-Bassel et al., 2003, 2005; El-Bassel, Jemmott, et al., 2010) where individual counseling is focused on the partner relationship, at the dyadic level (El-Bassel et al., 2003, 2005; El-Bassel, Jemmott, et al., 2010) in which both members of the dyad are present for counseling and education, or the group level (El-Bassel, Jemmott, et al., 2010; Jones et al., 2005; Koniak-Griffin et al., 2008) where multiple couples meet in a group setting to deal with generic issues.

To date in India, there has only been one other couples' intervention described in the literature (Yore et al., 2016), and that intervention focused on gender equity and family planning. The intervention reported here is the first in India to address the interactional and dynamic forces within the marital dyad that contribute to sexual risk. This intervention focused on groups of married couples with the proposition that improving the marital relationship would enable women to achieve better sexual health status and avoid HIV risk. This article describes the methodology, a brief overview of the quantitative results from each of the project intervention components, and then focuses on the results of qualitative evaluation from both men and women engaged in the couples' intervention process.

METHODS

The data and intervention described in this article were drawn from the NIMH project, "The Prevention of HIV/STI among Married Women in Urban India (2007–2013; RO1 MH075678; S. Schensul, PI)." This project was a part of a decade-long Indo-U.S. collaboration (Maitra et al., 2015). Through this collaboration, the program, *Research and Intervention in Sexual Health: Theory to Action* (RISHTA, meaning "relationship" in Hindi and Urdu), was established. The RISHTA married women's project utilized a randomized controlled trial (RCT) whose objective was to determine the efficacy of medical treatment, paired with either individual counseling (IC), group couples' (husband and wife) intervention (CI), or a combination of individual counseling

and group couple's intervention (IC + CI), to improve women's health outcomes. In addition to individual counseling, group couples' intervention, and medical treatment, the RISHTA married women's project also included a community education component that worked with Imams and nongovernmental organizations (NGOs) to promote gender equitable norms in the study community (see Schensul et al., 2009 for further design details).

The Study Community

The RISHTA project was conducted in a community of 600,000 in northeast Mumbai, India. The community includes one of the largest trash dumping grounds in India. In the 1970s, migrants from the states of Uttar Pradesh and Bihar in the north, and rural areas of Maharashtra (the state Mumbai is located in), settled in the community, and the majority of these migrants were Muslims. The community is now 80% Muslim, 16% Hindu, and 5% Buddhist and Christian. The mean length of residence in the community is 14 years. Approximately 80.4% of the population lives in a single room, with a median household size of six individuals; 96.6% of the men are employed and work primarily as daily wage workers, salaried private workers, auto rickshaw drivers, industrial workers, and petty traders, with a median monthly income of 4,000 rupees (U.S. $63.96). The employment rate for women is 25.4%, with 60% of those that generate cash income involved in home-based piece work.

Sample Selection

The RISHTA project established a Women's Health Clinic (WHC) in the study community's municipal Urban Health Center (UHC). The WHC was staffed with resources and personnel to provide gynecological examinations (previously unavailable) to women who came to the clinic. All women were triaged upon arrival at the UHC. If they had nonreproductive health problems, women were directed to the outpatient department in the UHC. If the women presented reproductive health problems, they were directed to the WHC for medical care.

Inclusion criteria for participation in the study were as follows: women aged 18–40 years old, women living with their husbands, residing in the study community for at least a year, not pregnant at the time of enrollment, and having at least one of six gynecological or related symptoms (vaginal discharge, genital itching, burning micturition, lower abdominal pain, genital ulcers, and inguinal swelling). If it was determined that the women being seen at the WHC met the criteria to participate, they were given a description of the RISHTA project and asked for written consent if they chose to participate in the RCT. All women irrespective of their eligibility and/or their refusal to participate in the RCT were provided with medical care. The project was approved by the Indian Council for Medical Research and the IRBs of all the participating partners.

Women who consented to be part of the RCT were then randomly assigned to one of four conditions that were paired with medical treatment. Of the 1,125 women who were enrolled in the RCT, 285 women were assigned to the control group (medical treatment only), 275 women were assigned to individual counseling (IC), 284 women were assigned to the group couples' intervention (CI), and 281 women were assigned to individual plus group couples' intervention (IC + CI). This article focuses on the group couples' intervention process, structure, and results.

RISHTA Couples' Intervention Development

The couples' intervention addressed the psychological and sociocultural factors related to the sexual health concerns of both women and the couple. The couples' intervention program was based on the Narrative Intervention Model (NIM). Using gender equity as the core of the intervention program, the NIM process integrated principles and strategies from narrative therapy, cognitive therapy, and cognitive-behavioral approaches to sexual risk prevention and reduction (Nastasi et al., 2015).

The themes for the CI sessions were standardized and based on the data from the formative research, which included 39 in-depth interviews with women, 21 in-depth interviews with men, and 15 in-depth interviews with couples. The transcripts from these interviews were then analyzed in Atlas.ti (v.7.0; Muhr, 2013) to identify the factors in the marital relationship that impacted women's sexual health and HIV/STI risk, and subsequently used to develop the CI program

curriculum and the CI manual (Nastasi & Maitra, 2013; see supplementary file 1). The analysis of these data generated six sessions: roles and responsibilities in marriage, tensions in marriage, marital sex and sexuality, sexual risk and its prevention, violence in the marital relationship, and healthy marital relationships. The CI sessions were composed of 5–8 couples that met for 2 hr, once a week, for 6 weeks. The first four sessions were single-gender groups, with wives and husbands meeting separately with trained facilitators matched by gender. Sessions 5 and 6 were mixed-gender sessions, and were co-facilitated by male and female facilitators. Further details on the training of the facilitators and content of the sessions are provided in the manual.

Each of the CI sessions began with a brief introduction by the facilitator(s). The sessions were structured around discussion and role plays related to hypothetical scenarios such as a disagreement between a couple, suspiciousness, differential expectations, household responsibilities, and sex in marriage. Each module provided the mechanism for introducing educational messages, reframing beliefs that support sexual risk, and providing skills training on the topic under discussion. Sessions were concluded with plans for applying the content to daily life. Facilitators, primarily with master's degrees in social work and related graduate training, were provided extensive training, regular refresher training, and weekly consultation from project PIs.

Evaluation

A variety of methods were used to evaluate the fidelity and outcomes of the couples' intervention component. Every fourth CI group was observed and followed over the course of their six sessions. Of the total of 69 groups that met for all six sessions, 16 groups were observed and documented by RISHTA evaluation team members who were not involved in facilitating the couples' intervention. The evaluation team members had postgraduate training in social sciences. Session documentation followed a process-recording format with detailed descriptions of participants' seating arrangement, nonverbal cues and verbatim recording of the facilitator–participant interaction. After each session, selected participants were interviewed individually and asked to provide feedback on the session. The interviews focused on the activity they liked the most, one they liked the least, their opinion on the duration and location of the session, and suggestions for making the sessions better. Each interview lasted between 15 and 30 min.

Eighty-nine couples participated in all the six CI sessions and 200 women attended a minimum of three CI sessions. At the end of the final CI session, in-depth interviews were conducted to document their experiences and reflections on the CI program and to record the impact that CI had on their lives. A total of 14 couples who had attended all the six sessions participated in the in-depth interviews. Postfinal session interviews explored participants' views of their CI experiences, the behavioral changes in themselves and their spouses, and ways in which the marital relationship itself had changed. The reports of each session (which included the discussions and responses) were organized by gender and entered into Atlas.ti, coded, and analyzed to identify common themes, conceptions, and norms reported by participants.

Analysis of Qualitative Data

The procedures for transcription, storage, and analysis have been established by the Indo-U.S. collaborative team across a decade of collaborative research and intervention. All qualitative interviews were conducted in Hindi or the state language of Marathi. Detailed handwritten notes were taken during the interviews, and within 2 hr of the interview, the research investigator fully transcribed these notes into full English sentences and paragraphs, maximizing quotes and retaining key Hindi/Marathi terms useful in interpretation. The resulting Word file was then entered into Atlas.ti, v7.2 (Muhr, 2013) a computer-based text management, search, and analysis program. The key to effective qualitative data analysis is the coding system, based on the project's key variables. Codes were developed utilizing a tree diagram method allowing analysis to occur at the domain factor and the variable levels (Schensul, 1993) consistent with the project theoretical model. As data were collected, the coding scheme was tested, modified and finalized, with codes defined and coders trained. An initial five interviews were coded by three staff and the coding matched to find discrepancies. This process was repeated until 85% of the coding was consistent. This step was repeated periodically as a quality check. Coded segments were then assessed for primary and secondary patterns,

exemplary quotes identified, and hypotheses tested through the association of multiple codes, a feature available in Atlas.ti.

RESULTS

Summary of Quantitative Intervention Results

The qualitative results of our study, our primary focus of this article, provide an in-depth perspective on what the couples' intervention meant to the participants. At the same time, to provide context, we briefly summarize our quantitative intervention results below. The quantitative results for each of the study components demonstrate a positive effect of community education, couples' intervention (CI), and individual counseling (IC; Maitra, et al. 2015; Mehrotra, Schensul, Saggurti, Burleson, & Maitra, 2015; Schensul et al., 2015). There was a statistically significant change in gender equity perceptions in the study community, driven largely by positive changes in men's attitudes (Schensul et al., 2015). Women who received CI showed significant positive pre–post intervention changes in sexual health ($p < .001$), physical health symptoms ($p < .001$), and emotional health ($p < .001$) compared with women who did not receive CI. A significant improvement was found in comparing pre–post sexual health ($p < .001$) and physical health symptoms ($p < .001$) for women who participated in IC.

Demographic Information for the CI Participants

The mean age of women who attended at least one of the couples' intervention sessions was 28.71 years, and the average age at marriage was 17.5 years. The women averaged 3.7 pregnancies, 2.7 living children, and 5 years of education. Consistent with the religious make-up of the study community, the women in the sample who attended CI were predominantly Muslim (90.6%), with 9.0% Hindu, and 0.4% Buddhist. On average, husbands were 5 years older than their wives. A majority of husbands (97.1%) were employed at the time of the intervention, with a median monthly income of 4,500 rupees (U.S. $76.79), and a mean education level of 5.5 years. The employment rate for women was 28.4% and a mean education level of 5 years.

CI Attendance

Men and women were expected to attend a total of six CI sessions each, consisting of four single-gender sessions and two mixed-gender sessions. One of the major hurdles at the beginning of the intervention was obtaining the husband's consent to participate in CI. This proved difficult as some women did not know their address (new to the community or had limited mobility), provided the wrong address (particularly in the illegal settlement areas), or moved during the course of the intervention. If the home could be found, it was often difficult for RISHTA staff to meet the husband as many men work until late into the evening. Once the husband consented, the couple was informed of the meeting time and location of the first CI session, generally held at the WHC. The novelty of the concept of couples' intervention made some husbands reluctant to attend, despite repeated follow-up visits. While most women were positive about participation, when the men did not attend the sessions, neither could their wives. Due to these challenges, of the 565 couples that were assigned to the couple's intervention (CI or CI + IC), 45.1% of the women and 49.4% of the men never attended a single session. The 4.3% differential in men's and women's entry into CI had to do with women coming with the promise of men's participation, which was not realized.

Table 1
Women and Men's Attendance at Each CI Session (percentages based on 565 couples assigned to CI)

Session	S1	S2	S3	S4	S5	S6
Women	284 (50.3%)	252 (44.6%)	224 (39.6%)	202 (35.8%)	138 (24.4%)	143 (25.3%)
Men	249 (44.1%)	216 (38.2%)	197 (34.9%)	190 (33.6%)	138 (24.4%)	143 (25.3%)

The second hurdle with CI attendance was the decline in participation that occurred over the course of CI, as attendance peaked in session 1, and then slowly declined through session 6 (Table 1). After attending the first CI session, couples were contacted through mobile phone calls to inform them of the timing of the next CI session. Issues arose, however, when their phone was turned off or not picked up, or when the message was transmitted through a third party (child or relative) and was not delivered. If the individual did respond, those who did not attend often gave numerous reasons why they could not attend. Other issues arose when individuals would confirm their attendance and then not attend, or show up very late or when the session was over. Despite these challenges, each session was attended by at least 25% of the assigned sample and 17% of the sample attended all six sessions.

CI Session Analysis

This section presents an overview of the content of each session and participants' responses. Additional information on the structure of each session can be found in the manual provided in supplementary file 1.

Session 1: Roles and responsibilities in marriage. The objective of session 1 was to identify differences in expectations as a possible source of conflict in marriage and facilitate the process of communication and negotiation regarding roles and responsibilities in marriage.

Participants in both the men's and women's sessions described similar responsibilities and expectations for men in the marital unit, which included taking care of and educating their children; looking after the health and well-being of their wife, children, and parents; and providing adequate financial support for their household. In addition to these responsibilities, however, women expected greater sharing of household responsibilities by the husband beyond financial provisioning, and support when there were family disagreements.

> If wife has any problem then husband should support her, if a woman can do it and take care of husband then why cannot the husband do? (Woman, Session 1)

Women, contrary to men, also expressed expectations that focused on companionship, husbands' noninvolvement in extra-marital relationships, and attention to their emotional needs through expression of love and respect:

> He should give time to his wife; my husband goes out even on holidays. (Woman, Session 1)

> I also expect that he should respect me. (Woman, Session 1)

However, there was a match when both groups identified the wife's responsibilities and expectations: that they maintain a good relationship with in-laws, look after children and in-laws, manage household expenses within the available income of the husband and meet the husband's sexual needs.

> A woman should think about husband's izzat [honor]. As I told earlier after marriage, give one full year to wife to understand the household and it is much more important if marriage is arranged marriage. In case of love marriage, husband and wife know each other prior to marriage. For arrange marriage both are unknown (ek dusare se anjan). A wife should accept in-laws way of life (Patni ko sasural ke sanche men dhalna chahiye). (Man, Session 1)

> A man can leave his wife. If a woman is not capable of doing it, then a man can go outside for sex. (Man, Session 1)

> This question is related with relations [sex]. Whenever a husband wants [sex], wife should satisfy. Sometimes husband wanted [sex], but wife doesn't. Then also wife has to fulfil the wish of husband. If it doesn't happen like this, then fighting-violence starts at home. (Man, Session 1)

Many of the participants mentioned that the session helped them understand the importance of discussing expectations with their spouse. Participants recognized that unfulfilled or

unrealistic expectations were often the cause for conflict and disagreements between the couple. There was recognition that communication played a vital role in marriage and could reduce disagreements.

Session 2: Tenshun (tension) in marriage. The concept of *tenshun* (the Hindi term derived from the English word tension) has become the cultural expression for anxiety, stress, and poor emotional status, used commonly among low-income individuals in India (Chatterjee et al., 2008; Karasz, Patel, Kabita, & Shimu, 2012; Maitra et al., 2015; Weaver, 2017). The objective of Session 2 was to identify common sources of *tenshun* for women and men and identify effective and ineffective *tenshun* coping strategies.

Women's sources of *tenshun* included being over-burdened with household responsibilities, tenuous relationships with in-laws (particularly the mother-in-law), children's health and education, obtaining water, managing household expenses, husband's earnings/job status, and relationship with the husband. Several women reported that marriage itself was the issue:

> Marriage itself is one big tenshun. Many a times I feel I was far happier before marriage. After marriage, one has to worry about husband, children, expenses etc. Then, men fight with us; all this gives a lot of tenshun. (Woman, Session 2)

> I feel like crying. I feel that I was in a better condition when I was alone, why did I get married? (Woman, Session 2)

Men's sources of *tenshun* included paying bills, finding work and generating adequate income, paying for their children's education, obtaining water, marital conflict, and the health of their family members. Both men and women reported husband's perceived unmet sexual needs and husbands' demands for sex as a source of marital conflict.

Many of the participants identified the *tenshun* coping strategies discussed during the session and the role play as their favorite part of the session as part of their feedback on the session.

> I liked the [second] role-play very much. Both the husband and wife talked nicely with each other in the second role-play, they took advice from each other and tried to find a solution for the problem. (Man, Session 2 in postsession interview)

> Anger makes the problem more severe. We can achieve everything by love; nothing can be achieved by fights. (Man, Session 2 in postsession interview)

One of the emerging themes in Session 2 was that husbands and wives rarely communicated the concerns that produced their *tenshun*, and the participants reported a sense of isolation and perceived lack of spousal support in addressing *tenshun*-related issues as a couple.

Session 3: Sexuality and sex in marriage. The objective of Session 3 was to provide information on male and female sexual and reproductive health, discuss misconceptions about sexuality and identify factors that lead to and interfere with a positive sexual relationship, and brainstorm strategies that could be used to discuss sex and sex-related matters with their spouse.

At the start of this session, women were reluctant to discuss matters related to sex due to societal taboos and a culture of silence that surrounds such issues. However, they opened up gradually, and described sex (*jismaani sambandh,* an Urdu term used to denote sex/sexual relationship) in the following ways:

> Talking with husband and spending quality time with each other.

> When husband wants sex that time they talk very sweetly but when their needs are over they even don't remember what all they talked.

> Sex is dirty.

> Sex is painful.

> It is husband's need and wife is responsible to satisfy them.

> Violence and coercive sex (Maar-peet aur jabardasti).

> Sex and fear. Whenever I think about sex, the fear of coercive sex comes to mind (Women, Session 3)

During the session, women revealed a limited understanding of reproductive health and sought clarification on several issues: *How is the baby conceived? What is the best way to avoid pregnancy without using contraceptives? Is swelling in the abdomen related to regular forced sex? Why do women experience pain during sex? What is the connection between using Copper-T (Intra-Uterine Device) and menstrual problems? Why do women have white discharge?*

Men focused on the lack of privacy for sex, and described this as a reason for engaging in sex outside marriage. Women often discussed their husband's continual readiness and demands to engage in sex, and their reasons for refusal, including lack of privacy, poor health, and the fear of pregnancy due to nonuse of contraception, and coercion and violence.

Both men and women expressed limited knowledge of sexuality, reproduction, and anatomy. During the discussion on what are the ingredients of a good sexual relationship, women said,

> Understanding the partner's problem, sexual desires, satisfying them, good communication, lead to happy sexual relationship (Woman, Session 3)

> Ill health… lack of privacy, [and] having many children is the barrier to a happy sexual relationship. (Woman, Session 3)

> When sexual relationships are strained, it leads to dissatisfaction in the relationship. It leads to fighting, quarreling, violence and sometimes it may lead to divorce, too. (Woman, Session 3)

While women initially felt inhibited talking about sex and sexual behaviors, by the end of the session, they reported that they had enjoyed the session. Men, however, demonstrated immediate curiosity and an eagerness to have their doubts clarified. Like the women, they too appreciated the session and the facilitators' openness in dealing with such topics. In the post-CI evaluation, participants reported that Session 3 was the highlight of CI.

> My information related to this topic increased. There were many points, which I did not have any information, but I came to know about it by coming here. I did not have information about physiology, contraception, etc. There was nothing about the session that I disliked. (Woman, Session 3 postsession interview)

> I liked the information about safe period, because I did not know about it. So we used be afraid every time while having sex. All people used to say that pregnancy occurs if sex takes place immediately after the menses. Because of such misconceptions I took pills for three years. (Woman, Session 3 postsession interview)

> The role play was very good. People do behave in such a way. It commonly happens in the houses. My information also increased, I came to know that how woman gets pregnant, how a female gets menses. Now I can tell this information to others also. (Man, Session 3 postsession interview)

> I have got the information about ova and sperm. Earlier I was not aware about it. First time, I have understood the safe period concept as well as woman is not responsible for female child (Man, Session 3 postsession interview)

Session 4: Sexual risk and its prevention. The objective of Session 4 was to review risk behaviors and preventive measures related to HIV/STIs. The session began with the facilitators playing an educational card game with the participants to assess their initial knowledge base and teach them about the signs and symptoms of STIs/RTIs, emphasizing the importance of recognition, treatment, and preventive practices.

Reflecting on the session, many of the participants identified the information they received on HIV transmission, sex during pregnancy, and general knowledge they obtained about sex as the most valuable parts of the session.

> I think we got the information about HIV very openly, that was good; the care that should be taken to maintain a safe sexual relation, importance of maintaining sexual relations with only one partner. So I think I got overall good information about sex. (Woman, Session 4)

For both women and men, the session provided a safe space to discuss their personal views and attitudes. For many participants, the session also validated the need for mutually pleasurable sex within marriage, contrary to the culturally dominant paradigm of satisfying men's sexual demands without attention to women's needs.

Session 5: Violence in marital relationships. Session 5 was the first of the two joint sessions in which husbands and wives met together in a group co-facilitated by both the male and female facilitators. This session was designed to help couples have a better understanding of violence in its various forms, understand the factors that lead to marital violence, and develop skills to resolve contentious issues in the marital relationship through nonviolent communication.

When discussing violence, men provided a variety of situations that led to violence in the household, including a lack of income, husband's drinking, mother-in-law problems (mother complaining to son about his wife), birth of a female child, and arguments with wives about unfulfilled household responsibilities. Women linked men's frustrations outside of the home as common causes of domestic violence.

> Verbal abuse hurts much more than physical abuse. The wounds caused from physical violence disappear with time, but hurt that is caused because of verbal abuse never goes off. (Man, Session 5)

> Verbal abuse is more painful than physical violence. Because physical violence can be treated by medicine or rest but emotional violence gives deep pain in soul. No one can understand the severity of emotional violence. (Woman, Session 5)

Initially, several men insisted that both partners are responsible for violence while simultaneously emphasizing the need for spousal communication as the main way to resolve household violence:

> Clapping is only possible when two hands come together similarly men and women are equally responsible for violence and they should sit together and solve the issues. This is the only solution of violence. (Man, Session 5)

However, an in-depth discussion on the use of violence as an expression and assertion of power and masculinity was generated when men were challenged to reflect on the forms of "violence" and "power" used by men.

Men dominated the mixed-gender sessions although women were quite vocal and participative in the single-gender sessions. The facilitators had to make an effort to elicit responses from women and get them to voice their views rather than let the men speak for them. As part of the end-of-the-session feedback, one man had this to say,

> Today's session is very good because we both husband and wife were together in the entire session. Now our understanding increases. Sessions are helping a lot for our marital relationship. (Man, Session 5 postsession interview)

Session 6: Toward a healthy marital relationship. Session 6 was the final session and the second of the two joint sessions. The objective of the session was to understand the importance of trust, communication, and listening in marriage and to define and identify factors that led to a positive marital relationship. The facilitators worked with the group to define what constitutes a positive marital relationship and identify the essential qualities and traits that couples needed to achieve it. The facilitators then asked each of the couples to choose one member to be blindfolded. The nonblindfolded participants had to lead their blindfolded partners around the UHC with verbal directions only. The blindfolding process was then reversed, and the activity was repeated. Following the exercise, the group discussed the activity and focused on the importance of trust during the exercise and in marriage. Through this discussion, the facilitators worked with the group to

brainstorm ways in which couples could both foster and undermine trust in their marital relationships.

Common causes of mistrust identified by men were interaction of their wives with other women, neighbor's gossip, being caught in a lie, and suspecting that their wife had an extramarital affair. Causes of a wife's mistrust included neighbor's gossip, decreased communication between the couple, and husband's behavior when the wife is visiting her natal family (for pregnancy or extended visits to distant rural areas). Men associated distrust with increased fights, divorce, and loss of love and affection, while women most often associated distrust with loss of love, and increased dislike, suspicion, and loneliness between the couple.

Postintervention Reflections

At the end of the final CI session, couples were invited by evaluators to answer questions and reflect on the intervention. Couples who did not mind waiting after the final CI session and were willing to provide feedback on all six of the sessions were requested to spare approximately 30 min for this reflection. The key areas that participants cited could be categorized as informational (those pertaining to a change in knowledge), relational (those pertaining to a change in marital and family relationships because of enhanced understanding of spousal expectations), or emotional (those that impacted participants' psychological well-being).

Informational changes. Participants reported an increase in knowledge related to anatomy, fertility, contraception, sex, and HIV/STIs. Participants specifically referenced increased knowledge of male and female anatomy, proper birth spacing, factors that determine the sex of the unborn child, menstrual cycle, contraception (including condom use), masturbation, sex during pregnancy, sexually transmitted diseases, the risks of unprotected sex, and general knowledge on HIV/AIDS and its transmission.

Relational changes. Participants also reported improved relationships with their spouses, mother-in-law, and children. While women often referenced an improved relationship with their mother-in-law, men often talked about changes in the husband–wife dynamics and the balance in their relationship with their wife and mother. Both male and female participants noted an increase in communication, and a reduction in *tenshun*, fights, and mistrust in their marriage.

Men and women often referenced changes in the parent–child relationship. Men referred to their efforts to become better role models for their children and reflected on an increased involvement in their children's life and education. Women's responses focused on an improved relationship resulting in decreased anger and conflict. As part of the change in the marital relationship, many male participants commented on increased participation in household responsibilities and wife's fulfillment of household responsibilities.

Psychological well-being. As a result of the CI sessions, both male and female participants reported changes in their *tenshun* levels. For women, this change was often reflected in decreased anger and resentment. Men reported decreased anger and irritation when solving conflicts with their spouse, children, or other family members. Effective spousal communication, particularly related to the day's events and frustrations experienced by both spouses, was seen as the key to the reduction in *tenshun*.

DISCUSSION

Findings of studies on marital interaction and well-being suggest that it is the quality of the dyadic interaction that is crucial for individual well-being, and that the effects of marital quality are a stronger concern for women than among men (Qadir, Khalid, Haqqani, Zille, & Medhin, 2013; Schmitt, Kliegel, & Shapiro, 2007; Williams, 1988). The dynamics of the marital dyad in India play a key role in sexual health, sexual risk, and emotional well-being for both the husband and wife. Patriarchy, gender inequity, violence, coercive sex, poor communication, and lack of knowledge contribute to increased sexual risk and poor sexual and psychological health among a significant subset of marital couples.

In a context where the dominant norms support patriarchy and gender inequity, why would men want to change? We suggest a number of factors. Men as fathers and husbands in urban, economically marginal communities have now begun to recognize the financial advantages of more

education and acquisition of skills leading to employment for wives and daughters. In turn, this recognition has led to later marriage, increased educational attainment, more contributions by women to household income, and a greater degree of empowerment. These trends are supported by globalization of media, the changing images portrayed by Hollywood and Bollywood, the building of women's networks through the cell phone, access to the Internet, the growing women's movements in India, and the work of community-based organizations (CBOs) that have promoted vocational training and increasing women and girls' empowerment (Ghosh, 2011; Mankekar, 2004; Mishra, 2011; Netting, 2010; Tenhunen, 2008). While there is no doubt that normative patriarchy still exists, and was responsible for the initial and declining participation of men, and consequently of women, the implementation of CI and the participation and response of those men who participated is a recognition of these social and cultural changes.

To our knowledge, this couples' intervention is the first to address marriage, dynamics of the spousal relationship, and sexual health in India. Unlike many of the couples' intervention efforts internationally or domestically in the United States, the intervention reported here was conducted in a low-income community with a general population of married couples, rather than with high-risk behavior groups such as sex workers, drug users, and persons with HIV. Perhaps, for this reason and the fact that CI was conducted in a community setting, the rates of initiation of the first session was a little over 50%, despite the initial consent provided by the women. This percentage is in sharp contrast to that for women who were assigned to individual counseling. While individual counseling was equally new and unfamiliar, 80% of women attended at least the initial IC session. Clearly, the difference in the level of participation in the two modes of intervention involved the requirement that wives secure husbands' consent to also participate in CI. The barriers to male participation in women's reproductive health have been well documented (Dudgeon & Inhorn, 2004; Msuya et al., 2008; Mullany, Becker, & Hindin, 2007). In this case, men's reluctance to be involved in couples' intervention included the lack of familiarity and understanding of the objectives and process of the intervention, the commitment to long hours of work, and the lack of support from other family and community members.

Several possible strategies for more effective recruitment and retention of men should be considered for the future. The RISHTA staff supplemented women's efforts to involve their husbands, but more emphasis on programmatic contacts might have helped. Organizational meetings for men prior to the start of CI sessions might have been effective in making men more comfortable with the concept of CI. Endorsement and encouragement by Muslim religious leaders from the community for participation in CI might have provided an additional incentive for participation. Individual sessions or some form of male-specific counseling may also have better prepared men to participate in the CI intervention. Fewer sessions may have also helped with retention without sacrificing the efficacy of the intervention, as noted in previous studies (Bradford, Mock, & Stewart, 2015; Pettifor et al., 2014). These strategies and others that may be relevant to specific cultures and communities need to be developed and implemented prior to initiation of couples' intervention. Practitioners attempting to implement CI elsewhere should also consider the challenges associated with sustainability and support for couples after the intervention ends. The WHC in the UHC could sustain individual counseling but couples' intervention would need support within the NGO or religious sectors. RISHTA is still seeking opportunities to build capacity for CI in the study area.

The documentation of the sessions indicated that women were much more vocal and participative in the single-gender sessions, while men tended to dominate the interaction in the mixed-gender sessions. It may be possible to better prepare women for the joint sessions, and facilitators could provide more space for women to communicate their views in the joint sessions. This gender difference has implications for consultation and coaching with facilitators linked to formative evaluation; for example, program staff could observe participant as well as facilitator communication and provide feedback and coaching on how to address disparities in communication between male and female participants.

There are formidable barriers to the involvement of men, as we have seen; however, men's communication, knowledge, and emotional status play a significant role in the dynamics of the couple. It is important to continue the efforts to engage men in sexual and reproductive health

interventions. As one man stated in the postsession 6 feedback, “I was never so able to see, when I had the blindfold on and was guided by my wife.”

In a patriarchal society, where marriage as an institution is highly valued and promoted, women’s well-being and health is often sacrificed for the priorities of other members of the family. While women’s expectations of marriage call for mutual understanding and respect, many men do not move beyond their “bread-winner” role. Often, women accept the husband’s authority and may justify men’s use of violence as part of marriage. Thus, men’s patriarchal values and behaviors and women’s subordination within the marital dyad need to be challenged and shifted. The evaluation results indicate that couples’ intervention provides an opportunity for spouses to understand each other’s perspectives and address issues of power, violence, and trust in a marital relationship with the goal of strengthening and investing in the relationship.

CI was effective for both men and women in improving sexual knowledge. Women receive little or no information about sexuality, anatomy, or sexual relationships in most Indian communities. The great majority (90% in this sample) have early (<18 years of age) and arranged marriages in which they have limited familiarity with their prospective spouses. Consequently, they enter marriage without the basic information for sexual health and may continue that pattern even after childbirth. With strong segregation of the sexes, most men have limited interactions with women prior to marriage and limited sexual experience. Men’s knowledge of sexuality may be drawn from misguided peers, pornography, or visits to sex workers as an entry into “manhood” and preparation for the “first night” of marriage. The sessions dealing with reproductive anatomy and sexual risk were the most popular sessions, addressing misconceptions and discussing positive sexual relationships with an emphasis on mutuality and noncoercion. These results suggest sexuality education is needed for married couples and may be best achieved in a format such as CI.

For a subset of married couples in low-income communities, communication between husband and wife is limited to the basic logistics of daily life, devoid of shared decision-making, and negotiating perspectives. This lack of communication particularly characterizes those arranged marriages that started poorly, where the couple has not grown together. The CI process emphasized the improvement of the marital relationship as well as relationships with children and other family members. Qualitative feedback from participants at the end of each session and from men and women who responded to the formal postsession and postgroup evaluation indicated recognition of the utility of improved communication with their spouse. The improved spousal communication also had a further effect of generating better relationships with children, mother-in-law, and other family members, contributing to overall well-being for women and men.

Life in a low-income community in Mumbai presents many challenges including infrastructure (water, sanitation, and roads), financial (inconsistent employment, insufficient finances to maintain the household, and children’s education), and relational dynamics (marital dyad and the family) in limited residential quarters. These stressors contribute to *tenshun* and coping strategies were found to be frequently dysfunctional, producing even greater *tenshun*. Participants reported that, as a result of the CI sessions, they were using better coping strategies that began with improved spousal communication.

A subset of marriages in the study community face many challenges, both internal and external to the couple. These challenges negatively impact on sexual health and contribute to emotional and sexual risk of husbands and wives. For middle- and upper-income Indian couples who cannot resolve these issues, the most productive alternative may be separation or divorce. For low-income urban women, this alternative is only available in the most extreme cases due to issues related to absence of shelter and livelihood options, inadequate support of the natal family, and stigma attached to being divorced or separated. In such circumstances, one of the approaches to address a wide range of issues is to strengthen the marital dyad. Couple’s intervention provides an empirically tested approach to strengthen the marital relationship by creating an opportunity for wives and husbands to address challenges together, discuss mutual expectations, and resolve differences in a collaborative and nonviolent way in a safe environment.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article:

Data S1. Intervention manual.