



A Culture of Contrasts: The Celebration and Stigmatization of (Safe) Sex

A qualitative study on the sexual risk-taking of university students in the Netherlands

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ABSTRACT

“The body itself can be read as a text on which the most fundamental values of a society are inscribed” – Marica C. Inhorn (2006, p. 353)

With university students increasingly engaging in unprotected sex and being identified as a growing risk group for STIs, this study aims to understand how and why these higher educated youths partake in sexual risk behaviour. Besides interrogating personal incentives, this research aims to uncover the underlying socio-cultural patterns that facilitate this sexual risk-taking. Hence, this research touches upon significant theories from the field of Medical Anthropology, ranging from structural violence, to theories on women’s health, socio-cultural norms and values, and intersectionality in the context of health concerns. Together with a variety of cross-country literature on factors influencing the spread of STIs, this research intends to give meaning to a case study conducted on the sexual risk-taking of university students in the Netherlands. This case study consists of the personal accounts and experiences of eight students, brought to light through in-depth interviews and a focus group discussion, as well as the academic accounts of three experts in the field. The analysis of these accounts exposes a multiplicity of socio-cultural factors that affect students’ sexual behaviour and condom use. It reveals how university students in the Netherlands are faced with the consequences of a society perpetuating a performance-driven culture, gendered power relations and taboos around the body, to the extent that it influences their sexual behaviour. Students find themselves in a unique position where such socio-cultural patterns intersect with specific aspects of student life. This study hereby hopes to contribute to the understanding of sexual health concerns for university students, and argues that intervention programmes require adaptive strategies that cater specifically to needs of this unique population.

Key words: Medical Anthropology, global health, gender, sexuality, risk behaviour, structural violence, societal norms, women’s health, intersectionality, SRHR, STI, student culture

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1. INTRODUCTION

“Anthropological inquiry often starts with current events and the ethnographically visible”

– Paul Farmer (2004, p. 309)

In line of a recent internship at an Addis Ababa-based non-governmental organisation, a qualitative study on the sexual behaviour of Ethiopia’s most at risk populations was conducted. This mainly concerned female sex workers’ vulnerability to the HIV/AIDS epidemic, in the context of education on sexual reproductive health, safe sexual behaviour and adequate health care; as well as access to either (Brunsting and Huijsman, 2017). As literature on sexual reproductive health (SRH) suggests, sexual risk behaviour is often associated with race, poverty and social inequality (Shefer, 2012). This, too, appeared to be the case with the sex workers targeted by the organisation: their limited opportunities for access to the job market, to education, and to knowledge on safe sexual behaviour had been particularly the result of socio-economic and infrastructural constraints (Brunsting and Huijsman, 2017). Nevertheless, as many researchers are familiar with: for each finding, new questions arise. In this case, there appeared to be more to some of the findings of this study and upon analysing them, one remarkable gap appeared, which did not comply with the literature and the above arguments. It concerned the sexual risk behaviour of university students. Considering that student populations are not necessarily identified by the socio-economic inequalities that kept female sex workers at risk, it was a most remarkable discovery. This finding became the foundation of the current study.

The sexual risk-taking of university students

Several female sex workers had indicated their concern about university students: their lack of care, their lack of knowledge, and their lack of confidence in condom use would stimulate unsafe sexual behaviour and put students at risk of being infected with STIs – to the extent that one sex worker indicated that despite her “risky business (...) we are less at risk than students” (Brunsting and Huijsman, 2017, p. 96). Whilst the female sex workers were structurally and systematically faced with social inequality, poverty and limited access to health facilities and education on SRH as factors that kept them at risk (Brunsting and Huijsman, 2017), this does not seem to relate university students as such. They, on average, do not have a lower socio-economic background, do have opportunities, and most certainly do have access to knowledge on SRH through their education, as sexual education is part of most curricula worldwide. Moreover, most university areas enable access to preventative means, such as distributing free or inexpensive condoms, as well as counselling and/or testing services (Cragg, 2014). Given this, it brings up many questions. If these elements do not play a role, then what factors do facilitate the overall sexual risk taking of university students, and are these factors universal? What

makes university students so particularly vulnerable, that even female sex workers – a ‘most at risk population’ – fear for their sexual health?

“Worldwide, STIs are most prevalent in those aged 20-24” (Cragg, 2014, p. 4). Moreover, it appears that there is a growing gap between knowledge on STI-prevention and actual safe-sex practices amongst educated youths on a cross-country level. Young people would be familiar with safer-sex practices and have access to preventative means, but “in spite of this changed context, with increased access to information and resources as well as exposure to constant prevention messages, young people evidently remain at risk for contracting HIV and other sexually transmitted infections” (Shefer, 2012, p. 117). Hence, Shefer (2012) argues that, within this population, the spread of STIs might be related with gender, age and lifestyle instead. That university students are a risk group, often more than we tend to think, appears from a wide variety of literature ranging from all corners of the world. This will be further elaborated upon in the literature review, touching upon studies from multiple countries (see: ‘3. Conceptual framework’).

Particularly amongst students “there is a continuous trend towards riskier sexual behaviour, with an increased number of sexual partners, increased unprotected first-date intercourse, an increase of STIs, and more use of emergency contraception. This trend is worrying as it might have serious consequences for women’s future health.” (Tydén et al., 2011, p. 218). Recently, in a study conducted in the Netherlands in 2017, it appeared that students have become an apparent risk group for STIs and that their condoms use has rapidly declined since 2012 (de Graaf et al., 2017). Furthermore, in a study conducted on a university campus in Sweden, it appeared that one-third of its female students had suffered from an STI at some point during their university career (Tydén et al., 2011). Similarly, in Canada individuals of 15-29 make up for one-fourth of its HIV cases, and within this “age group, new HIV cases are often attributed to heterosexual contact”, and thus concerning a majority of its population (Cragg, 2014, p. 41). Although “sexual health services are free and generally available to most Canadians, only some individuals choose to access them. For those at high risk for sexually transmitted infections (...) their future sexual health and well-being may be directly impacted by this decision” (Cragg, 2014, p. 3). Similarly, regardless of the available means of prevention, in the Netherlands it appeared that currently four out of ten youths do *not* use a condom during one-night stands (de Graaf et al., 2017).

As the phenomenon of university students being at risk of STIs seems to appear on a cross-country level, this study assumes the phenomenon to be particularly related to certain aspects of ‘student life’ rather than solely country-related aspects of culture. Hence, besides analysing existing literature originating from different countries, this study takes an anthropological stance by understanding ‘student life’ as a culture on its own, and an intersectional approach by interrogating how certain aspects of this culture influence the sexual health of university students.

Research Objectives

In a nutshell, amongst university students there appears to be a gap between what is known about safe sexual behaviour and what is practiced. Hence, the current study aims to understand which factors facilitate this gap and why, through a case study conducted in the Netherlands. This Bachelor's thesis therefore raises the following question:

How can the sexual risk-taking of university students in the Netherlands be explained from a socio-cultural perspective?

The numbers on unsafe sexual behaviour amongst students in the Netherlands are evident (see: '3. Conceptual framework'), but what this study aims to understand is *why* these numbers exist. It will aim to create a framework for understanding how the culture of 'student life' influences sexual risk behaviour, through touching upon important theories from the field of Medical Anthropology (see: '2. Theoretical framework'), an extensive review of cross-country literature on students' sexual behaviour (see: '3. Conceptual framework') and a qualitative case study conducted amongst university students and SRH experts in the Netherlands (see: '4. Methods'; '5. Findings'). Subsequently the findings will be elaborated upon through applying the theories as a tool for explanation. Hereby the research aims to draw conclusions that contribute to the framework around the sexual health and well-being of university students, and the understanding of societal factors that enhance this risk (see: '6. Discussion').

“Characterizing those individuals more at risk of STIs and least likely to be tested would allow clinicians and other health services providers to refine their targets for STI testing (...) and associated health promotion strategies” (Cragg, 2014, p. 41). This study therefore hopes to contribute to the understanding of the spread of STIs in a university student population, and may be used as a point of reference for improving intervention projects.

2. THEORETICAL FRAMEWORK

“Before understanding the framework around the contraction and prevention of HIV/AIDS, one must first understand the context in which it manifests itself. Globalisation, gender roles, widening poverty gaps and racism are important factors that have contributed to the spread of HIV/AIDS. All theories come together in a topic called ‘intersectionality’.” (Brunsting and Huijsman, 2017, p. 6). Although this quotation focusses on HIV/AIDS in particular, the same approach can be taken for understanding any other kind of epidemic or disease: to thoroughly understand its spread, it must be understood in its full context. Hence, a similar approach will be used for understanding the spread of other STIs: only by understanding the key theories around global health and women’s health, in combination with case studies, will we be able to understand the spread of STIs. This important, as they shape the framework for how we understand the spread of infections and viruses today, and remain a foundation upon which most intervention programmes lie. This literature will therefore touch upon theories of globalisation and gender discrimination; structural violence; women’s health, socio-cultural values and the body; and finally, intersectionality, to create a theoretical framework applicable to this research. How these global theories then relate in particular to the case of STIs, and amongst Dutch university students in particular, will be further explored in the Conceptual Framework (see: ‘3. Conceptual Framework’), and the chapters thereafter. These theories on globalisation, structural violence and intersectionality remain vital for understanding why university students are a risk group. One cannot simply use some of their aspects without understanding the essence of these theories first.

2.1. GLOBALISATION AND GENDER DISCRIMINATION

Globalisation effects the ways through which we perceive gender, both in positive and negative ways. Although globalisation has encouraged women worldwide to join the labour market and to pursue academic careers, it also has put women under economic stress. They are expected to flourish in the workplace, and yet to simultaneously balance a household and a family. Although opportunities for women have increased, so have their obligations. Hence, globalisation’s contribution to gender equality remains questionable. The accumulation of global wealth seems to intensify “the structural, institutional and entrenched patterns” of sexism and racism. Therefore, the cost of globalisation is paid particularly by those residing in countries “histories of racism and sexism powered by an ideology of patriarchy” (both: Bolles, 2002, p. 11), as race and gender are being reinforced as social constructs.

2.2. STRUCTURAL VIOLENCE

“ ‘Sinful’ social structures characterized by poverty and steep grades of social inequality, including racism and gender inequality. Structural violence is violence exerted systematically—that is, indirectly—by everyone who belongs to a certain social order: hence the discomfort these ideas provoke in a moral economy still geared to pinning praise or blame on individual actors. In short, the concept of structural violence is intended to inform the study of the social machinery of oppression. Oppression is a result of many conditions, not the least of which reside in consciousness.” (Farmer, 2004, p. 307)

Being infected with STIs is often not simply a case of ‘uncareful behaviour’. Instead, one’s likelihood of getting an infection, is determined by structures of power that are distributed unequally. Those in an inferior position, experience an elevated risk of infection. The structures that determine such positions, are violent and unequal, and exercised systematically. It is this what Galtung (1969) coined as *structural violence*, or “violence built into the structure [that] shows up as unequal power and consequently as unequal life chances” (p.171), manifested in the imbalance of potential circumstances, and actual circumstances. Hence, “structural violence is structured and structuring. It constricts the agency of its victims” (Farmer, 2004, p. 315).

Medical anthropologist Paul Farmer (2004) applied this specific notion to the HIV epidemic phenomenon, and interrogated how structural violence affected the lives of those living with HIV/AIDS. It appeared that structural violence did not only affect the likelihood of infection, but that it also extended itself to the access to treatment and care. He hereby aimed to challenge the misconception of HIV/AIDS being the infected individual’s fault. What he noted in particular, is that this structural violence manifested itself unequally and affected mainly those who were already in a disadvantaged or marginalized positions, such as those who are impoverished, those who are not hetero-sexual, and even women in general. The instruments of power would affect the bodies of those who are marginalized, in particular. As a result, “the degree to which people can fight back against such infernal machinery—or its symbolic props—has been the subject of much discussion in anthropology”, and so Farmer “seeks to understand how suffering is muted or elided altogether” (Farmer, 2004, p. 307). This extends the problem of structural violence as being exercised through hegemonic practices, fostering the mere acceptance of it.

Farmer (2004) elaborates on this through the following metaphor: “any social project requires construction materials, while the building process is itself inevitably social and thus cultural” (p. 308). The ‘construction materials’ are a symbol for the building blocks that structural violence thrives on. They consist of historical, biological and political factors, the intertwinement of which is often referred to as *intersectionality* (see: ‘2.4 Intersectionality’). Only by understanding these pillars, we can aim to understand the essence of structural violence exercised on a population. For example, it helps us understand not only *why* people are infected, but particularly *how* their risk of infection is increased in the first place, and through what mechanisms. This is valuable, as such knowledge on any kind of

research population could be used in such a way that access to preventative means and healthcare is increased. Similarly, for the current study, by understanding why students are at an elevated risk of contracting STIs, access to information and the effectiveness of campaigns and facilities could be improved. This will be elaborated on in the following chapters.

2.3 SOCIO-CULTURAL VALUES AND THE BODY

Views on women's health and women's bodies can be understood from a framework developed by medical anthropologist Marcia C. Inhorn (2006), which emphasizes the importance of anthropology in understanding global health phenomena, such as women's health. According to Inhorn (2006), majority of research into women's health is done in a biomedical interest, rather than aligning with the voices of women globally. Rather than referring to women's health through biomedicine, medical anthropology would aim to understand it through the perspective of women themselves. In that sense, anthropology, and ethnography in particular, has a better way of capturing and understanding their view on illness and health. She summarizes the purpose of her works as:

“My point here is to suggest that a specifically ethnographic approach to women's health leads to a particular set of insights that are important, timely, and quite different from the women's health research agenda currently being promoted within biomedical and public health circles” (Inhorn, 2006, p. 346)

Hence, Medical Anthropology would have the unique characteristic of being able to identify ‘the priorities of *women* in women's health’, by understanding the social, economic, cultural and political forces (see: ‘2.4. Intersectionality’) that impact these women's health from *their* perspective. Moreover, her work provides a critique on the negative influence of certain institutional practices on women's well-being, particularly when do not adopt such an approach. Yet, besides criticizing, this aims to give an insight for future improvements to be made in the health sector – how can institutional health practices be optimized?

Throughout an extensive meta-analysis of ethnographies on women's health, Inhorn (2006) created a framework for understanding norms and values that applicable worldwide. “Examples taken from this analysis are: (a) that health is influenced by a wide range of socio-cultural aspects; (b) that women worldwide are generally seen as ‘reproducers’, making childbearing their major role in society; (c) the body can be seen as reflection of society and societal values, as “the body itself can be read as a text on which the most fundamental values of a society are inscribed” (Inhorn, 2006, p. 353); (d) bodies can be (politically) controlled through society, as e.g. bodies of different genders or races are not always treated as equal; (e) gender oppression impacts women's health; and (f) discourse plays an important role in understanding the body, for example calling childbirth ‘labour’ implies a certain task and duty for women. It shows how even the smallest norms and values, or even language, can constitute certain

power structures within gender dynamics” (Brunsting and Huijsman, 2017, p. 8). Hence, Inhorn (2006) aims to bring back socio-cultural aspects onto the global health agenda, particularly because the way through which we view the human body and the way we understand its processed, is founded through cultural, political and historical processes.

Referring back to the political control of bodies (d), Inhorn (2006) highlights particularly the ‘health-demoting effects of patriarchy’, by illustrating how gender oppression impacts women’s health through various examples; by touching upon “gender discrimination or gender bias in health care research” (p. 359); and by addressing themes such as neglect, (sexual) violence, *lack of safe sex*, daughter discrimination, and so on (Inhorn, 2006). The focus on discourse and hidden transcripts in this, is of incredible importance. Patriarchal societies, for example, can have a tremendous impact on the lives of women, occurring in the smallest of things, yet with the ability to make women “subject to discriminations, humiliations, exploitations, oppressions, control and violence” (Ray, n.d., 1). Such hidden manifestations of gendered power structures, can impact women’s health to the extent of influencing their rights to health care and decision-making about livelihoods. Moreover, as gender is a social construction, gender-discrimination is socially, structurally and culturally embedded too. This is particularly relevant to women’s health, as “social worlds dictate which social categories of people may touch whom and in what ways” (Henderson, 2011, p. 41), Hence, understanding how socio-cultural norms and values impact the body is key to understanding how culture becomes a vector of behaviour, and how culture can be used to achieve a certain desired behaviour. “A thoughtful consideration of culture moves us beyond the language of the dominant institutions into the understandings that women themselves have about their health-related behaviours, and into a more rounded consideration of the ways in which equity and power are expressed in everyday life” (Moss, 2002, p. 653), and how this can be used and altered to benefit women’s health.

Inhorn’s (2006) framework is used as an inspiration for the questions asked in the current study, particularly for collection of data (see: ‘4. Methods’). Referring back to the quotation in the third paragraph, understanding how a ‘student culture’ influences sexual risk taking, concerns particularly points (a) – when understanding student life as a culture; (c) – referring to the societal values ascribed by students on the body; (d) – the way institutions affect the students’ bodies and their corresponding behaviour; (e) – particularly concerning female students’ access to agency and preventative means in sexual behaviour; and (f) – the discourse used by students to address the body and sex. This will appear further in the literature review (see: ‘3. Conceptual framework’).

2.4. INTERSECTIONALITY: A HOLISTIC VIEW ON WOMEN’S HEALTH

For a long time, biomedicine believed that education and knowledge were enough to alter the behaviour and decisions of the individual. Hereby it argued that individual responsibility was the main cause that stimulated e.g. the HIV/AIDS epidemic, as well as the spread of other STIs, yet completely ignored the

macro-factors under which these personal decisions were influenced. Biomedicine expected behavioural changes to solve the epidemic. However, it failed to understand for example the importance of “social, demographic and health questions of the extent to which (...) women can control or modify their sexual relations with their partners” (Orubuloye, 1993, p. 859). Within relationships, societal pressure and dependency of the female would make it questionable to what extent women actually have agency, and exercise control, over their sexual behaviour (Ulin, 1992). As described before, this might have been further enhanced through globalisation.

Hence, bodies are the “products of history, culture, society and economy” (Taylor, 2007, p. 966). Medical anthropology therefore argues that health concerns are more than solely a problem of the body, and points to the fact that biomedicine alone has so far failed to provide a solution to epidemics, such as HIV/AIDS. It calls for the need to include culture in its prevention programmes, as culture is something omnipresent, and thus also extends to itself to health. However, simply the notion of ‘culture’ being related to health problems, is not enough – the problem with reifying culture as such is that it can be easily manipulated to fit different kinds of agendas, and for example to re-establish unequal power relations that might unjustly label ‘culture’ as a causing factor (Taylor, 2007).

So how does one relate the spread of STIs to culture? Taylor (2007) describes the ongoing battle between epidemiologists and anthropologists in light of HIV/AIDS. For decades, the former understood culture and related behaviour to cause the spread of HIV. Anthropologists, however, aimed to dissect this hopeless notion and to understand whether culture could be an advantage instead. As culture has the ability to influence behaviour, it could be used as a tool for making campaigns and interventions more effective (Inhorn, 2006). Hence, medical anthropology aimed to build a bridge between two opposing parties, and strives to use culture to *prevent* the spread of HIV. Hence, “culture has variously been understood as both the cause of, and solution to, the epidemic” (Taylor, 2007, p. 965). Although the prevalence of HIV in the Netherlands is relatively low, the current study aims to use a similar discourse for understanding the increasing spread of other prevailing STIs, such as chlamydia: by understanding how a ‘student life’ culture fosters the spread of STIs, it aims to contribute to a framework through which intervention can be catered to students particularly.

Inhorn (2006) defines *intersectionality* as the crossroads of forms of oppression of various nature, often “based on gender, race, class, age, nation, religion, sexual orientation, disability or appearance” (p. 361). Hence, she suggests that applying “specifically ethnographic approach to women's health leads to a particular set of insights that are important, timely, and quite different from the women's health research agenda currently being promoted within biomedical and public health circles” (p. 346).

In the current study, this approach is applied to (female) university students in order to understand what forms of oppression and how their intersection has an impact on sexual health, with regards to risk-taking. This is important to note, as “women's health problems often cannot be separated from the larger social, cultural, economic, and political forces that shape and sometimes constrain women’s lives. It examines the macrostructures from patriarchy to globalization to the “structural

violence" of (...) political despotism." (Inhorn, 2006, p. 348). In a nutshell, this is what 'intersectionality' entails: the intertwined network of factors that impact one's health – in this case (female) university students in particular.

Yet how does one apply such structural forces, that occur on the macro-level, to the individual? Moss (2002) uses the example of the 'household': "the locale for the exchange of the resources that are basic to life, *sex*, food, warmth and *emotional* sustenance," which influences behaviour, such as "eating patterns, use of tobacco, *alcohol* and other mood-altering *substances*, and exercise" (p. 655). Although the population under the current study [students] does not engage in the 'households' described by Moss (2002), this approach still remains applicable. Namely, the notion of 'the household' can be applied to university towns, campuses, student-houses and student unions, which make for the average student's experience of a 'household'.

All in all, medical anthropology strives to expand the existing medical frameworks around health issues. Where on the one hand biomedicine explains health concerns through biological interpretations, anthropology strives to understand the same phenomena from the eyes of those whom it concerns, and the societal factors they are exposed to. The role of medical anthropology is then to build a bridge between the two parties, aiming to lead to more effective approaches. In the current study, this applies to understanding the priority of youths' voices on youths' health, instead of the priorities set by medical institutions. What might seem like a minor change in discourse, has the potential to uncover issues on the effectiveness of preventative campaigns, as well as to come up with plausible solutions.

3. CONCEPTUAL FRAMEWORK

3.1. APPLYING INTERSECTIONALITY TO SEXUAL RISK-TAKING

Sexual risk-taking is defined as “the non-use of condoms in either vaginal or anal penetrative sex” (Donovan and McEwan, 1995, p. 320). Yet, definitions as such give little to no understanding of *why* sexual risk-taking occurs. As described before, “higher-risk sexual practices hinge on a complex of factors, including the intersection of normative gender roles and gender power relations with poverty, age and other forms of social difference and inequality” (Shefer et al., p. 118) – an expression of both *intersectionality* and *structural violence*. What the current study aims to find out, is how this applies to university students. What makes the theories and approaches by Inhorn (2006), Bolles (2002), Farmer (2004), Galtung (1969) and Taylor (2007) and others described in the previous chapter so particularly valuable to the current research, is that they identify the factors that must be taken into account for understanding health, and are thus also applicable to university students within the context of sexual risk-taking and the spread of STIs. As one cannot make assumptions about the spread of STIs without understanding the context in which it occurs, this study aims to shed light on that particular context. It aims to uncover the experienced structures of e.g. sexism, gender inequality, cultural constraints and other forms of oppression experienced through the sexual behaviour of university students, as well as educational thresholds. In the quest of aiming to tackle the spread of STIs, first and foremost the societal structure that fosters this must be tackled.

3.2. (FEMALE) UNIVERSITY STUDENTS

As described in the introduction, conversations held with several female sex workers illustrated their concern about another, untargeted risk population – namely, university students. They referred to students’ sexual behaviour as ‘risky’ and touched upon their excessive substance use, as well as their limited agency over the body and their engagement in sex often without consent. According to them, this would make female university students particularly vulnerable (Brunsting and Huijsman, 2017).

Various researches have indeed confirmed that “undergraduate-aged students are a higher risk population for STIs” (Cragg, 2014, p. 3) and that “heterosexual college students do not consistently practice safe sex” (Holland and French, 2012, p. 443). Young people would be a vulnerable population for STIs, and in some countries infection-rates amongst higher educated youth are growing in numbers (de Graaf et al., 2017). Young people are aware of the risks and modes of transmission of STIs, yet “there is little evidence that young heterosexual people have altered substantially their sexual behaviour to avoid infection” (Donovan and McEwan, 1995, p. 319). Hence, it seems as if the gap between what university students know about safe-sex and STI-prevention and the extent to which they practice this,

is growing. This social phenomenon is recognized worldwide, across countries and cultures, and is therefore associated with a certain ‘student culture’ instead. This sub-culture is characterised by several factors that contribute to university students being a risk group, such as having, “multiple sex partners, serial monogamy, and combining drugs and alcohol with sexual activity” (Holland and French, 2012, p. 443), as well as the many uncertainties students face. As a study on a South African campus indicates, although “students were knowledgeable about HIV and had easy access to condoms on campus, a range of factors mediated their capacity to apply this knowledge to safer-sex practices” (Shefer et al., 2012, p. 113).

The following literature review aims to expand the finding of Brunsting and Huijsman (2017) on the sexual risk-taking of university students, with an academic background, and shapes a framework on which further research on university students in the Netherlands has been conducted (see: ‘4. Methods’). This framework provides a list of factors that is associated as to why this group in particular is so at risk of engaging in unsafe sexual behaviour and being infected with STIs, and includes examples from studies conducted in the Netherlands, Nigeria, South Africa, Sweden, the United Kingdom, and the United States to emphasize how it appears to be a worldwide phenomenon.

Norms and values

As any (sub-)culture, the culture of ‘student life’ is characterized by sets of norms and values, about what is accepted and what is not. Such common practices do not dictate one’s behaviour, but certainly do guide it. Hence, to some extent they will also influence the group’s sexual behaviour.

One factor associated with norms and values accepted in student culture, is that having multiple sex partners, being engaged in serial monogamy and having sex without being in a relationship has become widely more accepted. The amount of one night stands, flexible sex partners, multiple sex partners has become more normative. Moreover, students would engage in sex more frequently and have more sex partners than the general population (Shefer et al., 2012; de Graaf et al., 2017). However, simultaneously a ten-year study conducted in Sweden describes that although the number of sexual partners per individual had increased, the rate of “condom use when having sex with a new partner” (Tydén et al., 2011, p. 218) had decreased.

Another factor that is understood to be ‘typical’ of student life is the excessive use of alcohol and/or drugs, and it is mentioned across a wide variety of literature. “Undergraduate students in particular engage in activities, such as binge drinking, that further increases their risk” (Holland and French, 2012, p. 449). Moreover, the average consumption of alcohol and/or drugs is found to be higher amongst students than amongst the general population, and students would often engage in sex under influence (Shefer et al., 2012; de Graaf et al., 2017). “There is a belief that women (especially) and men will have sex more readily when under the influence of alcohol than when sober” (Donovan and Mcewan, 1995, p. 320).

Although drinking is “associated with having casual sex without a condom and having sex with someone known to have many partners” (Donovan and McEwan, 1995, p. 323), it would be too short-sighted to state that alcohol directly reinforces risky sexual behaviour. However, alcohol use does impair some of the elements that might restrain one from engaging in unsafe sex. Hence, alcohol is associated with risky sexual behaviour as its use can influence one’s judgement; particularly feelings of ‘uncontrollability’ would impair students’ ability in decision-making (Shefer et al., 2012; Tydén et al., 2011; Cragg, 2014). For example, one study showed that from those who were under the influence of alcohol during, only 13% of male respondents used a condom, but when sober 57% did. For females, these numbers were respectively 24% and 68%, indicating higher rates of condom use than men, but on average both parties used condoms much less when under the influence of alcohol. Hence, Donovan and McEwan (1995) argue that “alcohol was not perceived as causing risky sex; it was perceived as a social rather than a sexual disinhibitor” (p. 324). Hence, it is implied that that alcohol and/or drug use, as well as the frequent engagement of multiple sex partners, can foster scenarios which might influence the sexual risk-taking of students. *How* this occurs and is experienced by students themselves, will be further elaborated upon through this research (see: ‘5. Findings’).

Condom use

As described above, the sexual behaviour of these students is often characterized by infrequent condom use. Yet, this on its own provides too little understanding as to why students decide (not) to use this preventative means. What makes university students’ condom use so irregular?

One reason could be that preventative measures do not accommodate for the spontaneous nature of sex amongst students (Tydén et al., 2011). As Shefer et al. (2012) describe in their case study, “all of a sudden they’re drunk and they find themselves having sex. (...) How sex happens most of the time, it’s not something that is really planned” (p. 115). Furthermore, as mentioned in the study of de Graaf et al. (2017, p. 3) conducted amongst youths in the Netherlands, condoms are avoided as they would be less ‘comfortable’; “this reason was mentioned more often by males (58%) than females (45%).”

Another reason for not using STI-preventative means would be a much larger concern for unplanned pregnancy than for STIs. In South Africa, for example, “the reputation of having a baby is much bigger than HIV status” (Shefer et al., 2012, p. 117). Similar concerns are raised in European countries, such as the Netherlands where “the most important reason not to use a condom is because other means of anticonception are being used” (de Graaf et al., 2017, p. 3), emphasizing the fear of pregnancy as a result of unsafe sex over the fear of STIs. And so, this is reflected in the precautions students take upon engaging in sex, often stressing the use of other means of anticonception, such as the pill and IUD, over the overall use of a condom (Donovan and McEwan, 1995).

Lastly, one other factor that would limit the use of condoms, would be the idea of faithfulness in long-term relationships, and the use of condoms would suggest the questioning of it (de Graaf et al., 2017; Donovan and McEwan, 1995). In the study of Shefer et al., (2012) students indicated that the use

of condoms with long-term partners is often interpreted as not trusting your partner. Hence, condoms are less frequently used with long-term partners and relationships, than with casual sex partners and one-night stands. ‘Trust’ itself was therefore seen as a preventative method. Vice versa, “individuals in casual relationships have reported more condom use than individuals in monogamous relationships” (Holland and French, 2012, p. 444).

The studies above mention the spontaneity of sex, the discomfort of condom use, the fear for pregnancy over STIs and the dependency on faithfulness as factors that might contribute to infrequent condom use. How this is experienced in the Netherlands amongst a student population in particular, and whether there are underlying reasons to these beliefs, will be explored through the case study (see: ‘5. Findings’).

Agency and consent

Although the above mentioned factors for infrequent condom use are often motivated by personal incentives, this is not always the case. All too often, students are aware of safe sexual behaviour and even want to pursue it – yet, this is not always possible. There exist certain factors that might limit this group in their freedom of choice, their *agency* one might say, over their sexual behaviour and those they engage with. “Vulnerability is understood to be the product of power and inequality” (Taylor, 2007, p. 969) and issues with agency might constitute such vulnerability amongst university students, of which females in particular.

One such vulnerability might be the result of education. Studies worldwide indicate the worrying effects of insufficient education on sexual health and how certain subjects would be under-exposed, such as talking about sex or negotiating during sex (Shefer et al., 2012.). On the other hand, “information is an important aspect of reducing risky sexual behaviour, but it is not sufficient to have a direct and lasting effect on actual safe sex practices, such as condom use” (Holland and French, 2012, p. 443). Nevertheless, it might suggest that when certain subjects in sexual education are under-exposed, this could go hand in hand with a lack of training of skills and thus with how sex is practiced and whether its practiced safely. De Graaf et al. (2017) elaborate on this and describe that despite SRH being taught in high schools, it concerns mainly topics as contraception, reproduction and HIV/AIDS. However, little attention is paid to crossing sexual boundaries, sexual diversities, and sexual pleasure. Hence, Galati (2015) vouches for ‘comprehensive sexuality education’, in other words “accurate, evidence-based, age-appropriate information and education on sexuality and sexual health can improve sexual health knowledge and reduce risky sexual behaviours” (p. 82). It brings to question whether or not young people receive the information they need, and whether or not this is the case for university students in the Netherlands (see: ‘5. Findings’).

Furthermore, another aspect of agency is related to gender dynamics. The extent to which students have agency over their bodies, is often mediated by gendered power relations that limit their ability to exercise safe sex, regardless of their motivation to do so. Female students in particular are

faced with this, and their ability to make decisions about their sexual behaviour should be understood in the context of agency, as “social worlds dictate which social categories of people may touch whom and in what ways” (Henderson, 2011, p. 41). In order to understand how the spread of STIs is fostered through sexual risk behaviour, we must first understand which cultural power-relations foster this sexual behaviour in the first place. “Women’s ability to make decisions about sexuality should be understood in the broader context of their control to make decisions within a patriarchal society. Societal and economic pressure make it questionable to what extent it is in their ability to exercise control over sexual intercourse” (Ulin, 1992 in Huijsman, 2016b, p. 2). The impact of patriarchal societies on the lives of women, can occur in the smallest of things. But ultimately, it can foster patterns of “discriminations, humiliations, exploitations, oppressions, control and violence”, to the extent that “men control women’s production, reproduction and sexuality” (Ray, n.d., p.1). Such patterns can guide sexual behaviour, thereby affecting the health of females in a patriarchal society.

Such gendered power relations reflect themselves in sexual behaviour in various ways. “Difficulties in negotiating condom use, [are] a reflection of gendered power relations” (Shefer et al, 2012, p. 116). For example, condoms would be a male oriented preventative means that might give the male more agency in deciding the use of it, and that buying condoms is a man’s job (Shefer et al., 2012; de Graaf et al., 2017). Furthermore, girls would be obedient to male partners out of fear of rejection, as “most girls will keep quiet because they do not want their man to run away” (Shefer et al., 2012, p.116), and as a result that women would have less of a voice in negating condom use as they “don’t have that strength or that power to initiate condom and negotiate condoms.”

All in all, “gendered power relationships make it difficult for many young heterosexual women to assert safer sex needs” (Donovan and McEwan, 1995, p. 319). How issues of gender in the context of sexual risk-taking are experienced amongst university students in the Netherlands will be touched upon later in this study (see: ‘5. Findings’ and ‘6. Discussion’).

Stigma

Part of the irregularity in which safe sex is practiced, is related to misconceptions, stereotyping and stigmatization associated with the consequences of unsafe sex. Stigmatization occurs in various forms, one of which is stigmatization around STIs. Although the literature touches mainly upon HIV/AIDS, a frequently stigmatized STI, some of these arguments may be extended to other STIs frequent in e.g. countries like the Netherlands. In Southern Africa, for example, many people remain hesitant about HIV testing and disclosure if infected out of fear of “responses of denial, silence, fear and stigma” (Niehaus, 2007, p. 846). The stigmatization of AIDS and its victims sometimes even leads to social isolation and “ideas of physical and moral pollution” (Henderson, 2011, p. 41). Although HIV/AIDS is less of a concern in the context and population of the current study, university students in the Netherlands, such ideas about ‘pollution of the body’ might appear too in the context of frequently occurring STIs in the Netherlands, which will be further explored in the de findings (see: ‘5. Findings’).

Yet, stigma around STIs is not the only shape in which stigma might influence opinions around unsafe sexual behaviour. Stigmas, too, exist around safe sexual behaviour, and sexual activity in general. Shefer (2012) explains that, in Southern Africa, “the normative construction of female sexuality as passive and focused on having a relationship rather than enjoying sex, and therefore denotes the continued repression of positive discourses on female sexual desires” (117), and this would extend itself to the discourse used around sex and the female body. In her study, for example, particularly female students indicated to be ashamed of buying condoms as they fear name-calling. Similarly, in the study conducted by de Graaf et al. (2017) “more than 50% of female participants indicated that buying condoms as a woman, is a call for sex” which leads to believe that stigmas around safe sexual behaviour might also exist in the Netherlands. Whether this is indeed the case, and whether and how stigma affects students’ sexual behaviour, will be explored further in the current study (see: ‘5. Findings’).

Risk denial

Lastly several studies touch upon the severe denial of students, and young people in general, to be at risk of STIs and that this is reflected in their behaviour. “Young people had risky sex because they did not think they were at risk” (Donovan and McEwan, 1995, p. 323). Many heterosexual students, particularly those in relationships, tend to believe that they are not at risk of STIs, and HIV in particular. They might be aware of the risks, but ignore them according to the strong belief that ‘it won’t happen to me’ (Shefer et al., 2012). As a result, those who believe that they are not at risk, are also unlikely to get themselves tested and are often unaware of potential infections (Cragg, 2014). Similarly, in the study of de Graaf et al., (2017), the most common reasons for youths to not test on STIs, were that participants did not believe they were at risk and because they did not show any symptoms. For example, 75% of guys and 66% of girls in a relationship did not get tested upon deciding to quit condom use. Yet, *how* and *why* young people, and students in particular, believe they are not at risk and to what extent that influences their decision-making for during sex, will be further explored through the current study (see: ‘5. Findings’).

All in all, these intersectional factors mentioned above might be manifested through sets of “subcultural practices particular to student life. These include peer pressure to be sexual, the drinking culture on campuses and insecurities amongst many students who live away from home, which may all exacerbate the gender normative behaviours that facilitate higher-risk sexual practices.” (Shefer et al., 2012, p. 118). Whether this, too, is the case for university students in the Netherlands and whether this framework might indeed be applicable universally, will be explored through the next chapters.

3.3 COUNTRY CONTEXT: THE NETHERLANDS

A majority of the following numbers and figures have been taken from the recent study ‘Seks onder je 25e’, translated as ‘sex below your 25th’ by de Graaf et al. (2017): a large-scale study conducted this year in the Netherlands amongst youth below the age of 25, of which students are a sub-group, as well as an accompanying lecture (Studenten en Seks, 2017) and national data taken from the NGO Soa aids (Soa aids, n.d.).

STI prevalence in the Netherlands:

“In the Netherlands around 100,000 people are infected with an STI annually. Chlamydia, herpes, genital warts, gonorrhoea, HIV, syphilis and hepatitis B occur most frequently” (Soa aids, n.d.). Under the age of 25, 75% of guys and 66% of girls in a relationship, decide not to get tested upon deciding to quit condom use; only 18% of girls and 13% of guys has been tested for any STIs in within 12 months after sexual intercourse; and only 6% of girls and 5% of men under 25 who have had sex, has ever been tested for HIV. Most common reasons not to get tested on STIs were that participants did not believe they were at risk of STIs and because they did not show any symptoms (de Graaf et al., 2017)

Overall knowledge on sex in the Netherlands:

“The knowledge about sexuality, reproduction and STIs is mediocre on certain aspects and has decreased as compared to 2012” (de Graaf et al., 2017, p. 3). Moreover, youth are using the internet more as a source of information, yet talk less about the subject with family or friends as compared to 2012. Out of this research conducted on youths (age: 12-25), higher educated youth (students) appeared as one of the major risk groups. As compared to lower educated youths, higher educated youths (i) have sex more frequently; (ii) have more sex partners; (iii) engage more in sex without being ‘in love’ (casual sex partners); (iv) engage in sex under the influence of alcohol and/or other substances more frequently; (v) and although they do get tested more often, they also have higher rates of STIs (de Graaf et al., 2017).

Condom use amongst students:

There has been a reduction in the use of condoms amongst students in the Netherlands over the past 5 years (Studenten en Seks, 2017). Today, 4 out of 10 Dutch youth do not use a condom during one-night stands (de Graaf et al., 2017). On top of that, 40% of female students indicated not to carry around a condom (Studenten en Seks, 2017).

4. METHODOLOGY

4.1. RESEARCH POPULATION AND LOCATION

As the research question of this study aims to understand how the sexual risk-taking of Dutch university students can be explained from a socio-cultural perspective, the research population consists of university students in the Netherlands. As the case study was conducted within the student town Utrecht, it concerned particularly students of Utrecht University (UU) and University College Utrecht (UCU). In total, four UU students and four UCU students were approached, out of which half participated in in-depth interviews and half in a focus group. Moreover, to provide a nuanced perspective, three experts were interviewed from various organisations. These concerned experts within the fields of SRH consultancy and sexology. A brief description of the interviewees and focus group participants can be found below (see: ‘4.2.1. Biography of interviewees’ and ‘4.2.2. Biography of experts’). Lastly, two events were attended as part of participant observation (see: appendix 7), to witness discussions and to understand the public discourse used around sex. These concerned the events ‘Bijspijkeren: échte seksuele voorlichting’ held in Tivoli on the 30th of November 2017; and the workshop ‘Studenten en Seks’ organised by the NGOs *Rutgers* and *Soa aids* and held during the annual national conference *Soa*Hiv*Seks 2017* held on the 1st of December 2017 during World AIDS Day. Details about these events can be found in the appendix (see: appendix 7)

4.2. SAMPLING APPROACH

In order to find interviewees and focus group participants, various methods were used. First of all, students were approached through convenience sampling via the personal network of the researcher, as well as the UCU network. Posters asking for participants were shared through social media, and published on both the personal and public networks via Facebook. This simultaneously created a snowballing effect, as students would ‘tag’ other students or forward the poster. Together with these posters links to online sign-up sheets were sent out, through which students could indicate their interest in an in-depth interview and/or focus group; some background information, such as their age, degree, year of study, relationship status and contact details; and the dates on which they were available. Invitations were sent out and appointments were made.

Secondly, experts were also approached through convenience sampling, however through a direct invitation. First, relevant organisations were looked into, as well as experts working on relevant projects in particular. Subsequently, these experts were then contacted through the e-mail addresses on the organisation’s website, or when this was not visible, via LinkedIn. Appointments were made depending on the availability of the expert.

4.2.1. BIOGRAPHY OF STUDENTS

As the oral consent indicated student interviewees to remain anonymous for privacy reasons, their identities have been allocated a number. These numbers are corresponding with the numbers in the results and discussion (see: '5. Findings' and '6. Discussion & Conclusion') and refer to the transcribed interviews found in the appendix (see: appendix 4-6).

In-depth Interviews (IDIs):

1. Male, 19, Dutch, single. Studies at UCU: Anthropology, Politics and Geography; 2nd year student. Member of campus committee.
2. Female, 21, Dutch and Turkish, single. Studies at UCU: Anthropology, Sociology and Geography; 3rd year student. Member of campus committee.
3. Female, 23, Dutch, single. Studies at UU: Linguistics (MSc); 2nd year student. Member of student sports association.
4. Female, 19, Dutch, dating. Studies at UU: LAS; 1st year student. Member of student sports association.

Focus group discussion (FGD):

5. Female, 20, Czech, single. Studies at UCU: Psychology and Neuroscience; 2nd year student. Not a member of student association.
6. Female, 21, Dutch, single. Currently studies at UU: SUMMA (MSc); 1st year student. Former UCU student. Member of student sports association.
7. Male, 25, Dutch, in relationship. Used to study in Groningen: Marine Biology. Currently studies in Utrecht: BMH; 2nd year student. Used to be member of both student and sports associations in Groningen, and is currently member of student sports association in Utrecht.
8. Female, Dutch, 19, single. Studies at UCU: Psychology and Neuroscience; 1st year student.

4.2.2. BIOGRAPHY OF EXPERTS

As the experts speak on behalf of their affiliation with organisations that have an affinity with the topic of research, as well as through their personal expertise, their identities have remained visible. The transcribed interviews can be found in the appendix.

1. Karin Rebel. Female, Dutch. Formerly HIV Consultant at *UMC*, Utrecht. Currently works part-time at *STI policlinic*, Amsterdam. Has an academic background in Sexuology.
2. Jitske de Vries. Female, Dutch. Formerly worked at LOS, Utrecht. Currently works as Sexual Health Consultant at *Rutgers*. Has an academic background in Psychology.
3. Rik van Lunsen. Male, Dutch. Doctor and Sexologist at *AMC* and *RINO*. Author of the book *Seks!*

4.3. DATA COLLECTION

According to the study of Holland and French (2012) condom behaviour exists of three components (i) *information* and knowledge about safe sex, (ii) *motivation* and the extent to whether one is willing to engage in protective sexual behaviour, and (iii) *behavioural skills* such as the ability to exercise the above. The “model asserts that information is an important aspect of reducing risky sexual behaviour, but it is not sufficient to have a direct and lasting effect on actual safe sex practices, such as condom use” (Holland and French, 2012, p. 443). Hence, it leads to believe that the origin of the problem lies particularly in the latter two components: *motivation* and *behavioural skills*. The current study therefore uses this as a foundation for its inquiry, in combination with the potential factors mentioned in the literature review (see: ‘3. Conceptual Framework’), and hopes to uncover underlying structures of power, gender inequality and access to knowledge. It was used as an inspiration for the framing of the questions within the interviews and focus group.

Four in-depth interviews (IDIs) were conducted with students and three with experts in the field, through a semi-structured approach. Furthermore, one focus group discussions (FGD) was conducted with four students:

In-depth interviews with students

These IDIs lasted for approximately 40 minutes to one hour. Semi-structured interviews with students were gradually built-up due to the sensitivity of the topic (see: ‘4.5. Ethical considerations), by easing into examining the interviewee’s overall familiarity with the topic and by illustrating several facts and figures taken from ‘Seks onder je 25e’ (de Graaf et al., 2017). Subsequently, students were asked to give their opinion about these facts and figures, which was then used as a tool for sliding into a personal conversation. Questions were inspired by the literature, yet were asked in an open-ended fashion as too avoid influencing the answers and left enough space for flexible altering and/or adding of questions throughout the interviews. These interviewing questions can be found in the appendix (see: appendix 1). Both general questions were asked, such as ‘what factors do you think influence sexual-risk taking?’ or ‘how do you think [e.g. alcohol consumption] relates to condom use?’ to bring up sub-topics, as well as probing questions to touch upon personal experiences and opinions, such as ‘what are your experiences with this?’ or ‘you said that [factor mentioned by participant], has that ever happened to you or your friends, and *why*?’ Particularly the latter, probing questions, were most important to the research, as these provided the findings with personal-story telling, case stories and rich data.

In-depth interviews with experts

These IDIs lasted approximately 30 minutes each. Semi-structured interviews with experts were more direct and focussed than with students, due to experts' time limit and availability. The focus of these interviews was particularly on the 'what', the 'who' and the 'why'. Interviews aimed to uncover a professional opinion on the matters raised by students, in order to understand even more why and how these patterns occur. In a nutshell, the following questions were raised: *What* are the main catalysts for risky behaviour amongst students? *Why* is there a gap between what students have learned about SRH and what is actually practiced? *What* are some of the thresholds and obstacles that these experts face when approaching students – which strategies work, and which do not? And for each answer, probing questions such as 'why?' were asked. These interviewing questions can be found in the appendix (see: appendix 2).

Focus group discussions

The FGD consisted of four students and lasted around one hour and 45 minutes. At the beginning of the focus group, notes were handed out on which students could write their associations with HIV. These notes were put away and used later in the conversation. Subsequently, the same facts and figures as during the IDIs were presented, and students were asked to react on these. Then, the research question was explained, upon which the discussion commenced. Notes were handed out, on which students were asked to write down three to five key words of aspects of student life that they associated with risky sexual behaviour. These were then collected and copied onto the blackboard by the researcher. Reoccurring keywords were then discussed. During the discussion probing questions were used to have students share their personal experiences. Later on, students were asked to mention several key words they associated with STIs; these were briefly discussed. Subsequently, the notes on which students wrote their associations with HIV, which is also an STI, were revealed. As these keywords differed quite a bit of those around STIs in general, the discussion resumed (see: appendix 3)

Participant observation

As described before, two relevant events were attended. Upon arriving at the events, the researcher scanned the audience: who is there, how old are they, who did they come with, etc.? During the events, the researcher listened carefully to the topics of discussions, both during the event as well as personal conversations between attendees: what are they talking about? Furthermore, besides the events, the researcher kept an attentive role during any kind of informal conversation with friends and family over the past months, and would note down anything relevant that appeared during such conversations. These overall field notes can be found in the appendix (see: appendix 7).

4.4. DATA ANALYSIS

Each interview was transcribed word-for-word, the relevant sections only, as well as the focus group (see: appendix 4-6). A colour-coding and number-coding system was then created, according to several occurring themes and sub-themes; these were partly inspired by the literature, but mainly by what was addressed during the conversations themselves. This coding system was then applied to the transcriptions, and useful fragments and quotations were labelled accordingly.

These fragments and quotations were then allocated to a separate document, which categorized these according to the themes and sub-themes. Hereby, the researcher could derive the key arguments and illustrate these with case stories. This extensive document was then later translated into the *findings* (see: '5. Findings'). Subsequently links were drawn between these arguments and the literature, providing the foundation for the *discussion* (see: '6. Discussion & conclusion').

4.5. ETHICAL CONSIDERATIONS

Throughout this study, and the collection of its data in particular, several ethical considerations had to be kept in mind. First of all, interviews and FGDs only began after oral and informed consent was given by the interviewees/participants. This consisted of the following items: (i) that the anonymity of the interviewee/participant would be remained throughout the research, and that no one but the researcher would be aware of his/her identity; (ii) that he/she has the right to opt out of the study at any given moment; and (iii) the agreement that the interview would be recorded and only available to the researcher and thesis supervisor.

Secondly, ethical considerations were adopted in regard to the sensitive nature of the subject, as the first and foremost protection of participants stood central to conducting IDIs and FGDs. This included the gradual guiding into the topics of conversation. Furthermore, participants were never forced to answer a question, and were made aware that they could indicate so, if they wished not to answer certain questions. Although probing questions were used for collecting rich data, if the participant would seem to feel uncomfortable or indicate not wanting to answer a certain question, follow-up questions could be asked replacing 'you' with e.g. 'your friends' or 'do you know anyone who...?' However, this hardly happened as the interviewees/participants were very willing to share their stories and opinions.

4.6. LIMITATIONS TO THE STUDY

One limitation to this study, is the presence of the researcher may have affected the outcomes. Namely, as the researcher was depended on her personal network for gathering participants, it may have influenced the answering of IDIs and FGDs, as well as the research population itself. On the positive side, it might have made participants more comfortable and honest about their opinions and sharing their stories. On the other hand, it might have caused for desirable answers. Furthermore, there is a risk that

some participants were quite likeminded with the researcher, particularly for those who share a similar academic background and degree, and who live in familiar circles; and that the researcher had a personal bias as being part of the general population under study: university students. Although the researcher avoided interviews with close friends and mainly approached respondents whom she did not know so well or not at all, and aimed to have a variety of backgrounds in degrees and student associations, there still exists a chance that throughout the process of gathering participants, the study might have failed to represent the full diversity within the student population.

5. FINDINGS

Throughout the conversations with students and experts, it appeared that sexual risk behaviour is not an uncommon subject of conversation. Students seemed to be aware of certain aspects, were familiar with the existing gap between knowledge and practice, and shared their opinions:

“Everyone agrees that when you have sex, you should do so safely. Yet, that doesn’t always happen.”
(3)

“It is striking that higher educated people, also have unsafe sex regularly.” (Karin Rebel, expert 1)

This raises several questions: what creates this gap; why is there a difference between what students know, and what students do; and which factors facilitate such risk behaviour? Eight students were asked for their opinion through four in-depth interviews (IDIs) and one focus group discussion (FGD), as well as the perspectives of three experts on the matter. A series of answers arose and were arranged according to the following main themes: (i) norms and values, (ii) condom use, (iii) agency, (iv) stigma, and (v) denial. These themes were subsequently divided into sub-themes, which will be elaborated upon in the according sections.

5.1 NORMS AND VALUES

According to Jitske de Vries (expert 2) “higher educated youths start having sex at a later age than lower educated youths. But once they do begin with sex, they go pretty wild. You’ll notice that they have multiple sex partners and often engage in sex under influence, which both bring about risks”. Students were asked to describe the characteristics of the student culture in the Netherlands, and subsequently, to relate that to sexual behaviour. What aspects of a ‘typical’ student-culture, as described by students themselves, might lead to risky sexual behaviour? Several sub-themes appeared: having multiple sex partners, peer pressure, experimenting, and the consumption of alcohol and drugs.

5.1.1. MULTIPLE SEX PARTNERS

Students indicated serial monogamy (the sequence of sex partners, not necessarily relationships) and one-night-stands to be a common and accepted practice amongst students. Having multiple sex partners was said to be “socially acceptable” (8); a common practice “seen as normal” (3). During the IDIs the researcher referred to facts and figures from the contextual framework, such as that four out of ten youths do not use a condom during one-night stands, and asked interviewees to respond. Interviewee 3 was not surprised: “When I look at my own circles and my student association at the people who frequently have one-night-stands... I hear stories like that a lot. I actually would’ve thought the percentage to be higher”.

Yet how does having multiple sex partner relate to the actual risk behaviour? Several students indicated how easy it is to forget protection, particularly when switching between long-term sex partners or after a relationship. Those who engage in one-night stands, on the other hand, would be more aware of their risk and make a habit of using protection:

“You would expect that people have safe sex if they know they are at risk. I think it works that way: that those who don’t have sex that often or not with that many different people, when they have a one-night stand sometime, they forget to do it safely. (...) It happened to me as well: I was in two long relationships, but after each relationship I completely forgot to use a condom with the next hook-up, because I hadn’t used one in forever!” (3)

On the other hand, *“if you have one-night-stands a lot and you make it a habit to use a condom, it also becomes normative.” (4)*

5.1.2. PEER PRESSURE

During the IDIs and FGD, a new factor appeared, that had not been mentioned within the conceptual framework, namely that of *peer pressure*. Several students indicated to experience an active sex culture within student life. Being sexually active is encouraged through conversations between students and/or by the discourse used within student associations, and creating certain social expectations and pressure. Moreover, several students touched upon the celebratory discourse around an active sex life and the status that is employed with this. Particularly in the fourth example (6), sexual activity nearly seems to be part of a rite of passage within certain student associations:

Interviewee 3 refers to her former board position at her student sport association: *“one time, our student association was approached by the GGD, because they were shocked by our club magazine (...) and the amount of explicit references to sex.”*

*“You’re **socially expected** to have a lot of sex, especially in fraternities and sororities.” (1)*

*“Well, imagine my rowing club. ‘Did you have sex last night?’ ‘Yep.’ [imitates typical Dutch saying for congratulating someone for having sex]: ‘Aight, lekker gewerkt pik!’ [Gives **highfive**].” (7)*

*“it’s such a **celebratory** thing. It is a thing that is like cement in our culture! You get ‘panda points’ for the amount of days you haven’t had sex, and ‘tiger points’ for the times you’ve had... And for some sororities and fraternities I know that if you want to live in one of their student houses, you have to ‘**earn** your door’: (...) they take out your door and you’ll earn it back once you’ve had sex with someone in your room, or three. There’s so much pressure...” (6)*

The extent to which sexual activity is encouraged, however, does differ per gender. Rik van Lunsen (expert 3) argued that gender notions play an important role within the sexual activity of students. According to him, patterns around sex, within student associations in particular, would be of a traditional character: “within certain student circles exist very traditional gender roles, with females on the receiving end. When a female does take an active approach, she’s often labelled as a **slut**. (...) Within certain student cultures, there is quite some gender inequality.”

Students agree, and indicated that, overall, sexual activity is encouraged, yet male students are expected to have a high sexual activity, which is seen as a status symbol. Girls, on the other hand, are expected to have a moderate sexual activity. Non-adherence to this 'norm', particularly in the case of girls, results into name-calling:

*"There's this whole system with 'panda points', that you get more points which each day that you have sex, and it's seen as something **negative**. Or at least for men: it's seen as if having sex is good, and having a lot of sex is more **masculine** and you have a higher **status** – it's seen as more powerful and more **respectable**. But then for girls it's a whole different story, because there's this whole idea of '**slut shaming**.'" (1)*

*"For guys it's kind of 'cool' to sleep with a lot of girls, whereas girls can't really sleep with a lot of guys, otherwise you're a **slut**." (4)*

The above examples illustrate how peer pressure encourages sexual activity. However, does it also stimulate unsafe sex? One expert assumed that it might, and that particularly amongst girls a peer pressured culture of performance and a self-image based on the (imagined) perception of others, might be affecting their sexual behaviour:

"Within certain student associations girls have the feeling that they are supposed to be sexually active. On top of that, higher educated white females have the feeling that they are supposed to be good at everything. This includes sex. That means that they often also listen too little to their own feelings: what is my opinion, what do I want, what are my desires? These high educated ambitious women suffer from something we call an 'external locus of control'; they derive their self-image from what they believe others think and desire of them. Hence, they are continuously occupied, also sexually, with fulfilling the expectations of others. (...) I think that might be the reason that a lot of higher educated women experience issues with unsafe sex." (Rik van Lunsen, expert 3).

5.1.3. EXPERIMENTING

Three students mentioned 'experimenting' as a character trait of student life, implying a time of exploration and of trying out new things. They were then asked how this relates to sexual risk-taking. Students responded that this was partly related to the exploration of 'new things', overall sexual development, as well as a sense of carelessness: "not really thinking about the future; which might mean not using protection or not getting tested a lot" (2). On top of that, one student emphasized that "the Dutch are really proud of being these free folks. I think that also makes a difference" (7).

5.1.4. ALCOHOL AND DRUGS

The consumption of alcohol and drugs was an aspect mentioned by all students and experts as a predominant trait of student culture. This is particularly because the highest proportion of alcohol and drugs consumption of the entire Dutch population is amongst students (Jitske de Vries, expert 2). "Often alcohol is a big part of student life, at least in the Netherlands, and a lot of things are accompanied with 'borrels' and drinking beer" (1).

Rik van Lunsen (expert 3) described how this might affect the sexual behaviour of “higher educated youths: they start having sex relatively late and during a period in which they have also just begun their student lives. Often, these two coincide: the control on wishes and boundaries thereby becomes limited by alcohol and substance use.” Students, too, understood the consumption of mainly alcohol to influence their sexual activity:

“When I would talk to my friends about the first time they had sex, it would always include alcohol, to take the edge off. In general, when you party, alcohol kind of blurs your borders a bit and it makes it a lot easier to do things you normally wouldn’t do.” (6)

“We went for a drink, then we went home for more drinks, and then we kissed and then... I think that if wouldn’t have drunk this much during our first date, we wouldn’t have kissed, and we wouldn’t have had sex with each other. At least, not during our first date.” (4)

During the FGD a discussion arises: *“it’s certain visions and ideas that people have when getting drunk or using drugs – like getting laid” (5). “But isn’t the problem then, and correct me if I’m wrong, that people feel like they need to use alcohol/drugs in order to achieve their desires?” (7)*

“I think that when you’re drunk, you give in to pressure a lot easier. (...) I think that guys make use of that.” (4)

The above examples illustrate how alcohol consumption can foster scenarios that lead to increased sexual activity. In a nutshell, one is more likely to have sex under influence of alcohol than when sober. Yet how does this relate to the actual risk-taking? Expert (2) Jitske de Vries described that students’ “ratio fades”, particularly in the moment and under the influence of alcohol. “Even though students have the knowledge and the intentions to have safe sex, you’ll see that these are thrown overboard in the *heat of the moment*. It fits with the lifestyle of most students, particularly when they become a member of a student association, go out a lot, hang out in bars a lot, go to a lot of festivals... Those are all settings in which alcohol and drug use are prevalent; these increase the risks.” How do students experience this increased risk-taking as a result of the consumption of alcohol and/or drugs?

“I think that if you would ask anyone when they’re in a sober state of mind they obviously know they need to use a condom, but I think that in the moment they might forget or they might not have one. I think that adds onto it: it might not be something they think about immediately.” (1)

“I am stupid when I’m drunk though. I don’t know for how long I would be able to keep up the façade of no condom no sex. I’m pretty confident that I’d try to keep it up for a few minutes or so, but I bet I’d give in quicker [than when sober].” (7)

“You have sex a lot quicker [than when sober]. You also have unsafe sex a lot quicker – you’re just not really engaged with that, in that moment. (...) The moment you’re intoxicated, you don’t really think about the consequences, you have less thresholds, you’re acting ‘in the moment’. I recognize this in myself too.” (3)

“I also think intoxication plays a role. It blurs the boundaries of your agency and ability to express yourself, especially in a culture where people engage in sex often.” (1)

Two FGD participants discussed how alcohol also tends to be used as an excuse for sex, and as a means of justification. The following examples give an insight on social norms and expectations concerning sexual behaviour when intoxicated versus when sober:

*“Also, in my environment, alcohol is often used as an excuse. Like, ‘yea I did some stupid things, but I was really drunk’. And then it’s suddenly **socially acceptable**? They use it as an excuse to explain their actions.” (6)*

*“I think it’s also part of a social **stigma**. When you’re drunk it’s **normal** to have sex with a stranger, but when you’re sober suddenly everyone’s like ‘why did you do that?’ Or when you forgot to use a condom when you were drunk, people will say: ‘that’s not very smart, but oh well, you were drunk’, whereas when you’re sober, you’d be called ‘really stupid’.” (8)*

5.2. CONDOM USE

During the workshop ‘Studenten en Seks’ (2017) at the national congress for STIs, HIV and sexuality, expert Suzanne Meijer raised the question: “how many students do not use a condom during one-night-stands? A. 19%, B. 31% or C. 46%” The correct answer is 46% and the audience is surprised – some gasp in awe. They wonder why this percentage is this high.

Other than the norms and values described in the previous section, students were asked to describe factors they associate with the (non-)use of condoms. What are some of the obstacles they experience, when it comes to engaging in safe sex? And how do they experience their sexual well-being? Several sub-themes appeared: the spontaneous nature of sex; the discomfort of wearing condoms; the breaking of the mood; the elevated concern of pregnancy over STIs; faithfulness and trust; and barriers when getting tested.

5.2.1. THE SPONTANEOUS NATURE OF SEX

“Sex usually isn’t something that is planned beforehand; this makes condom use difficult.” (Karin Rebel, expert 1). Students confirmed that, indeed, sex often occurs unplanned, and comes with being unprepared. Students expressed how they would forget to wear a condom or didn’t have one on them at all, and shared their personal experiences:

Interviewee 3 responds to her first time having sex, which was without a condom: “you’re not really that concentrated on what is happening – it just happens. It wasn’t really a conscious decision.” “Did you ever forget a condom after this first time?” “Yes, quite regularly, actually.” (3)

“With some guys I didn’t use a condom with, it was because we didn’t happen to have a condom, but we wanted to have sex... I know it’s not smart, but sometimes it just happens.” (4)

5.2.2. ‘CONDOMS ARE UNCOMFORTABLE’

Students strongly associated the use of condoms with discomfort. Using a condom would be less “intimate” and “sensual” (1). Several students indicated that they, or their partner, experience sex to be

nicer ‘without’ and identify the use of the condom as a ‘burden’. This discomfort is expressed mostly by guys.

*“I’ve heard friends say stuff like ‘I have to use a condom because she wants it’. (...) I think it’s still seen as a **burden**.” (2)*

“It’s much nicer without a condom.” (4)

“Often the other person brings up things like ‘I don’t feel anything with a condom’ or ‘I don’t like the feeling of a condom’. You have to be quite strong to still convince someone to use one.” (Karin Rebel, expert 1)

This student, however, plays the devil’s advocate, and argues the opposite: *“but then again, if a girl doesn’t feel the need to use a condom, it might be more difficult for a guy to take the initiative to use one, if he does want to use one. Because it’s **socially expected** that he doesn’t want to use a condom. (...) That must also be quite tricky, if society pushes you into the role of not wanting to use a condom.” (3)*

This last comment touches upon societal expectations, pressuring guys to take on the role of disapproving of condom use, regardless of their true opinions. Hence, experts indicated that there might be more to the phrase ‘it doesn’t feel good’. Rather, it would be related to a performance-driven sex culture, in which the dismissal of condoms would be based on fear (Jitske de Vries, expert 2):

*“Guys tend to say that they don’t want to use a condom, because it’s more comfortable without. In reality, it’s just an excuse: they are **scared** that they might lose their erection when they put on a condom, which, in the end, comes down to a lack of practice or training with a condom. If you use it frequently, you won’t **fear** it and your erection will be just fine.” (Rik van Lunsen, expert 3)*

Moreover, this would be emphasized even more through the use of alcohol, as *“it diminishes your sexual performance. Guys, particularly when their erection isn’t too stable, will then avoid the use of a condom even more. Because that is what they are most **afraid** of: that they will **fail** because they lose their erection.” (Rik van Lunsen, expert 3)*

5.2.3. ‘CONDOMS RUIN THE MOMENT’

As sex is an intimate and sensual activity, students expressed their fear of ‘ruining the moment’ when negotiating for and/or putting on a condom. Students express experiences in which this question or act was, hence, avoided:

One interviewee tells the story of a friend who did not use a condom during sex: *“they were just in the moment and wanted to have sex, and didn’t want to break this moment. And I get it, you know, you’re having fun and then all of a sudden you’re like ‘first of all...you know, STDs...’ It’s an annoying position to be in. I could see why someone would decide to skip that.” (2)*

“In my house we used to have a communal box of condoms in the kitchen. But I lived on the first floor, and I’d have to walk all the way down to the kitchen to grab one... So I didn’t.” (7)

5.2.4. UNPLANNED PREGNANCY

When it comes to experiences of unprotected sex, students tend to express their fear of unwanted pregnancy over contracting STIs. Moreover, there is a strong association with the word ‘protection’ and birth-control, rather than with STI-prevention. For example, after having unprotected sex, most female students indicated their immediate response to be taking “just a morning-after pill” (2), yet neglected the chances of STI infections:

“My friends were telling me about this, twice during intro week actually, that they had to get the morning after pill, because they had sex without a condom and they feared being pregnant.” (1)

*“The responsibility of bringing condoms is often put with the other half. (...) Girls often seem to take more responsibility in preventing pregnancy, so they take the pill and think they’ve pulled their weight – and to have covered their **biggest fear**. As a result, the responsibility of bringing a condom is left with the guy.” (Jitske de Vries, expert 2)*

This perception of a pregnancy scare over an STI scare appears to be a pattern. During the workshop ‘Studenten en Seks’ (2017) Suzanne Meijer explained how the risk perception of students has changed. When referring to safe sex, students tend to refer to contraceptive means, mainly the pill and IUD, above STI-preventative means. It seems as if the concern about pregnancy is higher than with STIs. Hence, students’ focus currently lies more on avoiding pregnancy than on avoiding STIs. In fact, the most common reasons for students not to use a condom is because of the use of another preventative means (pill, IUD), even if that just prevents pregnancy and not STIs.

5.2.5. RESPONSIBILITY

Between the lines, several students indicated gender to play a role in the responsibility of procuring condoms. Relating to the above arguments, one student explained how most of her friends are under the impression that “it’s the man’s duty to bring the condoms. I don’t fully disagree with them: because women already take care of birth control, IUD, and so on. I feel like the men can also take some responsibility in providing condoms” (2). This notion of the provision of condoms being ‘the man’s job’, was repeated several times by other students:

*“I think there’s still the idea that **the male is the actor** within sexual conduct or behaviour. Whilst women are still somewhat seen as **passive**. Also with flirting; people still expect the man to be the one to take initiative and the woman has to wait. But also with putting a condom on, it’s kind of **‘the man’s job’**. (...) Of course, it’s two people having sex, and it concerns both the guy and the girl, so it’s a mutual thing. But it’s still expected that the guy brings the condom, and it enforces a stereotype: the man being the actor.” (1)*

“I expect all guys to always carry around a condom (although that doesn’t always happen). I expect that if you’re going to have sex with someone, the guy will have brought a condom. Particularly if you go home with someone, I expect that person to have condoms at least somewhere. And if he goes home with you, I expect him to bring at least one or two. I expect guys to be attentive of this. It doesn’t always happen, but I would find it normal if it did.” (4)

A combination between the notion of the male being the ‘actor’ in the procuring of condoms as well as peer pressure (see: ‘5.1.2. Peer pressure’), might be reflected in the negotiation of whether or not students will engage in safe sex. Students indicate that often, this decision lies with the guy and that the male counterpart might have a slightly have a bigger say in this than the female. Hence, several students are irritated with idea that girls “are not expected to take the initiative” (3), thereby becoming somewhat dependent on the willingness of the guy:

“I remember one friend who didn’t use a condom, because the other person [guy] did not want to use it; which frustrates me so much, and makes me so angry. Because I don’t think you should be allowed to take risks. (...) If somebody tells you that he/she wants to use it... That person shouldn’t have to justify themselves for wanting to use a condom.(...). But after someone tells you that it’s about safety and health, I feel like the conversation should end there, that should be enough.” (2)

“He was too lazy to grab them. First, he actually said that he didn’t have them, so I told him I didn’t want to have sex. Then he suddenly said that he did have them... [sounds annoyed]. I mean, what the fuck? So I was like ‘well, grab them!’. ‘No, I’m too lazy to grab them,’ he said and that went on for I while. I told him I didn’t want it [sex] anymore, and then I left. (...) Not even because I was really wanting to use a condom, but because he was lying and being so difficult about it.” (4)

5.2.6. GETTING TESTED

Students indicated that often with a long-term sex partner or relationship comes the decision not to use a condom anymore. However, upon that decision, some students admitted, they and their partners did not get tested. Karin Rebel (expert 1), recognized this pattern. “We often come across things like ‘oh, but I’ve been tested recently’, and then you let yourself be convinced a little. Or you know someone’s reputation and you assume it’ll be alright.” Furthermore, students indicated that, overall, they and their peers are not that preoccupied with the topic of STIs. For many, getting tested frequently is not a habit. Furthermore, they experienced multiple barriers for getting tested:

“I’ve actually never been tested. (...) And when I look at my friends, hardly anyone’s ever been tested. (...) I do think about it, sometimes. After the first time having sex without a condom with someone, I ask myself ‘was that really smart [name]?’ (...) I think about it, but I don’t act on it. That’s pretty skewed.” (4)

“Often, my friends say things like ‘I should really do an STD test’ or ‘I should really go to the GGD’. Okay, so make an appointment, go do it. And then 5 months later they still haven’t done it.” (6)

One student, who has a Dutch and Turkish nationality, notices something peculiar about the Dutch along these lines. “Back home, in Turkey people might be taking more risks and stuff. But all my friends get tested more regularly. Right here [Netherlands], however, I feel like that is not the case. I feel like, here, getting a pap smear regularly or going to the gynaecologist is not really a thing” (2). As for those students who do get themselves checked once in a while, they were asked to share their experiences. How do

they feel when getting tested? It appears that students strongly experience feelings of shame and discomfort upon exposing their sexual activity, and unsafe sex in particular:

*"I didn't feel at ease. (...)I very much had a feeling of 'you did something **wrong** and now we have to solve it.' (...) Normally I talk about sex very openly, but not to healthcare workers, because they are there to reduce unsafe sex...and then you get there, as if you have **sinned**." (3)*

*"A lot of people feel a little bit **ashamed**." (Karin Rebel, expert 1)*

5.3. AGENCY

The way we practice sex might be related to our agency over it, which touches upon issues of access to knowledge. What we know, and what we have been taught, might affect the decisions we make regarding sex. What kind of information about sex is distributed, and is this information distributed equally? How do we engage with such information, and how do we communicate about sex and sexual well-being? Throughout the conversations with students and experts several sub-themes arose, such as: assertiveness, insufficient education and communication, lack of interest, unawareness and misconceptions, and the role of the media. Agency also touches upon issues of equality: do we all have an equal say in how we practice sex, and whether or not we do it safely? Another important sub-theme arose, namely the role of gender in sexual activity and sexual risk-taking, and potentially, underlying structures of gendered power relations.

5.3.1. ASSERTIVENESS

Assertiveness, and the means to express oneself, was a factor brought up by three experts. Karin Rebel (expert 1), for example, believes it is a "development skill" – something you learn through practice. Furthermore, during his lecture, Rik van Lunsen (2017) explained how two of the key elements to an enjoyable and healthy sex life are autonomy and communication. Students would experience difficulties with both:

*"It asks a lot of your assertiveness: when do you start talking about a condom? When do you grab it from your pocket, or do you do that beforehand? And how do you time it? You need to be quite assertive for that, which is difficult for some people, and girls in particular. I do think it's more difficult for girls to be assertive than guys." "Why?" "Because girls sometimes tend to let themselves be **overruled**, by guys." (Karin Rebel, expert 1)*

"In general, people feel extremely uncomfortable with presenting their wishes and their boundaries." (Jitske de Vries, expert 1)

5.3.2. INSUFFICIENT KNOWLEDGE AND EDUCATION ABOUT SEXUAL HEALTH AND WELL-BEING

In the Netherlands, sexual education is often taught briefly in high school, and during one the first years. There exists a strong assumption that higher educated youths are aware of sexual health and well-being,

and the means to achieve this. Hence, it would be a common assumption that these students need no further education (Jitske de Vries, expert 2). Expert Suzanne Meijer explains that for a long time, the focus on sexual education was directed towards low-educated youth, as it was assumed that higher educated youths were aware of their sexual health. However, thereby “we may have forgotten about students entirely, and now they appear to have become an apparent risk group instead.” (Studenten en Seks, 2017). Other experts agree. During the discussion ‘Studenten en Seks’ (2017) one teacher explains that “at my school, teachers expect higher educated pupils to be aware and understand these things.” He thinks this is a misconception and that more attention should be paid to these students. Rik van Lunsen (expert 3) adds on to this: “‘oh, they know’ is what is commonly thought. The opposite is true! I always tell first year students [*puts on a humorous voice*]: ‘regarding sexuality, you guys are the stupidest of the Netherlands. You have the highest chlamydia percentages, you have the most unwanted pregnancies, you guys are idiots!’ [*laughs*]. And that’s when we start talking.”

These misapprehensions concerning the knowledge of higher educated youths on sexual health and well-being, are reflected in students’ experiences. Several, but not all, students indicate to have had some sexual education at the start of their high school career. However, this has not been repeated or added onto ever since. Moreover, the study ‘Seks onder je 25e’ indicated that over the past years, knowledge on safe sex has decreased (de Graaf et al., 2017). How come?

“I don’t really remember having sexual education in school. I vaguely remember that I had to put a condom on something at some point... I think I learned more from the internet than from school. (...) I don’t think I ever had a refresher course.” (3)

*“I never had it! Because I did TTO [*bilingual track in high school*].” (6)*

“I think they should impose these things later. Because I was 13 when someone showed me how to use a condom. But I hadn’t even had my first kiss yet, so I was definitely not interested in knowing what to do with condoms. And when I actually could use that information, it was already like 7 years ago since someone had last showed me, and since then no one had ever talked about it anymore...” (8)

One of the experts seems surprised and frustrated with these examples, and responds that “I thought there would be more [*sounds surprised*], this is quite little indeed. Because fun teaching programs and means are available, but apparently that is not being introduced everywhere” (Karin Rebel, expert 1). Furthermore, according to the students, the current education on sexual health adopts a discourse that centres around danger and threats. It is propagating warnings instead of stimulating safe sexual behaviour. These students highlight elements in sexual health education that seem to be missing in the current schooling system, and that they consider as important:

*“In my high school, it was all very factual. There was nothing about emotions, nothing about sexuality, nothing about different orientations. It’s was all about safety. So I guess the main message that they wanted to propagate was ‘be safe, be careful and use a condom’. We had entire presentations about chlamydia and hepatitis and whatnot. But it was never about **consent**; it was never about **different orientations**. I think that should change.” (1)*

*“The other day I was talking about sexual behaviour with a friend, and she said that for many people it’s not really articulated as much in school. It’s more about ‘be safe’ instead of having a conversation about sex, and sexuality, and enjoying it. **Just the dangers are emphasized.** And parents are usually not really open to talk about it either; they talk about it as a safety thing, but not really as something personal, and something about you and the person you’re doing it with.” (2)*

Experts indicate that the difficulty with sexual education lies in the risk of it becoming something “patronizing” (Karin Rebel, 1), and recognize these fear-based patterns as well. Rik van Lunsen agrees. During his lecture (van Lunsen, 2017), he mentions that “during the sexual education taught to us in high school, we are mainly taught how to say no.” When asking his audience what they remember from their sexual education back in high school, most responses focus on negative aspects of sex: disease, unwanted pregnancy, harassment or no sex at all. None of the audience members mention any positive aspects that were taught to them. Rik responds with the slogan, ‘me and my sexuality are mine!’ and adds that “rather than learning how to say no to things, we should learn to explore what it takes and what is needed to say yes to things” (van Lunsen, 2017). On top of that, sexual education would also be coloured by gender discrimination:

*“Education is often focussed around the **dangers**, the negative aspects of sex. ‘Don’t get pregnant’, ‘don’t get an STI’; all illustrated with scary pictures of STI symptoms. It catches your attention, but it doesn’t present the right message. (...) Moreover, there’s also very little focus on **pleasure** in sex; the wishes, how you have **enjoyable** sex, and what the preconditions for pleasant sex are. Within sexual education you also hear more about the sexual pleasure of guys than girls, which is a big flaw in the education system. Often we’re taught that during puberty “guys have their first erection and ejaculation”, whilst “girls, they menstruate”... but those are two completely different things! With both genders something changes, but it implies that when guys grow up something around ‘sexual pleasure’ starts, whilst the same moment for girls is marked with something that is not at all that pleasant.” (Jitske de Vries, expert 2)*

5.3.3. SAFE SEX AND THE MEDIA

Several students brought up the role of (social) media, which was not included within the interview questions. Besides our schooling and conversations with parents and friends, the media was said to have an important educational role and contributes to the shaping of our norms, including norms of sexuality. For example, the use of condoms is usually not addressed in popular series or movies, unless when “brought up as a joke” (2). Yet avoiding important topics as such, could impact our interpretation of what sexual behaviour is ought to be like:

“In the media, sex is portrayed as a very spontaneous thing (...). The media rarely portrays someone putting on a condom. And I think you might internalize that message and start viewing condoms as something that ‘kills the mood’, or make it less sensual. And so, you might feel more uncomfortable or awkward bringing it up, because it’s seen as something very factual (...) and emotionless.” (1)

Moreover, Rik van Lunsen (2017) describes during his lecture that the topic of sex in the news is often published according to its negative aspects; we hear things about ‘breezer sluts’, ‘lover boys’, sexting

and teenage pregnancy in the news. Yet, the positive aspects of sex remain underexposed. This would also influence policy makers and other stakeholders. As a result, they would often focus on the negative rather than the positive approach. What aspects do such messages have on our sexual behaviour?

*“I think it makes people uncomfortable and anxious, and that it implies that ‘to some extent’ sex is something ‘bad’. (...) And that sex is something **dangerous**. Particularly if you look at this history of the portrayal of sexual lust of the female, it was represented as something dangerous” (Rik van Lunsen, expert 3). Notions on gender will be discussed later in this chapter.*

5.3.4. INSUFFICIENT COMMUNICATION ABOUT SEXUAL HEALTH AND WELL-BEING WITH FRIENDS AND FAMILY

During his lecture, expert Rik van Lunsen (2017) explained how good communication is key to a good, healthy and enjoyable sex life. Furthermore, informal conversations with friends and family about sexuality are, too, an important source for information. However, during the interviews and focus group, it appeared that students do not talk sexuality that often. For example, barely any of the students felt comfortable discussing the topic of sex with their families. “We never talk about sex with my family” (4). Instead, students would talk to their friends about sex. However, within such conversations sexual health and well-being would not be a topic of discussion:

“I talk a lot about sex with my friends, but we never ask someone whether they had safe sex. It’s not something that is on our minds.” (3)

“I think that barely any students are concerned with their sexual health.” (4)

*“We do discuss certain things, but very little about sexual health and safety etc. I think that if we would discuss things more, there would be less **stigma** around e.g. STIs. And I think that if we would discuss things more openly with each other, there would be less of a need for Facebook pages like ‘UCU Confessions’, where people post questions anonymously – though it’s often kind of jokingly.” (1) The sub-theme of ‘stigma’ will be discussed later in this chapter.*

Tying back to the previous topic of knowledge, during the student panel of ‘Studenten en Seks’ (2017), several indicated that the things taught to them in high school were very matter of fact, but that they did not learn how to communicate to one another about sex. “Talking about sex is still a taboo, and that makes it difficult and uncomfortable to talk about.” As a result, and tying in with the topics of education, assertiveness and communication, Rik van Lunsen (2017) adds that “men and women do want to communicate with each other, but they have never been taught how to do so.”

Furthermore, upon asking Rik van Lunsen (expert 3) why he hosted his event and whether there was a need to do so, he responds: “considering the interest in this event [it was fully packed], I think it’s clear that young adults feel the need for a grown-up conversation about sex, and not the child-like sexual education they’ve had in school.” Yet, why have we not learned to talk about sex in school or with our families and friends? What keeps us from doing so?

*“Because it’s not **normal**, because sexuality is surrounded by feelings of **shame**. For a long time, it’s been said that sex is something for ‘after marriage’, therefore you don’t talk about it, and so you don’t learn to talk about it either. (...) In the end, it’s about making it more normal to talk about these subjects. (...) It’s about creating a climate in which sexuality is a normal topic of discussion, anywhere. Because the biggest problem we face now, is that there’s a lot of **silence** around sexuality, also within relationships, people hold their tongues about sexuality. And if there is one source of sexual problems, it is a lack of communication.” (Rik van Lunsen, expert 3)*

Hence, subsequently, the students were asked *why* sexual health and well-being were not addressed when talking about sex among friends. They touched upon the uninteresting nature of the topic. It would not be “the most exciting” (3) or “the most interesting part to discuss when talking about sex” (1).

5.3.5. ACCESS

Another new item arose, namely that students indicated to struggle with finding information about sexual health facilities online. The information available, would be confusing and messy. Several students indicated not to be able to find the information they were looking and criticized the information spread by these institutions. “I have no idea. I don’t know where the nearest [testing service] is” (1), are common remarks. The same student indicated that “it would be nice if they laid down all the information simple language, or had a subsection or page for our age group specifically”, seeming unaware of existing websites, such as *sense.info*, that cater specifically for this request. Furthermore, students touched upon of discrepancies between what friends say and what is said online, resulting in confusion:

“One says that tests are expensive, the other says they’re free. It’s unclear how quickly there’s a spot available, and whether that is free, or only if you belong to a certain risk group. And when are you part of a risk group? And which things should I indicate? (...) I thought the online information was very unclear and confusing.” (3)

Other students indicated a series of structural thresholds limiting their access of testing facilities, often related to their financial and physical accessibility. They mention the typical ‘hassle’ to go there, to make an appointment, the lack of space, issues with insurances, the inaccessibility of available information, having to call back, and additional costs:

*“One time, when I was at my GP’s to have my IUD taken out, I asked her if she could also do an STI test. She looked at me and said it looked fine down there – so I asked her again. She told me I would have to make a new **appointment**... [annoyed] Come on, it really takes just a minute to get a swipe!” (4).* This student touches upon bureaucratic obstacles.

*“Going to the GGD is always free, but they have quite a long **waiting list**, I think. But making an appointment with a GP often isn’t covered by your **insurance**; at least, not in cheap student insurances.” (6)*

Moreover, due to a change in health laws in the Netherlands, free STI tests are no longer available to those above the age of 25. One student, who had just turned 26, experienced this as impactful. He noticed that for him and those around him, money has hereby become an obstacle for getting tested – particularly

to those who are still studying: “Students above the age of 25 get tested less because of this” (Studenten en Seks, 2017).

5.4. STIGMA

During the IDIs and FGD both students and experts addressed certain issues of stigma around safe sex, the use of condoms and STIs. These stigmas were expressed through the following sub-themes: embarrassment when procuring condoms and when using condoms; stigma and negativity around STIs; discomfort around the subject of STIs.

5.4.1. EMBARRASSMENT

Upon buying condoms, students indicate not to feel at ease. Although this does not keep them from buying the condoms, it does affect their experience of doing so. Particularly feelings of awkwardness and exposure are emphasized; students have difficulty with publicly displaying their sexual activity. The students and experts were asked to reflect on this:

*“They might think it’s **awkward**. It’s like a **visibility** of being sexual in public.” (1)*

*“She [mother] doesn’t like the idea of people knowing what she’s doing. But still, I feel like that is part of the problem: acting like sex is something you can’t talk about. I know it’s private, but still... I mean, you’re not **ashamed** of buying something like toothpaste. And I think that buying condoms should be as easy as buying toothpaste or tampons. You’re not ashamed of buying those either, not should you be about buying condoms.” (2)*

*“Apparently this indicates that you’re supposed to be **ashamed** of what somebody else thinks of the fact that you are sexually active (...). I think we are living in a **culture of shaming**.” (Rik van Lunsen, expert 3)*

Students indicated that part of the problem with buying condoms, is that they are placed most “visibly on the counters in drugstores” (4). The following examples illustrate how condoms are put on a pedestal as, seemingly, seen as something to be exposed. As a result, some students indicated to feel more comfortable when buying condoms anonymous.

*“Last time, they put the condoms behind the counter, and so I asked cashier for a pack of condoms. ‘What?’, the old lady said. I repeated it. She didn’t hear me again. So, I repeated it again: “**CONDOMS!**” Subsequently the entire line of customers is **frowning** at me and the old lady gets me the wrong pack of condoms [irritated]. (...) It’s quite strange if you think about it, when someone orders a medicine at the counter, it’s ordinary; when someone buys condoms, people look up.” (4)*

*“There’s also places where it’s **anonymous**. Like here at UCU, the vending machines used to have them.” “So because it’s anonymous, these vending machines make buying condoms more accessible?” “Yes, because there is not interaction with another person” (1). Interviewee 7 adds on to this: “And there’s no **shame** in buying them, because you don’t have the pressure. It’s anonymous. (...) And that’s why most people order their condoms on Bol.com! [online].”*

Similarly, in the workshop ‘Studenten en seks’ (2017) the topic of awkwardness around buying condoms is addressed, and the audience and student panel think of ways to make buying condoms less awkward. Indeed, promoting the online purchasing of condoms is one of the solutions they come up with. Nevertheless, this could perpetuate the idea that procuring condoms is something to be done anonymously.

5.4.2. STIS: AN UNCOMFORTABLE SUBJECT

Students give examples of rumours or jokes made around STIs. They also said to rarely talk about STIs, and thought that if their friends might have had an STI, they might not have told them. STIs would be an uncomfortable subject, that tends to be “laughed away” (7), rather than actually being talked about. The following examples imply that students find it difficult to talk about STIs and/or tend to laugh it away. Particularly, the tendency to avoid the subject or to joke about it, would make it more difficult for students to openly talk about STIs:

*“I don’t think any of my friends has had an STI, but we also don’t really talk about it. Sometimes **jokes** are made about STIs.” (4)*

“I don’t know a person who has it. But also in this world, I’d understand it if someone who’d have it might not share this, before knowing how I would react... I wouldn’t be surprised if someone had it and wouldn’t tell me.” (2)

*“Well, I had a bit of an STD **scare** once. In the Netherlands you have this system, so they send you a text or an e-mail that’s anonymous. One of your old partners can give up your e-mail or phone number, and if he/she gets tested and it’s positive, they send you an e-mail and you get a free STD test [explains that he got one of those, but not sure of whom and of how long ago]. (...) it scared me, because I might’ve had chlamydia for years, and I might’ve infected my girlfriend, etc. How the fuck am I going to explain that to my girlfriend, because it’s anonymous. It turned out I wasn’t [positive], but yeah... **I can imagine that if it’s such a scare, it also sucks to have it.**” (7)*

5.4.3. STIGMA AND NEGATIVITY AROUND STIS

Related to the awkwardness around the procuring of condoms and the exposure of sexual activity, as well as the difficulty of addressing the topic and the joking around STIS, are existing stigmas around STIs. Themes as promiscuity were mentioned, as well as a negative discourse around the association between STIs and ‘dirtiness’:

Interviewee 1, for example indicated that STIs and safe sex was not much of a topic of discussion within his friend group, “*because my friends are not that sexually **promiscuous.***”

*“People react on it with a sort of disgust, as if that person is **dirty.** (...) That’s why I wouldn’t share it, if I had an STI, out of fear of being **criticised**, to be looked down upon. I think people would see you as **gross**, even though you do the same thing as anybody else, but it just didn’t go according to plan. You’re being **labelled.**” (4)*

Furthermore, during the workshop ‘Studenten en Seks’ (2017) expert Suzanne Meijer raised the question “why do students get checked for STIs? A. because they are scared of STIs; B. because they had unsafe sex, or c. just as a check-up.” The answer is A, implying that students get checked mostly out of **fear** for STIs, which might have been fostered by the negativity around it.

5.5. DENIAL

Related to the stigma around STIs, as discussed in previous section, could be the categorization and labelling of those infected with an STI, and thereby the distancing of oneself from it. As a result, students might underestimate their risk of infection. Indeed, students indicated not to feel at risk of STIs, even though recent studies (de Graaf et al., 2017) have indicated that they are. Students’ reasons for not feeling at risk are related to an optimistic as well as a worrying attitude of invincibility and/or naivety, through which they distance themselves from the potential risk:

“I don’t hear much about STIs (...) I know it exists, but it doesn’t seem like a threat to me.” (4)

“I had one experience where a guy was like ‘don’t worry about condoms, I’m really good at pulling out.’ And I was like ‘pregnancy is the least of my problems, but aren’t you scared of STDs?’ And he was like ‘those things never happen’ and I was shocked...” (2)

“The other day I was talking to my friend, because she never uses protection (...). She had such a strange argument for not doing so, ‘those kind of things, that doesn’t happen to me’, she said. We really had to talk her into using protection, or at least getting tested. And she also wasn’t on birth control...” (3)

Upon asking interviewee 4 whether she got tested when she and her current fling decided no longer to use a condom, she responds: *“No, I thought it was fine. I’ve actually never been tested.” (4)*

As can be derived from all of the above examples and illustrations, there exist a wide variety of factors that could potentially influence the sexual risk-taking of university students in the Netherlands. How these interrelate, intersect and come together, will be discussed in the next chapter (see: ‘6. Discussion and Conclusion’).

6. DISCUSSION AND CONCLUSION

The common assumption that highly educated students will behave more sexually safe is a pitfall, as the findings described in the previous chapter illustrate how the sexual risk-taking of university students is affected and influenced by a multiplicity of factors. These factors touch upon the norms and values by which students engage with each other and with their sexual activity; they touch upon formalities, duties and responsibilities around condom use; and they expose flaws in the educational system, in means of access, and in overall agency in and around sexual behaviour. From the quotations used by the respondents, certain discourses were used ascribing traits of sexual behaviour, as well as underlying patterns of meanings. To thoroughly understand how these factors operate, intertwine and influence the sexual behaviour of these students, as well as the underlying messages in some of the highlighted quotations, this chapter aims to uncover the underlying socio-cultural structures, through which we aim to understand the sexual risk behaviour of university students in the Netherlands.

6.1. STRUCTURAL VIOLENCE EXPERIENCED BY STUDENTS

When looking directly at structures that limit access to safe sex and/or harm reductions of STIs, students mentioned several obstacles that stand in their way. These tie in with Farmers' (2004) notion of *structural violence* (see: '2. Theoretical framework) to some extent, as it concerns obstacles that are systematically imposed – that is, by institutions such as health facilities, schools, and other points of information and reference. Students mentioned several access-limiting factors, such as the lack of availability of information targeted on students; the lack of availability at testing facilities and the long 'waiting lists'; the costs for testing services for those students above the age of 25; the costs of condoms; appointments with GPs not being included in students' insurances; the physical distances of testing facilities and the 'hassle' of going there; and bureaucratic issues when making new appointments.

However, it is debatable whether the above examples concern actual *structural violence*, or not. One can argue both ways. With structural violence being "a social machinery of oppression" (Farmer, 2004, p. 307), one could argue that it is not: higher educated Dutch students generally do not find themselves in the most marginalized or oppressed positions within Dutch society. However, some of the other aspects of structural violence do apply, such as that the aforementioned obstacles do limit youth from reaching their full potential – their full health potential, that is. On the other hand, this does not stem from systems of exclusion per se, although it does slightly when touching upon gender (see: '6.2. Socio-cultural norms and the body). Yet, the relative violence that is exercised on the bodies of these young adults, is indeed exercised through institutions, as described before, and thus is exercised systematically. However, it is not necessarily of a hegemonic character, as this violence does not

necessarily strive to maintain social hierarchies or separate social classes. Hence, it remains debatable whether the mentioned obstacles are indeed forms of structural violence, or whether they are not.

Either way, it only slightly tells us about the priorities set by institutions. What is more important to investigate is where the priorities stem from, and particularly, what students' priorities are in regard to sexual risk-taking. How these relate to underlying the social structures will be elaborated in the next section through Inhorn's (2006) theory of socio-cultural norms and the body, which will function as the main theory for this discussion.

6.2. SOCIO-CULTURAL NORMS AND THE BODY

Inhorn's (2006) theory on the body (see: '2. Theoretical framework'), seems particularly useful for understanding not only the sexual behaviour of university students, but also the discourse they employ to describe it. Particularly the notion that the body can be read as a script reflecting the norms and values inscribed by society (Inhorn, 2006), will be applied to the findings of the previous chapter. What do these findings tell us about the society university students find themselves in? And what underlying socio-cultural pattern have these students touched upon through their examples and their discourse?

In section 5.1. 'Norms and values' students describe which aspects they associate with a 'typical' student culture, and subsequently, how these aspects could influence sexual behaviour. Having multiple sex partners, being exposed to peer pressure, experimenting, and the consumption of alcohol and drugs are all examples of norms they mentioned, that could potentially increase students' sexual activity. Students used words as 'carelessness' and 'free folks' to describe their environment. A culture of being 'care-free', marked by elements as forgetfulness, spontaneity and not being concerned with the consequences, could explain the above. However, in order to understand why students engage in actual sexual *risk* behaviour, we need to dig a little deeper and touch upon the underlying social mechanisms that affect students' risk.

6.2.1. A PERFORMANCE-DRIVEN CULTURE

From the examples mentioned by students in section 5.1.2. 'Peer pressure', it can be concluded that within a student environment, students experience a high encouragement to be sexually active, to the extent that it becomes 'socially expected'. Discourse used around this high sexual activity, such as 'highfiving', 'earning' and other status-enhancing expressions mark sex as something celebratory, an achievement to be proud of. It implies that status and respect can be achieved through sex. Particularly, the passage about 'earning your door' in sororities and fraternities seems to imply a sort of rite of passage, an achievement to ensure your belonging to a group; as well as a defeat, if one does not adhere to this tradition. Associating sex as an achievement, could be a reflection of a culture driven by the will to perform and to acquire status amongst one's social circles, being reflected in everyday practices, such as sex.

This strive towards performing would not only reflect how students talk about and encourage sex, it would also affect the ways in which they have sex. Both guys and girls are faced with social pressure, particularly when it comes to having safe sex, though both in different ways. With girls, the performance-driven culture would be mainly manifested through their “external locus of control” (see: ‘5.1.2. peer pressure’); that young ambitious females derive their self-image through what they believe others think and desire of them. This extends itself to sex, and the desire to please the other half. Hence, it comes to affect *safe* sex, particularly, when it is believed that the counterpart does not enjoy using protection. It makes one think of the anthropological notion of *habitus*, as coined by Bourdieu (1979), which describes how one’s framework of the world is, on the one hand structured, as it is shaped by what we see and hear in our social environments; and on the other hand structuring, as we strive to live and act accordingly to perpetuate the social structure. In this case, it would apply to girls being taught that guys find protection uncomfortable, set in a structure where she wishes to please him, and resulting in an act where the condom is thrown overboard as ‘he won’t like it’ – thereby strengthening the belief. Vice versa, this habitus and the social expectations that come with it, affect the male student as well. When the dismissal of a condom is associated with a better sexual performance, and in a society where guys are expected to perform and to ‘score points’, it will foster his believe that he should not like condoms, and thus he will not. Hence, condoms become associated with a negative discourse, such as ‘a burden’ or ‘I *have* to use it’, and not being able to perform sexually is seen as a ‘failure’ or something to be ‘afraid’ of.

On top of that, as alcohol and the consumption of which students are notorious for, affect one’s sexual performances negatively, it will strengthen the fear of underperforming, and thereby diminishing the likelihood of using protection under influence even further.

6.2.2 GENDERED POWER RELATIONS

The above example already briefly introduced how norms and values affecting the body, and thus affecting sexual behaviour, impact both guys and girls, though often in different fashions. How such gender differences operate, particularly in a supposedly progressive and tolerant society of highly educated youths, will be explored in this sub-section. How do gender differences impact the sexual risk-taking of students, and do underlying structures of power exist within this?

The first item that appeared within minutes of most conversations with respondents, was the discourse used around sexual activity. As described in the previous sub-section, being sexually active is encouraged within a student society. However, the extent to which differs between males and females. Overall, being sexually active is associated with status. Yet, with males this status is achieved with a high sexual activity, described as ‘cool’ and ‘masculine’; whilst with females such a status is only acquired through a moderate sexual activity. When she exceeds the degree of sexual activity deemed as normative, she is shamed and negatively labelled with words as ‘slut’. It creates the expectation that, within a student environment, both genders are ought to engage in sex, but males are ought to do so

more. And so, the performance-driven sex culture described in the previous section becomes gender-dependent. This touches upon patriarchal notions of gender roles and divisions within the sex culture.

Moreover, such somewhat ‘traditional’ gender roles are reflected in the ways students engage with means of protection. It is manifested through the procuring of condoms, such as it being ‘the man’s job’ or ‘duty’ even, yet thereby also putting the power over protective means with the male counterpart. Moreover, in the examples given by respondents, female students are understood to be less assertive than males in sex and condom negotiation; they are marked with words as ‘receiving’, ‘passive’ and ‘being overruled’, which might affect their (believed) ability to negotiate for condom use.

Yet, it could be that such ideas are fostered not only by conversations between students, but also through what is taught in the educational system. Marking the start of puberty for males with ejaculation, and thus something associated with ‘pleasure’, whilst marking the same start for girls with menstruation, and thus something of ‘discomfort’, might contribute in perpetuating the idea that a pleasurable sex life belongs first and foremost to a male, and potentially to a female.

6.2.3. TABOOS OF THE MODERN DAY: A CULTURE OF SHAMING

During the conversations with respondents, particularly when referring to talking about sex, buying condoms, engaging in safe sex and getting tested, students often showed symptoms of awkwardness or shared experiences in which they had felt as such. In their case stories, feelings of awkwardness were particularly manifested through difficulty of talking about sexuality, joking about STIs, and uneasiness or fear around STIs. Yet where does this culture of discomfort come from? It could be that persistent taboos and stigmas might create discomfort as a result

For example, as described in section 5.1.4. ‘Alcohol and drugs’, alcohol is often used as an excuse or a means of justification after having had sex, and one-night stands in particular. Having had sex with a casual partner or a stranger is ‘socially acceptable’ when under influence, yet when doing the exact same when sober it is marked as something ‘bad’. This might stem from the underlying idea that sex is something ‘bad’, and might contribute to why it is something so difficultly talked about. We see this in the portrayal of sex as something negative, through the discourse employed in the bare minimum students receive on sexual education, in which sex is marked as something ‘dangerous’. Hence, the sexual education that is given, is centred around the potential dangers of sex and the prevention of negative outcomes. Thereby we learn to say ‘no’ instead of ‘yes’, implying that too often sex and acts associated with it come with things we do *not* want, rather than learning what we do want – making sexuality something to be blamed and shamed.

As such, portraying sex as something ‘bad’ and ‘dangerous’, might affect our ability to talk about the subject. It is another example of *habitus*, in which learning that sex is something negative affects how we see the act of having sex, and consequently how we treat it as an uncomfortable topic that ‘should not be talked about’, and hence, it is not talked about – thereby perpetuating the structure once more. Sexuality is being silenced and taboos are being perpetuated as a result. We see this in the

way particularly female students face difficulty procuring condoms. The feeling of uneasiness around this stems from the exposure of students' sexual activity upon buying condoms, and the frowning of those in that environment. The visibility of it all, leaves students to prefer 'anonymous' means of buying condoms, such as online or through vending machines. Hence, on the one hand being sexually active is encouraged in a student culture, yet openly exposing this in public settings is strongly stigmatized, which could be a reflection of our inability to talk about it.

Similar discourse can be found when looking at the conversations around STIs and getting tested. Having STIs is strongly shamed: not only are they joked about or is the topic avoided, but certain discourse used by students to identify STIs or expressing their feelings when getting tested includes words as 'wrong', 'sinned', 'ashamed', 'dirty', and 'promiscuous'. This implies an association with both a physical 'pollution' of the body and a social one. Therefore, it leads to believe that not only STIs, but sex in general, is still shamed between the lines. Hence, this sub-section then strongly opposes the first sub-section around performance and peer pressure. This is both a worrying and contradictory thought: on the one hand, student culture encourages students to be sexually active, and on the other hand it shames promiscuity. Yet, negative discourse around condom use strongly discourages having *safe* sex, when in the meantime, it stigmatizes the consequences of unsafe sex. No wonder students find it increasingly difficult to talk about this subject, as it is full of contradictions!

Potentially, these contradictory messages around safe sex and the discomfort and uneasiness that arises as a result, might contribute to students' risk denial: could it be that students are in risk denial because they do not want to think about the chance that they might have an STI, because they do not want to have an STI, out of fear of being shamed upon, stigmatized or rejected by society? If that is indeed the case, this is most worrying, as social stigma and taboo thereby come to impact health concerns.

6.3. INTERSECTIONALITY

To conclude, the above discussion showing the multiplicity of factors imposed on the body and sexual health of university students in the Netherlands, as well as their at times contradictory nature, discloses how the understanding of their sexual risk-taking is a complex one. This discussion has shown that the sexual risk behaviour of these young and highly educated adults is affected by numerous factors, exposing underlying socio-cultural patterns of a performance-driven society, gendered power relations that perpetuate notions of patriarchy, and taboos and stigmatizations around sexuality in a modern epoch.

Taylor (2007) argued how health and health concerns can only be fully understood from a holistic perspective, and that bodies are the "products of history, culture, society and economy" (Taylor, 2007, p. 966; see '2. Theoretical framework'). This discussion has shown that, indeed, this too appears to be the case with the STI concerns amongst a student population. How and why university students in the Netherlands engage in sexual risk behaviour and have become an increasing risk-group, can only be

understood from an intersectional point of view, implying the intertwining of all the aforementioned factors. It is not about how these factors, separate from one another, pose a risk to students' sexual health and well-being. It is about how this specific combination of factors, a combination unique to a student population, perpetuates risks of its own. It is what makes students such a unique and peculiar risk-group, as they their sexual behaviour is a reflection of the intersectionality of these contexts. Hence, it becomes evident why it is necessary to thoroughly understand this intersection: if we want to alleviate students from being an increasing risk-group, we must understand their sexual health and well-being in *full context*, and we must act accordingly. Hence, this study hereby hopes to have contributed to the understanding of the sexual risk-taking of university students and the consequential health concerns, and argues that intervention programmes require adaptive strategies that cater specifically to needs of this unique population.

RECOMMENDATIONS

for future research

As described in the conclusion, throughout the case stories shared by respondents resonated a strong call for new intervention strategies, which should focus particularly on the unique population of higher educated youths, or university students. To establish the content and the means prosecution further research would be necessary. However, as a response to this study, several preliminary recommendations can be made:

1. There is a need for sexual education that perpetuates not only the biological and factual messages around sex, but particularly addresses the emotional aspects of sex, sexual diversities and the negotiation of sexual behaviours.
2. There is a need for sexual education that does not propagate messages of danger and threat, but that stimulates pleasure and teaches youth how to live a healthy and *enjoyable* sex life.
3. There is a need for sexual education to be repeated more frequently, yet gradually, and that is adaptive to age and life-style.
4. There is a need for young adults to have an open grown-up conversation about sexual activity and sexual health, both within institutions and informal circles. This may be stimulated through, but should not be dependent of, institutions with the aim to inspire a broader conversation within the personal spheres.
5. Potentially, within the above, educational institutions such as schooling, parenthood, student associations and the media could be used as allies instead of inhibiting actors to increase the public conversation on sexuality and sexual health.

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8. APPENDIX

Appendices:

Appendix 1: Interviewing questions students

Appendix 2: Interviewing questions experts

Appendix 3: FGD outline

Appendix 4: Transcriptions IDIs students

Appendix 5: Transcription FGD students

Appendix 6: Transcriptions IDIs experts

Appendix 7: Participant observation

Note: all the interviewing questions, FGD set-up, transcriptions and field notes have been compiled in a separate document. This 70-page document can be provided upon request. Please contact the author.

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