

Knowledge, Attitudes, and Practices of Family Planning Among Women of Reproductive Age in Suva, Fiji in 2017

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Abstract

Objective: This study aims to identify the level of knowledge, attitudes and practices of family planning among women of reproductive age in Suva, Fiji in 2017.

Methods: A quantitative, cross-sectional study using a self-administered questionnaire among women of reproductive age who attended three designated health clinics around Suva, Fiji from 15th March to 28th April 2017 was used. Using random sampling, those who met the inclusion and exclusion criteria of the study were asked to fill a questionnaire survey. Once the data was collected, it was analyzed with SPSS.

Results: About 325 women participated in the study with the mean age of 31.53(± 7.35). Less than half (148 or 45.5 %) of the participants had a good level of knowledge towards family planning whereas 178 (53.5%) of them had a moderate level of knowledge of family planning. An overwhelming majority of the participants (176 or 54.2%) had high level of attitudes towards family planning. Only 3% of the respondents showed poor level of attitude towards family planning. With regards to practice, the participants showed a poor level of practice of family planning at 80 (24.6%) whereas those with good level of practice of family planning constituted only 31 (9.5%).

Conclusion: This study provides a useful source of empirical information to policy makers to achieve the desired goals in family planning. These findings of the study will help health care providers promote family planning in Fiji.

Keywords: Family planning; Reproductive age; Contraceptive; Pregnancy

Introduction

Family planning refers to couples making informed decisions about having children-that is spacing the pregnancies and number of offspring they will have using contraceptive methods. Over 200 million women in developing countries do not desire pregnancies and they fail to use modern contraceptive methods [1]. This is in spite of the fact that several contraceptive methods, such as condoms, hinder the transmission of sexually transmitted infections (STIs) as well as the risks, pains, and costs associated with abortions [2]. Notably, abortions in developing nations account for a large number of pregnancy-related deaths among mothers and infants [3]. Clearly, irrespective of its considerable benefits, family planning practices are not being carried out by most of the developing countries. The WHO lists several reasons for the lack of motivation in family planning: lack of accessibility to contraceptive methods; fear of side effects and approbation based on social and religion sentiments; the quality of education on the subject that can also be linked to provider bias [4].

Remarkably, all these reasons can be directly linked to the lack of awareness associated with the inability of education to dispel ill-formed ideologies [5]. A study conducted by Sun-Hee Lee in the Pacific Islands showed that the contraceptive prevalence rate (CPR)

was below 50 in all the islands including the urbanized ones; the increase in the teenage pregnancy rates by 30% was a matter of concern; and all nations reported high maternal morbidity rates along with the high infant morbidity rates in some nations [6]. In recent times, the problem has possibly aggravated, with the Pacific Islands shown as mostly in deficit in terms of family planning initiatives compared to other developing countries [7,8]. In Fiji, high unplanned pregnancy rates have been found linked with high poverty rates [9].

To explicate the situation, the low fertility and high mortality rates experienced by the nation in the past century was beginning to be overcome by the 2000s. However, since 2009, the level of population growth accompanied by the high number of births had shown that Fiji faces a threat of increased poverty levels because of high birth rates [10]. Clearly, in spite of the considerable efforts toward it in the 1980s, family planning remains a concern for Fiji. The aim of this study is to identify the level of knowledge, attitudes and practices towards of women of reproductive age in Fiji in 2017.

Methods

This quantitative, cross-sectional study was conducted among 325 participants who attended three designated health clinics around Suva, Fiji from 15th March to 28th April 2017. A self-administered questionnaire was used to collect data, which was content and face validated using a pilot study. To do face validity, the questionnaire was

given to 10 participants who met the study inclusion and exclusion criteria and were asked to read and let us know about readability and understandability of the questionnaire. We also gave the questionnaire to 3 experts (all academic staff) who were familiar with the study and worked in the relevant field and asked them to check the content of the questionnaire based on is the aim and objective of the study. After collecting their comments we modified the questionnaire. There were seven family planning health clinics which we have chosen three of them randomly including Nuffield Clinic in Tamavua, Wellness Center for Women/Oxfam at the Colonial War Memorial Hospital (CWMH) in Suva, and Samabula Health Center in Suva. The study population included all Fijian women of reproductive age. The inclusion criteria included women, ages 15-49 that were married and must have attended any one of the three identified family planning clinics under study from 15th March to 28th April, 2017. Furthermore, the study participant must have been a Fijian-anybody in Fiji who possesses Fijian citizenship. The exclusion criteria included men and women under the age of 15 or age 50 and over and those women who are not happy to participate in the study.

Participants who met the inclusion and exclusion criteria who consented to participate in the study were asked to fill a questionnaire survey to identify the level of knowledge, source of knowledge on family planning, and the barriers to their practice of family planning. Section 2 of the questionnaire survey was the knowledge-based section which contained 12 questions where the participant had an option to answer "True, False or Don't Know" or in the first question, "Yes/No and Don't Know". For coding purposes, the correct answer which is "Yes" in the first question, and may be "True or False" for the rest of the questions were recorded as 2. Whereas, the incorrect answer which was "No" in the first question or "True or False" for the rest of the questions was recorded as 0. An answer with "Don't Know" was recorded as 1. Total points to be scored were 24 and the minimum score was 0. The correct answers were quantified as: 0-11 as Poor (low level) knowledge; 12-18 as Moderate (medium level) knowledge; and 19-24 as Good (high level) knowledge. Data collection was done after the researcher received ethical approval from the College of Health Research Ethics Committee (CHREC) of Fiji National University and the Ministry of Health's Fiji National Health Research Ethics Review Committee (FNHRERC). The data was analyzed with SPSS Version 22 statistical software. The frequency and percentage of KAP are presented in tables and graph.

Results

The mean age of the participants was 31.53 (\pm 7.35) with a majority of the participants in the age group 25-29 (26.8%). I Taukei women made up a large portion of the sample at 212 (65.2%). A majority of the participants belonged to a Christian denomination, 210 (64.6%). Just over half of the participants were employed (197, 60.6%) with 34.2%

(115) of them with an annual income in the income range of \$8,000.00 to \$14,999.00. A large portion of the participants have a higher level of education (198, 60.9%). Two hundred five or 63.08% of the participants have between 1 and 3 children. In terms of residence, 229 or 70.5% of the participants live in urban area (Table 1).

Variable	Frequency	Percentage
Age	25-39 (87)	26.8
Ethnicity	iTaukei (212)	65.2
Religion	Christian (210)	64.6
Education	Higher (198)	60.9
Employment status	Employed (197)	60.6
Annual Income	8000-14,999 (34.2)	34.2
Number of children	1 to 3 (205)	63.1
Area of residence	Urban (229)	70.5

Table 1: Demographic profile of the participants.

A majority of the participants have heard of some form of contraceptive in their life, 293 (90.2%). Only 74 (22.8%) of the participants correctly answered that birth control pills were not effective if a woman misses taking them for two or three days in a row. A majority, 275 (84.6%) of the participants were aware that sterilization (tying a woman's fallopian tubes) was one way of preventing pregnancy. A large majority, 314 (96.6%) of the participants agreed that health education was important for women who want to use contraception. A majority of participants, 253 (77.8%), agreed that contraceptive pills did not guarantee 100% protection.

A majority of participants, 285 (87.7%), correctly answered that condoms prevented Sexually Transmitted Infections (STIs). A majority, 255 (78.5%) of participants correctly answered that contraceptive pills produced side effects of mood swings and weight gain. Only 74 (22.8%) of participants correctly answered that oral estrogen-containing contraceptive pills had an increased risk of causing breast cancer. A large majority of the participants, 268 (82.5%) answered correctly that a Depo Provera intramuscular injection contraceptive shot must be administered on three monthly basis. A majority of the participants, 275 (69.2%) correctly answered that women who experienced side effects of a contraceptive pill can switch to another form of contraceptive that might have less side effects. A good majority of the participants, 222 (68.3%), correctly answered that using a combination of condom and a contraceptive pill was considered very effective contraception (Table 2).

Questions (n=325)	Responses	N	%
1. Have you ever heard of contraceptive?	Yes	293	90.2
	No	26	8
	Don't know	6	1.8
2. Birth control pills are effective even if a woman misses taking them for two or three days in a row.	Yes	74	22.8
	No	178	54.8

	Don't know	73	22.5
3. Female sterilization is one way to avoid pregnancy.	Yes	275	84.6
	No	10	3.1
	Don't know	40	12.3
4. Health education is important for women who want to use contraception.	Yes	314	96.6
	No	5	1.5
	Don't know	6	1.8
5. Contraceptive pills do not guarantee 100% protection.	Yes	253	77.8
	No	26	8
	Don't know	46	14.2
6. Condoms prevent STIs.	Yes	285	87.7
	No	21	6.5
	Don't know	19	5.8
7. Common side effects of contraceptive pills include mood swings and weight gain.	Yes	255	78.5
	No	21	6.5
	Don't know	49	15.1
8. There is an increased risk of breast cancer in women taking estrogen-containing contraceptives.	Yes	74	22.8
	No	117	36
	Don't know	134	41.2
9. Women using the birth control shot (Depo Provera) must get an injection every three months.	Yes	268	82.5
	No	12	3.8
	Don't know	45	30.8
10. If a woman is having side effects of one kind of contraceptive pill, switching to another type might help.	Yes	225	69.2
	No	41	12.6
	Don't know	59	18.2
11. Using both a condom and the pill is considered to be a very effective contraceptive.	Yes	222	68.3
	No	39	12
	Don't know	64	19.7
12. Using the pill increases a woman's risk of ovarian, endometrial or cervical cancer.	Yes	60	18.5
	No	145	44.6
	Don't know	120	36.9

Table 2: Frequency of responses on knowledge-related questions.

Table 3 displays the results of the participants' attitudes based on a Likert Scale scoring system consisting only of responses of "Strongly Agree/Agree" which are combined to show the total percentage of the responses of the participants to each question.

A majority of the participants, 273 (84%), agreed/strongly agreed that contraceptives should be used to limit a woman's number of

children. Likewise, a majority of the participants, 286 (88%) agreed/strongly agreed that contraceptives were necessary to control the spacing of a woman's childbirths. A large majority of the participants, 293 (90.1%), agreed/strongly agreed that spacing allow for healthier children. More than three quarters, 291 (89.5%), agreed/strongly agreed that the ideal age of a woman's child-bearing age is 20-30. About 221 (68%) of the participants agreed/strongly agreed that the

ideal number of children is between 3 and 5. A majority of the participants, 289 (88.9%) agreed/strongly agreed that contraceptives provided a sense of safety. For participants on contraceptives, 255 (78.5%), agreed/strongly agreed that the type of contraceptive method they were using was adequate.

Three quarters, 254 (78.2%) agreed/strongly agreed that contraceptives benefited males. Only a small fraction, 82 (25.2%), of the participants agreed/agreed strongly that discussion of contraceptives with their spouses was embarrassing. An even smaller sample of the participants, 66 (20.3%) agreed/strongly agreed that their husbands did not approve of their use of contraceptives. A majority,

291 (89.5%) of the participants, agreed/strongly agreed that contraceptives protected the health of the family and the community. Religion played a big part in a woman's decision to use contraceptives, 271 (83.4%). Likewise, just over three quarters of the participants agreed/strongly agreed that cultural beliefs, 256 (78.8%) played a role into a woman's decision to use contraceptives. A majority of the participants agreed/strongly agreed that husband's objections influenced their spouse's decision to use contraceptives, 269 (82.8%). A majority of the participants, 261 (80.3%), agreed/strongly agreed that a male's attitude about contraceptives play a big role into a woman's decision to use contraceptives.

Attitudes (n=325)	Strongly Agree		Agree		Neutral		Disagree		Strongly Disagree		Total N (%)
	n	%	n	%	N	%	n	%	n	%	
1. Contraceptives should be used to limit my number of children.	110	33.85	163	50.2	29	8.9	19	5.9	4	1.2	273 (84)
2. Contraceptives should be used to increase the time interval between my childbirths.	114	35.1	172	52.9	20	6.2	16	4.9	3	0.9	286 (88)
3. Spacing will allow a child to be healthier.	134	41.2	159	48.9	20	6.2	9	2.8	3	0.9	293 (90.2)
4. The ideal age of having a first child is 20-30.	109	33.5	182	56	25	7.7	7	2.2	2	0.6	291 (89.5)
5. The ideal number of children should be between 3-5.	78	20	143	44	54	16.6	41	12.6	9	2.8	221 (68)
6. Contraceptives provide a sense of safety.	100	30.8	189	58.2	23	7.1	10	3.1	3	0.9	289 (88.9)
7. The method of contraception I am using is adequate.	88	27.1	167	51.4	60	18.5	9	2.8	1	0.3	255 (78.5)
8. Contraceptives benefit males too.	75	23.1	179	55.1	49	15.1	18	5.5	4	1.2	254 (78.2)
9. Discussion about contraception with spouse is embarrassing.	17	5.2	65	20	44	13.5	130	40	69	20.9	82 (25.2)
10. My husband does not approve my use of contraceptives.	16	4.9	50	15.4	54	16.6	151	46.5	54	16.6	66 (20.3)
11. Contraceptive methods can protect the health of family and community.	114	35.1	177	54.5	22	6.8	11	33.9	1	0.3	291 (89.5)
12. Religious beliefs can prevent women from using contraceptives.	99	30.5	172	52.9	22	6.8	23	7.1	9	2.8	271 (83.4)
13. Cultural beliefs can prevent women from using contraceptives.	91	28	165	50.8	30	9.2	31	9.5	8	2.5	256 (78.8)
14. Husband's objections to contraceptives can prevent women from using contraceptives.	84	25.9	185	56.9	23	7.1	28	8.6	5	1.5	269 (82.8)
15. Change in male attitudes on contraceptives may improve contraceptive use.	96	29.5	165	50.8	25	7.7	31	9.5	8	2.5	261 (80.3)

Table 3: Frequency of responses on attitudes- related questions.

Table 4 displays the results of participants' family planning practices. The total frequency and percentage are derived from combing the "Always and Usually" responses to each question.

With regards to a participant's consultation with family planning services, just over half of the participants always or usually consulted with health care professionals in a health center for family planning services, (186 or 57%). Responses of always or usually to the family planning practices, which constitute ideal or positive practices, registered the highest proportion under use of contraceptives for

unplanned pregnancy (212, 65%) or roughly two thirds of the participants. Only 2 (0.5%) of the participants have experienced an unplanned pregnancy as a result of lack of family planning. A majority of the participants always or usually practiced family planning every time they did not intend to get pregnant, (196 or 60%). Only 27 (8%) of the participants changed their family planning method from time to time. Similarly, less than 10%, 41 (13%) of the participants practiced a traditional method of family planning (Table 4).

Practices Questions (n=325)	Always		Usually		Sometimes		Seldom		Never		Total N (%)
	N	%	N	%	N	%	N	%	N	%	
1. How many times a year, do you visit a health centre for family planning services?	123	37.5	64	19.7	59	18.2	27	8.3	52	16	187 (58)
2. Do you use contraceptives to prevent unplanned pregnancy?	157	48.3	55	16.9	40	12.3	9	2.8	64	19.7	212 (65)
3. Have you ever had any unplanned pregnancy due to lack of contraceptive use?	1	0.3	1	0.3	91	8	0	0	232	19.7	2 (0.6)
4. Do you use contraceptives every time when you do not intend to get pregnant?	142	43.7	54	16.6	47	14.5	13	4	69	21.2	196 (60)
5. I use different types of contraceptives.	7	2.2	16	4.9	65	20	53	16.3	184	56.6	23 (7)
6. My current method of contraceptive changes from time to time.	4	1.2	23	7.1	53	16.3	54	16.6	191	58.7	27 (8)
7. Do you practice any traditional contraceptive methods including withdrawal, infertility period, herbal and breast feeding if you were not using any contraceptives?	19	5.9	22	6.2	111	34.2	24	7.4	149	45.6	41 (13)

Table 4: Frequency of responses to practice-related questions.

Discussion

This study addressed the current knowledge, attitudes and the practices among 325 participants. In terms of contraception awareness and the need of health education for women, a high number of the participants answering positively indicated that the United Nations and governmental family planning initiatives from the 1980s to present were potentially successful. This echoes the finding in the Hayes and Robinson study that showed the low fertility rates experienced by women in Fiji resulted in the success of the subsequent family planning initiatives in the 1980s [11]. However, the barriers to knowledge were apparent in the manner in which contraception methods and their use was being perceived. For instance, only 54% of the respondents were aware that missing contraceptive pills for more than 2-3 days in a row can result in pregnancies [12,13]. Similarly, a notable number were unaware of the side effects of taking contraceptive pills, and the potential link between cancer and estrogen-containing contraceptives. Since the latter is still a matter of contention, one can state that the lack of awareness here is not relevant.

However, the fact that many (40%) do not know that such as a contention exists is indicative of the low penetration of the details of family planning among the people in Fiji. This has also been shown in the certainty (68.3%) and uncertainty (19.7%) associated with idea that contraceptive pills are all the same and can be replaced. Another factor shows the lack of detailed awareness among the participants in Fiji. Although a relatively high number of participants (77.8%) were aware that contraceptive pills do not guarantee absolute protection from pregnancy, a lesser number (66.8%) is aware that using a condom and the pill together considerably increases the contraceptive protection. Another possible matter of concern is that female sterilization as a means of avoiding pregnancies was well-established (84.6%). While a corresponding question regarding male sterilization was not asked in this study, the fact that gender disparities have been associated with family planning challenges can be recalled here [14]. A lack of clarity was also observed in the manner in which 30% of the respondents did not know if the birth control shot (Depo Provera) should be taken every three months-owing to the close-ended questionnaires employed here, it was unclear whether this was because they never used the shot

as a means of contraception or because they did not know how to use it.

The barriers to the use of contraceptive use among the participants in this study were linked to religious beliefs as well (30.5% strongly agreed/52.9% agreed). Similarly, cultural beliefs were a considerable force in demotivating women from using contraceptives. This finding can be associated with the idea that refusing contraception has been linked to the missionary foundations that enabled colonization [15,16]. The fact that gender disparities are a strong barrier against contraception use has been established by the fact that most of the respondents were of the opinion that contraception use could be better if husbands did not object to contraception and if male attitudes toward contraceptive could be altered. The issue of gender disparity in disabling effective contraception use across developing nations has been established in other studies as well [17]. In addition, the religious beliefs that inhibit women in Fiji from using contraceptives had been linked to the female subservience to males in the Fijian society, especially the large Indo-Fijian population [18].

Clearly, the male control over female sexuality is a thriving problem in Fiji as it is in many developing nations. Greater gender equality is the sign of development, and in resolving this issue [19], Fiji can potentially induce social development as well. Another notable factor here is in the fact that most respondents seem to agree that the ideal number of children should be between 3 and 5. This attitude is possibly an indicator of the fears associated with the reduced rates of fertility Fiji has experienced in the past. However, the fact that poverty is associated with the rapid population expansion needs to be considered here [20]. A family planning program that addresses this issue by describing the number of children in an ideal family unit can be a means of propounding awareness here.

As for the practices associated with family planning in Fiji, a dispersed response to the need for regular visits to the health centers for family planning services was found. This showed that the lack of depth in awareness could be linked to the fact that the health centers were the primary sources of in-depth knowledge and awareness regarding contraceptive use as opposed to advertisements and other such highly influential initiatives. Combining knowledge along with

condom social marketing programs can be an effective means of dealing with this problem [21]. Furthermore, changing the contraceptive frequently and using various kinds of contraceptives can be linked to the increased birth rates today. Considering that there is a lack of in-depth awareness regarding contraception use, changing contraceptives is probably not been done effectively, such that it pregnancies can be avoided. Nonetheless, the fact that there have been few unplanned pregnancies when people have been using contraceptives contradicts this fact. Since people do seem to take contraceptive when they do not want pregnancies, it is possible that changing or alternating contraceptive use is not a barrier to family planning in this case.

However, this cross sectional study is the first study was conducted in Fiji, it had some limitations such as using a questionnaire which was not reliable and also lack of generalizing the results of this study to all women in reproductive age in Fiji.

Conclusion

It can be concluded from the facts presented in this paper that the most prominent problem with the knowledge and attitudes regarding family planning was in that several crucial details regarding it were unknown or unclear among the people in Fiji. Other important facts that emerged include the gender disparities and religious beliefs that impact contraceptive use, with gender disparities shown to be a defining factor in negatively impacting contraception use. Some aspects of the study, such as the attitudes toward male sterilization in comparison to female sterilization, also demand further research focus.

References

1. Salisbury P, Hall L, Kulkus S, Paw MK, Tun NW, et al. (2016) Family planning knowledge, attitudes and practices in refugee on migrant pregnant and post-partum women on the Thailand-Myanmar border: A mixed methods study. *Reprod Health* 13: 94.
2. Thorsteinson K, Lund SL, Storgaard M, Ronsholt FF, Johansen IS, et al. (2016) Sexually transmitted infections and use of contraceptives in women living with HIV in Denmark: The SHADE cohort. *BMC Infect Dis* 16: 81.
3. Family planning can reduce high infant mortality levels (2002) The Alan Guttmacher Institute pp: 1-4.
4. <http://www.who.int/mediacentre/factsheets/fs351/en/>
5. Mustafa R, Afreen U, Hashmi HA (2008) Contraceptive knowledge, attitude and practice among rural women. *J Coll Physicians Surg Pak* 18: 542-545.
6. Lee SH (1995) Discussion paper 14: Reproductive health and family planning in the Pacific: Current situation and the Way Forward.
7. Dix E, Nathan SA, Rawstorne P (2015) Informing the introduction of contraceptive implants in the Pacific: A mixed methods study of contraceptive beliefs and behaviors in Tonga. *Aust N Z J Public Health* 40: 115-119.
8. Kennedy EC, Buckley SM, Subramaniam S, Demmke A, Latu R (2013) The case for investing in family planning in the Pacific: Costs and benefits of reducing unmet need for contraception in Vanuatu and the Solomon Islands. *Reprod Health* 10: 30.
9. <http://www.pacificpolicy.network/2014/04/pacifics-high-teen-pregnancy-rates/>
10. Naidu SL, Heller GZ, Koroi Z, Dearkin L, Gyaneshwar R (2017) Knowledge, attitude, practice and barriers regarding safe sex and contraceptive use in rural women in Fiji. *Pac J Reprod Health* 1: 223-231.
11. Hayes G, Robertson A (2010) Family planning in Asia and the Pacific: Addressing the Challenges. In UNFPA-ICOMP Regional Consultation. Bangkok, Thailand.
12. Cammock R (2015) I taukei family planning behavior in Fiji's central division. *Pac J Reprod Health* pp: 34-46.
13. Davies C, Dubie M, Mesibov GB (2012) Intimate relationships and sexual health: A curriculum for teaching adolescents/adults with high-functioning autism spectrum disorders and other social challenges. Shawnee Mission, Kan: AAPC Publishing.
14. Chatter P (2014) Measuring poverty as if gender matters: Perspectives from fieldwork in Fiji. *SSGM Discussion Paper* P: 10.
15. Hodges S (2008) Contraception, colonialism and commerce: Birth control in South India, 1920-1940. Aldershot. Ashgate, England.
16. Bullough VL (2001) Encyclopedia of birth control. Santa Barbara, Calif: ABC-CLIO.
17. Vasilenko SA, Kreager DA, Lefkowitz ES (2015) Gender, contraceptive attitudes, and condom use in adolescent romantic relationships: A dyadic approach. *J Res Adolesc* 25: 51-62.
18. Chandra D, Lewai V (2005) Women and men of Fiji Islands: Gender statistics and trends. Suva: Population studies programme. Univ of the South Pacific.
19. Gill K (2010) Indian women in Fiji: Their health strategies. Vancouver: Webzines of Vancouver.
20. Frankel J, Firth S (2007) From election to coup in Fiji: The 2006 campaign and its aftermath. ANU E Press, Canberra, Australia.
21. Sewak A, Singh G (2012) Assessment of the Fiji-based condom social marketing (CSM) program. *Sex & Cult* 16: 389-407.