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Patriarchy and Sexual Health

A Feminist Analysis of STI Rates among Danish Youth

Annastassia Schwan

Master of Applied Cultural Analysis	**Supervisor**
Department of Arts and Cultural Sciences	**Rachel Irwin**
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Abstract

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What does Gen Z (those born 1995-2010) and Denmark have in common? Chlamydia.

Denmark reports the highest chlamydia rates in Europe among individuals aged 15–29, with the number increasing since 2012. Despite the availability of free sexually-transmitted infection (STI) testing and comprehensive sexual education, rates continue to rise. The underlying causes of this trend need investigation, particularly from a feminist perspective, as women often suffer disproportionately from STIs in various ways including delayed diagnoses, severe health consequences, and unequal responsibility.

This research investigates how Danish youth perceive and narrate their sexual health experiences and examines how these experiences may contribute to rising STI rates. By centering the voices of the youth, this study aims to shed light on their perspectives. Utilizing interviews with Danish youth and sexual health experts, as well as direct participant observation at STI clincis, this research seeks to understand the procedures and practices of sexual health in Denmark.

Through a critical feminist lens, the research highlights the hidden heteronormative and patriarchal structures embedded in the Danish sexual health system, drawing on theoretical concepts such as habitus (Bourdieu, 1977), dressage (Lefebvre, 2004), and disciplinary power (Foucault, 2008). Findings suggest that Danish societal dispositions and norms, combined with crucial gaps in sexual education and healthcare accessibility, combine to give the mistaken perception that STI risk is low and contribute to the perception of prevention and aftercare as a woman's issue. The research concludes by advocating for more stringent regulation of sexual education laws, a re-evaluation of educational content, and an enhanced focus on testing routines and healthcare infrastructure.

Keywords: Sexual health; critical feminist lens; sexually-transmitted infections (STIs); sexual education; heteronormativity; patriarchy; Denmark; gender inequality

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Abbreviations

AIDS: Acquired Immunodeficiency Syndrome

AFAB: Assigned Female at Birth

BIPOC: Black, Indigenous, Person of Colour

Cis: Cisgender

CFT: Critical Feminist Theory

CPR: Central Person Register (Danish Social Security Number)

FLINTA*: Female, Lesbians, Non-binary, Intersex, Agender

GP: General Practitioner

Het: Heteronormative

HIV: Human Immunodeficiency Virus

HPV: Human Papillomavirus

HSV: Herpes Simplex Virus

LGBTQIA+: Lesbians, Gays, Bisexuals, Trans, Queer and/or Questioning, Intersex, Asexual

NGO: Non-Governmental Organisation

PIV: Penis-in-Vagina

Sex Ed: Sexual/Sexuality Education

STD: Sexually Transmitted Disease

STI: Sexually Transmitted Infection

Trans: Transgender

UNESCO: United Nations Educational, Scientific and Cultural Organization

WHO: World Health Organisation

"Spread love, not gonorrhoea, come in a condom!"

(Bus advertisement in Scandinavia, Spring 2024)

(translated from Swedish)

1. Chlamydia and the Danish Youth: A Phenomenon

It was a cold, dark November afternoon in my shared flat in Malmö when I came across an Instagram reel[1] with the following caption: "Tell me you live in Denmark without telling me you live in Denmark". In the video, a young man in his early 20s sheepishly holds a self-swab chlamydia home test whilst grinning and shrugging his shoulders. That a chlamydia home-test was a marker of living in Denmark shocked me. This was not the only content referring to sexually transmitted infections (STIs) that I came across in Danish contexts – articles and advertisements referring to chlamydia, gonorrhoea and STIs kept appearing wherever I went, on social media, in bus advertisements or news articles. I was perplexed, so I approached one of my Danish friends.

She informed me about the high STI rates occurring in Denmark, specifically regarding chlamydia. Within 15–29-year-olds, Denmark has the highest chlamydia rates in Europe, and this number is steadily rising since 2012 (Sex og Samfund, 2023; Statens Serum Institut, 2022). The rise of STIs amongst Danish youth is no secret. In one popular Danish podcast, the hosts were talking about chlamydia and contemplating what could be causing the rise in numbers – they proposed that amongst the youth, having chlamydia is seen as cool. They theorised that in today's youth, catching chlamydia could signal sexual activeness or a sign of having multiple partners, hence making chlamydia a type of symbolic value.

Even though a part of me was shocked, another part of me was rationalising if this could be the case. In the 1960s, Denmark was the first country worldwide to legalise pornography (Gade, 2010). In the 1970s, Denmark legalised abortion (H. Goldstein, 1998). In the late 1980s, they were likewise the first country to legalise same-sex unions (Garrett, 2016). Sexual

[1] A short video on Instagram.

education has been mandatory since the 1970s and Danish sexual education is often regarded as being relatively comprehensive, covering topics such as contraception, HIV (human immunodeficiency virus), STIs, abortion, puberty, sexual rights and freedoms, gender sexuality, diversity and acceptance (R. Goldstein, 2017; Ministry of Education, 2019a, 2019b). In addition, there is quite a positive media narrative around Denmark and their "seemingly progressive sexual attitudes" displayed in movies or articles (Russell, 2015; Schaefer, 2014, p. 208). On one hand, I could understand why Danes might view chlamydia as cool. On the other hand, providing comprehensive sexual education (and not abstinence-focused sex ed) has proven to lead to safer sex and less risky behaviour (American Academy of Pediatrics, 2024; UNESCO, 2023; WHO, 2023). In my understanding, if individuals receive comprehensive sexual education, and have easy access to contraceptives and testing, STI rates would be low, yet here, the reverse seems to be happening. So, what is happening here?

Chlamydia is not as dangerous as other STIs, yet it still causes severe complications if left untreated such as pelvic inflammatory disease, tubal infertility or ectopic pregnancy (Darroch et al., 2003; ECDC, 2024). If caught early, treatment can cure it. However, chlamydia is asymptomatic in 75% of women and 50% of men. Due to differing reproductive systems, women and men experience chlamydia differently with "the burden of disease and infertility considered to be a predominantly female problem" (Dielissen et al., 2013, p. 2). Women's bodies are bearing more consequences of chlamydia, women's bodies have fewer symptoms, women's bodies are more likely already on birth control and women's bodies are testing more (Curtiss & Weinbach, 1989; Piróg et al., 2022; Statens Serum Institut, 2022, 2023). If everyone is getting chlamydia, then at least the testing rates should be equal.

There are many reports documenting various sexual-related behaviours and attitudes (Frisch et al., 2019; H. Goldstein, 1998; Statista, 2022)(e.g. the rise of STIs, contraceptive use, abortion etc.), resources and teaching material for Danish sexual education (Ministry of Education, 2019a, 2019b). However, I was struggling to find youth voices commenting on their lived experiences of the sexual education they received. Is the sexual education offered in school as comprehensive as the laws lead us to believe or is something else occurring? By conducting qualitative interviews with Danish youth and experts in the field and doing ethnographic participant observation at health clinics, I set out to investigate what is happening with sexual education and how it relates to the rise of STIs.

1.1 Aim and Research Questions

The world is unjust, and when it comes to sexual health, women experience more consequences than men. This continuous rise in chlamydia is I believe one of its manifestations, which is why I want to investigate it. My aim with my research is to understand the increasing levels of STIs in Danish youth in relation to sexual education and provide recommendations to combat it. My research questions are the following:

1. **How are the Danish youth narrating their experiences of sexual health?**

With this question, I want to place focus and importance on my informants' lived experiences of sexual education (in school, out of school, at home, with friends, with healthcare) and likewise their navigation of instances relating to sexual health.

2. **How do Danish experiences of sexual health education relate to the rise in STIs?**

Here, I take the main narratives from my empirical findings and combine them with my theories to see how they relate to the rise in STIs in Denmark.

1.2 Overview of Thesis

To position myself from the get-go, I start with my positionality as a researcher and the stance I take in my work. I then contextualise the study by talking about sexual health, STIs and sexual education. In chapter two, I delve into the concepts I will employ, starting with my critical feminist lens (E. Anderson, 2020; Crenshaw, 1989; Sprague, 2016), then Bourdieu's (1977) concept of habitus, Lefebvre's (2004) concept of dressage and finally, Foucault's concept of disciplinary power. In chapter three, I introduce my trajectory into the field and my methods, participant observations and interviews, followed by the ethical considerations, limitations and how I did my thematic analysis.

In chapter four, I contextualise my work by doing a brief history of Danish sexual education policies and their related events, complemented by current sexual education laws and standard healthcare policies. I then investigate previous research done on sexual education and chlamydia and tease out the main findings relevant to my research. The findings point out the many ways sex education is inadequate, the structural discrimination and the unassumed strong influence of the educators.

In my first analytical chapter, chapter five, I delve into how my informants and experts problematise and narrate their experiences with their sexual health (education). I contend that there is a discrepancy between how my informants and their teachers conceptualise sex ed, an unconscious assumption about who is responsible for prevention, and the detrimental effects of 'progressivity'. I also consider the ways my informants can break out of the norms. Using a

theoretical grounding, I tease out the patriarchal, heteronormative habitus and dressage that prevents sexual healthcare (e.g. contraception, testing, abortion) from being as effective as it could be and the disciplining power my individuals enact on themselves.

In chapter six, the second analytical chapter, I recount how I experience testing at the clinics. I use my visit to highlight the dressage and dominant cultures of healthcare that exist, and how conscious work is necessary in combating the detrimental dominant norms and dispositions if patients are expected to return.

In chapter seven, I conclude by summarising the main points from the analytical chapters and providing an answer for what is happening in Denmark regarding STIs. I end with concrete recommendations.

1.3 Who am I, the researcher?

I believe that "all researchers are positioned [in their research] whether they write about it explicitly, separately, or not at all" (Chiseri-Strater, 1996, p. 115; Haraway, 1988; Sprague, 2016). I therefore prefer to deal with this transparently. Positionality and how knowledge is produced reflect the conditions in which they are produced and are influenced by how one sees and experiences the world and by their social identities. This can include one's gender, race, class, upbringing and education as well as personal life circumstances. By sharing my positionality, I want to illustrate that I am aware of my subjectivity and situatedness in conducting this study and all that it influences and encourage my readers to likewise take this into account.

I am Annastassia Schwan, born in 1997 in Indonesia. I am a brown, queer, ciswoman who comes from a middle-class (Indonesian standards), non-academic household. My mother is Indonesian, and my father is German, and I grew up in Indonesia, a Global South country. I left my family and moved to Europe in 2017 to pursue higher education.

Growing up, I did not have much sexual education, if any, and had a lot of catching up to do when I left home and came to Europe. I was unhappy with my sexuality's upbringing, and this is one of the reasons why I focused on women's pleasure and sexuality in my bachelor's thesis in Germany. With my personal and academic background, I was curious to investigate what sex ed looks like in Denmark and how that impacts them. What does Denmark's sexual health agenda look like? How do they stand on pleasure, women and marginalised people's rights?

There is no 'neutral' or 'objective' research as highlighted above, hence why I clearly state my agenda with this paper. I am a critical feminist, and this paper is more than just an

academic exercise, I want to empower women and other marginalised people by exposing and challenging the oppressive and unequal societal structures in the realm of sexual health. Having a clear agenda does not equate to a lack of rigorousness in my academic undertakings, but rather the opposite. By stating my agenda, I have made myself bare and guided and welcomed your scrutiny, leaving my research to speak for itself.

1.4 Understanding Sexual Health, Sexual Education & STIs

Sexual Health & Sexual Education

Sexual health, and therefore sexual education, has a long history of being understood as the prevention or lack of negative consequences, such as the prevention of unwanted pregnancies, STIs and sexual violence (R. M. Anderson, 2013; Harden, 2014). Presenting sexual health as merely the absence of negativities often disregards the holistic physical, mental and social well-being that encompasses it. The World Health Organisation (WHO) has been working in sexual health since 1974 and currently defines *sexual health* as:

> a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO, 2010)

I likewise take the WHO (2010) working definition of *sexuality:*

> a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.

As these two definitions highlight, good sexual health and sexuality are not marked by the absence of disease, unwanted things or neutrality. Rather, it emphasises holisticity, well-being, pleasure and social aspects such as consent, discrimination and freedom. Though this is the current understanding of sexual health, it is not always what is understood or taught during sexual education. Sexual education can be sex-negative (attaching shame and judgement to sex and sexual diversity) and is often associated with abstinence or fear-based teachings, which

exaggerates the negative consequences of premarital sex and portrays sexual behaviour as dangerous or harmful and only a means to procreate.

However, a sex-negative attitude is not effective in protecting or improving people's sexual health, a sex-positive one does a better job. Sex-positive education has shown to increase overall health and wellbeing, empower marginalised individuals (FLINTA*[2], LGBTQIA+), emphasise communication and affirmative consent across multiple relationships and roles, increase pleasure, reduce sexual victimisation, reduce unwanted pregnancies and STIs and many more (Raymond & Hutchison, 2019). *Sex positivity* is an approach that "emphasizes the pleasurable, rewarding, and nonprocreative aspects of sex as well as "being open, communicative, and accepting of individuals' differences related to sexuality and sexual behaviour" (Williams et al., 2013). A sex-positive approach in sex ed encourages responsibility for possible sexual dangers and promotes its prevention (e.g. unwanted pregnancies), improvements in the psychological, social and overall health of individuals, and is more capable of reducing fear and boosting positive behavioural changes concerning desire and please (Askew, 2007; Harden, 2014; Philpott et al., 2006).

The WHO defines comprehensive sexual education as:

> [a] process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their well-being and that of others; and, understand and ensure the protection of their rights throughout their lives. (WHO, 2018)

Though the definition does not explicitly refer to sex-positivity, it refers to it by highlighting the holistic nature of sexuality and how all individuals have the right and necessity to learn about knowledge that empowers them to make their decisions and how it affects others. This is important to understand because when I discuss Danish sex ed, even if it aspires to be sex-positive on paper, what is taught is not always the case.

[2] A German abbreviation for Females/Women, Lesbians, Intersex, Non-binary, Trans and Agender people with the asterisk representing all non-binary gender identities (anyone who is not a cisman).

Sexually Transmitted Infections

STIs, formerly known as STDs (sexually transmitted diseases) is the more inclusive term that tries to remove the stigma as not all infections will lead to a disease. An infection occurs when a bacteria, parasite or virus enters the body and the body's immune system activates to try to fight it. A disease happens when the infection causes symptoms, damages parts of your body, and leads to an illness. Many infections never develop into diseases (Kendall, 2022).

More than 1 million curable sexually transmitted infections (STIs) are acquired daily worldwide among people aged 15–49, most of which are asymptomatic. In 2020, an estimated 374 million new infections occurred within this age group due to chlamydia, gonorrhoea, syphilis, or trichomoniasis. By 2022, 8 million adults were infected with syphilis, including 1.1 million pregnant women, leading to over 390,000 adverse birth outcomes. Additionally, over 500 million people in this age group have genital herpes (HSV), and human papillomavirus (HPV) is linked to over 311,000 cervical cancer deaths annually (WHO, 2024).

STIs primarily spread through unprotected sexual activities, including vaginal, oral, and anal contact. Some STIs can also be transmitted from mother to child during pregnancy, childbirth, breastfeeding, or through exposure to infected blood or blood products. STIs can have a significant impact on health, leading to severe complications if left untreated, such as neurological and cardiovascular diseases, infertility, ectopic pregnancy, stillbirths, and an increased risk of contracting HIV. Additionally, STIs often carry social stigma, can contribute to domestic violence, and negatively affect the quality of life (WHO, 2024).

The most prevalent and treatable STIs include trichomoniasis, chlamydia, gonorrhoea, and syphilis. However, the rapid rise of antimicrobial resistance poses a growing challenge. Viral STIs, such as HIV, genital herpes, hepatitis B and human HPV have limited or no treatment options. Condoms used correctly and consistently are one of the most effective methods of protection against STIs (WHO, 2024).

As the data highlights, for some individuals, STIs have quite serious consequences. Without proper treatment, these curable infections can result in a burden of diseases and complications, facilitate HIV transmission and negatively impact socioeconomic factors (De Schryver & Meheus, 1990). Globally, there is an uneven distribution in the burden of STIs, with prevalence higher in regions of Africa and the Americas (Sinka, 2024). Though Denmark is not one of the countries feeling the full consequences STIs can have due to available testing and treatment, it is still more dangerous than many understand (Fabian-Jessing, 2016).

Moreover, gonorrhoea and chlamydia antibiotic resistance are on the rise and Danes could view their role at a global level (Sinka, 2024).

2 Theoretical Framework

I start with my critical feminist lens to highlight the way I see the world and my data. I then introduce Bourdieu's habitus as a tool to deconstruct unconscious dominant dispositions, behaviours, and values that have accumulated over time. This is reinforced by Lefebvre's use of societal dressage, which repetitively impounds values and behaviours into the bodies over time. I then tie it together with Foucault's understanding of sexuality and disciplinary power to keep individuals in line through identity and a variety of public and personal control.

3.2 Putting on the Critical Feminist Lens: the Patriarchal & Heteronormative Society

I use critical feminist theory (CFT) as a lens as it aims to expose, critique, and challenge the existing power structures and their inequalities. CFT investigates how elements of race, class, gender, sexuality, ability, and other characteristics intersect (Crenshaw, 1989). CFT acknowledges the many levels that influence women's and other marginalised people's experiences from an intersectional perspective by highlighting the hegemonic effect patriarchy has on the experiences of women and these marginalised groups (Keedle et al., 2019). Like in most aspects of society, the realm of science is no different. Research has been chiefly conducted by men and focused on men, but the resulting knowledge has been represented as universal and objective (Jupp, 2006). I take a critical feminist approach because I want to acknowledge the intersectional ways our collective conceptions of knowledge and practices of inquiry and justification disadvantage certain groups of people (Anderson, 2020). To be a critical feminist and understand the challenges in the sexual health realm, we must acknowledge our heteronormative patriarchal society.

How the social world is experienced very much depends on the individual – who they are, how they see themselves, how they are perceived by others and the structures surrounding them (Archer, 2020; Crenshaw, 1989). Underlying structures, systems, beliefs, and social categories are present. Patriarchy is a system of relationships, beliefs and values that is entrenched in all aspects of our lives that structure gender inequality. Walby defines patriarchy as a "system of social structures and practices in which men dominate, oppress, and exploit women" (1991, p. 20). However, this is not as simple as all men have it better than all women. As Crenshaw exposes with intersectionality, multiple social and political identities intersect and overlap, resulting in unique combinations of discrimination and privilege (1989).

To uphold the patriarchal social order, heteronormativity is the ideology that heterosexuality is the "normal" or "ought to be" mode of sexual orientation that, in its understanding, reinforces the gender binary and its corresponding gender roles and sexualities (Butler, 2011; Rich, 1980). To unpack this and bring to light the taken-for-granted 'natural' or 'normal' norms of everyday life, I employ Bourdieu's concept of habitus.

3.2 Is That 'Normal' or Just The Unconscious Dominant? Bourdieu's Habitus

To expose and challenge existing power structures and inequalities, I first have to uncover the taken-for-granted dominant structures. In *Outline of a Theory of Practice* (1977), Pierre Bourdieu provides the concept of the *habitus*, which is a collective framework through which dominant cultural and social conditions are both established and perpetuated. It is a "'set of bodily dispositions and mental structures' through which the social world is understood, interpreted and reproduced as based on past experiences and socialization, such as through schooling, education or learning from parents" (O'Toole, 2021, p. 83). It is a "person's taken for granted, unreflected – hence largely habitual – way of thinking and acting" (Leander, 2009, p.3). Hence, habitus is both affected by external structures and imparts directly on the individuals. Habitus develops through socialisation (family, education, social class) and operates unconsciously, guiding how people perceive and act in the world, shaped by their experiences in particular social contexts. Bourdieu emphasises the subtle, often unrecognised, ways that social structures are reproduced through these internalised patterns. Applying it to this research, habitus influences how individuals perceive and engage in sexual health interactions, such as their sexual attitudes and behaviour, views towards sexual health, and so forth – shaped by family upbringing, cultural norms, social media, peer experiences and sexual education amongst other things. It also encompasses attitudes and behaviours towards STIs, testing, perceptions towards risk behaviour, responsibility for (sexual) protection and standards of educational materials. The habitus grants individuals skills to negotiate social environments as if by instinct based on their socialised dispositions.

Habitus is instilled through its institutions, typically starting at the family site, and later consolidated through schooling and employment. Institutions are structures of systems that shape, maintain and perpetuate social and cultural norms (e.g. places of worship, government bodies, market systems, schools, etc.). Individuals within the habitus internalise dominant social and cultural ideas, along with the available modes of existence. As a result, they become specific types of subjects (such as those defined by gender, race, sexuality, nationality). In

doing so, they support, reinforce, and ultimately perpetuate the habitus by embracing and spreading its dominant ideas and sociocultural ways of being. For example, adopting gendered norms and instilling them into the ways we think, feel and interact with others (Bourdieu, 2001; O'Toole, 2021). Hence, habitus (re)produces both itself and its subjects through its institutions.

It likewise reproduces sociocultural conditions through how individuals relate to one another. For example, the university endows the subjects the authority to denote themselves as teachers, doctors, lawyers, and so forth. The habitus produces and legitimises relationships of domination through its institutions by default, which is supported by the accumulation of capital by the individual. This system of habitus and its capital confers sociocultural privilege on certain individuals while obscuring this privilege. As a result, changing the sociocultural conditions of the habitus is difficult. Dominant subjects exercise their dominance by conforming to the status quo, while dominated subjects must disrupt the habitus from within to achieve change. Thus, the dominance of dominant subjects appears 'objective,' allowing them to simply 'be,' whereas the dominated must first 'clear the way' before they can 'be' (Gillespie, 2019). As de Klerk *et al.* state, "the habitus of the dominant tends to pervade the social system, making it difficult for those with an alternative 'habitus' (such as females or members of racial minorities) to participate as equals. In order to achieve change, some challenge of the status quo is necessary" (2007, p. 115). Even though Bourdieu focused on class inequalities and did not overtly explore issues of inequality related to sexual differences, his ideas offer a tool to conceptualise the unconscious discourse related to sexuality, gender and health received (early) in socialisation and their lasting dispositions that are then hidden and normative in nature (Morantes-Africano, 2023). The habitus is, I theorise, strengthened by the corporeal rhythms that are impounded into our bodies through a form of societal dressage.

2.3 Breaking Into Bodies: Lefebvre's Dressage

In his book *Rhythmanalysis*, Lefebvre notes that dressage requires participants "to enter into a society, group or nationality is to accept values (that are taught), to learn a trade by following the right channels, but also to bend oneself (to be bent) to its ways (…) Humans break themselves in [*se dressent*] like animals. They learn to hold themselves. Dressage can go a long way: as far as breathing, moving, and sex. It bases itself on repetition. One breaks-in another human living being by making them repeat a certain act, a certain gesture or movement" (1992/2004). Lefebvre's conceptualisation of dressage highlights the need for humans to perform actions to sustain their social existence (Moravec, 2022). Practices learnt through repetition are enforced on subjects from a young age through rhythmic regimes of training, like

how one would break in a horse (Kolb, 2022). Echoing Bourdieu's (re)construction of habitus through institutions, "Temporal and spatial arrangements of people in everyday contexts are produced through various (for example, parental or political) forms of control and become routine and habitual" (Kolb, 2022, p. 90).

Through dressage, socially acceptable conduct, norms, values, and rules are subliminally absorbed into bodies through rhythms over time. Often, there is also a point system that awards or penalises the individual for complying with or not complying with the sought-after norm. For example, children are repetitively taught to look left and right before crossing the street, being reprimanded when they do not. Institutionally, penalty points are given out for disobeying traffic laws. By using dressage, I can further highlight the rhythms that bodies are forced to operate over time, contributing to their habitus. However, rhythms are not only forced onto bodies over time but likewise policed and forced on their bodies by the individual, as it relates to their identity as Foucault theorises with disciplinary power.

2.4 Policing Identities: Foucault's Sexuality & Disciplinary Power

In his *History of Sexuality* (1978a), Foucault proposes that our understanding of sexuality is quite a modern phenomenon. By this, he means the way we recognise sexuality, that of our desires and sexual habits, are an essential part of our identity (1978b). Before this modern phenomenon, people performing sexual acts (such as sodomy) were committing sins, but it was an isolated occurrence, i.e. it would not affect their identity. However, with the growing discourse on sexuality, the sexual acts we do now are seen as integral to our sexuality, and thus the formation of our identity. Then, this normalisation of sexuality is kept in line not only by others but also by individuals policing themselves through what Foucault calls *disciplinary power* (2008). Control through disciplinary power occurs when people believe they could potentially be surveilled at any given time; behaviours are internalised as 'normal' and taken for granted but are in reality the result of surveillance and discipline (Foucault, 2008). Educational institutions function as a disciplinary institution because individuals are subjected to fit into societal norms that reinforce power structures through constant monitoring and regulation. Disciplinary power is not the explicitly enforced rules, but rather the moulding of individuals' behaviours and their ideologies through indirect, persistent techniques of surveillance and normalisation in line with their habitus. This form of control is much more ominous as the power of the individual is harnessed and controlled in the interest of the existing system (Foucault, 2008). It urges people to compare, evaluate and correct themselves against

'objective' standards or norms. In a way, not just society taken as a whole but individual people are dressaging themselves.

I argue that by using a CFT lens, and these theoretical concepts – habitus, dressage and disciplinary power –I can move to uncover the unconscious hidden cultures and norms that have been impounded into the Danish youth, institutions and other relevant actors, and explore how they discipline themselves.

3 Qualitative Ethnographic Research

There is an abundance of quantitative research investigating the increasing rates of chlamydia and STIs in Denmark and Scandinavia. Hedley et al., (2022) highlighted the decrease in chlamydia rates in Denmark during the COVID-19 pandemic, Herlitz & Ramstedt (2005) used mailed questionnaires to uncover the rising risky sexual behaviour in Sweden between 1998 and 2003, Jørgensen et al., (2015) emphasised the lack of condom use at sexual debut and last sexual encounter, and Redmond et al. systematically reviewed chlamydia prevalence based on population-based surveys across multiple countries which revealed consistent chlamydia prevalence amongst young adults, low response rates and the need for more nationally based, comparable reporting standards (2015). Whilst quantitative research has its strengths, such as mapping changes in large population-level patterns or correlating relationships between certain factors (Braun & Clark, 2013; Herlitz & Ramstedt, 2005), they cannot understand *why* things occur. Hence, why I took a qualitative ethnographic research approach. I took a bricolage approach to obtain different types of data, combining informant interviews, expert interviews, participant observations and document analysis.

Qualitative ethnographic research uses data as words and "seeks to understand and interpret more local meanings" whilst recognising "data as gathered in a context" (Braun & Clark, 2013, p. 4). It provides a "rich and deep understanding of the ways people make sense of, and put into practice" their lived experiences, the nuances and diversity within accounts (Braun & Clark, 2013; Christianson et al., 2007). Qualitative research allows us to capture the "complexity, mess and contradiction that characterises the real world, yet allows us to make sense of *patterns* of meaning" (Braun & Clark, 2013, p. 10). As exemplified in Narushima et al. research on youth's perspectives on sexual education (2020), Christianson et al. on sexuality and risk in HIV-positive youth (2007) or Newby et al. study on young adults' perceived risk of chlamydia (2012).

This first section examines why I chose my qualitative ethnographic approach; the following section discusses how I got acquainted with the field, then, I delve into participant observations and interviews before ending it with the limitations of the methods.

3.1 Trajectory into the field

As disclosed in my positionality, I focused my bachelor's thesis on sexuality and pleasure for assigned female at birth (AFAB) individuals. Being fed up with all the theoretical research out there only informing me about the pleasure gap and taboo surrounding FLINTA* sexuality, I took an action research approach to do practical change. In my past research, I investigated the potential of a holistic peer-led facilitated AFAB group to empower individuals to strengthen their sexual authenticity. *Sexual authenticity* being a "positive, self-determined and authentic sexual self-expression, being aware of one's own needs, desires, and pleasure, as well as society's impacts" (Schwan & Brenner, 2020, p. 3). The research assessed the impact of the group workshops focusing on different topics (the body & the vulva, masturbation & self-love, communication, needs & boundaries, and fantasies, sexual practices & sexual authenticity). Though each session was structured differently, they all encompassed an embodied activity, theoretical input, discussions, practical exercises, creative methods and (self-)reflection (Schwan & Brenner, 2020, p. 16). The research utilised surveys and diary studies to analyse the participants' experiences. Where I focused on creating change starting at an individual level in my bachelor's, I wanted to investigate sexual health from a different angle in my master's.

Curious about sexual education in Denmark (as I assumed Danish sexual education is comprehensive and sex-positive), having lived there and worked at Copenhagen Pride, my interest was sparked by the chlamydia case. I sought to broaden my understanding of AFAB sexuality, including sexual health. In general, due to pelvic inflammatory disease, infertility & ectopic pregnancy, foetal & prenatal infections, complications of pregnancy and neoplasia (cervical dysplasia & cancer), and female lower genital-tract infection, STIs impact AFABs more. Moreover, as AFABs experience fewer symptoms and are more easily transmitted from men to women, complications are much more frequent and serious (Agénor et al., 2023; Curtiss & Weinbach, 1989; Piróg et al., 2022). Additionally, sexual education tends to be androcentric and heteronormative, and testing on populations at diverse intersections is lacking (Agénor et al., 2023; Curtiss & Weinbach, 1989; Piróg et al., 2022). I wanted to expand my knowledge about AFABs' sexual health by looking at a current problem and how they potentially relate to themes that arose in past research.

I created an actor map by speaking with key actors, Danish acquaintances and conducting a document analysis. I looked at sexual education resources, Danish laws, Danish institutions, and popular media. Due to the topic's sensitivity, I started with a wide range of potential informants and field sites, knowing that I would not gain access to all of them. Even though certain topics are not inherently sensitive as "it is their social and cultural context that makes them so (…) the act of conducting research on sexuality with children as participants is frequently perceived as a sensitive topic" (Bruna Alvarez et al., 2022, pp.127-128). This is reflected in the last decades of research, where studies on sexual education focus on the perceptions of parents and teachers rather than the pupils (C. Davies & Robinson, 2010; Ribeiro & Facciolo de Camargo, 2003; Stone et al., 2013). Hence, there is very little research on how children understand their own sexual experiences and ideas about sexuality (Montgomery, 2008). Thus, why in my sampling, I reached out to schools in and around Copenhagen to obtain more youth voices. Sadly, none of the schools ever got back to me, which again highlights the sensitivity of the topic. I will delve deeper into this in section 3.5 Limitations.

3.2 Participant Observation

Participant observation is the "central and defining method of ethnographic research" in which "a researcher takes part in the daily activities, rituals, interactions (…) as one of the means of learning both the explicit and tacit aspects" of the lives and culture of individuals being studied (Bernard & Gravlee, 2015, p. 251). Participant observation allows me to experience behaviours and interactions within their real-world context, which better situates me in the research to have more meaningful discussions with my informants, have better rapport, and enhance the quality and interpretation of my data (Bernard, 2018; Bernard & Gravlee, 2015; C. A. Davies, 2008). It likewise grants me access to things otherwise too intrusive or only available through participant observation, such as the experience of being at an STI clinic, undergoing a medical procedure or anticipating the results (Bernard, 2018). I went to various clinics to have firsthand experience of how it feels to maintain sexual health as a person in Denmark.

Originally, I planned to visit schools and experience 'Uge Seks' (Week Six) in Danish schools; the week famous in the Nordics for being the time they focus on sex education. Sadly, of all the 15 schools I reached out to, no school ever got back to me. So, I visited three different STI testing locations in Copenhagen between February and March of 2024. Getting myself tested in Denmark was the closest routine I could do after one thinks they have an STI. As I do not currently reside in Copenhagen, but still have a social security number (CPR - central person register) from the time I used to live there, I was able to test at general testing centres

(which some of my informants do due to various reasons) but not at a general practitioner (GP)(which many of my informants likewise tend to do). This means I was unable to experience what happens at a GP.

I visited Bispebjerg Hospital's STI Health Clinic, Sex og Samfund's Contraception and Counselling Clinic and AIDS-Fondet's Checkpoint (I further discuss each location in Chapter 5: My Experiences). At Bispebjerg, I had self-administered swabs, had my blood drawn by medical professionals and answered a questionnaire. At Sex og Samfund, I only had self-administered swabs. At Checkpoint, I filled out a questionnaire, had a consultation and did the self-administered swabs. I selected the testing centres by conferring with Danish individuals and through my actor mapping. As huge parts of my participant observation happened on the go, I recorded my thoughts, observations and experiences as a voice recording on my phone before transcribing them and putting them into my diary. For example, at Checkpoint, where there were a lot of people in the waiting room, I used the bathroom to make a voice recording. If appropriate, I would likewise take notes on my phone (i.e. in certain waiting rooms where others are also on their phones). I also took pictures of the location, but this was often challenging due to the visitors at the clinics.

Figure 1 *Entering the STI department at Bispebjerg Hospital*

My participant observation was not only about the direct experience of being at the clinic but also all the steps and interactions that were involved, including my feelings. This comprised researching where to get tested, booking the appointment, my time at the clinic, my feelings of waiting for my results and my experience of receiving the results. By tracking what was happening to me through the observations, I could better empathise and understand the lived experiences of my informants. This lets me make stronger claims on what I have collected and "extends both the internal and the external validity" of what I learn through interviews and observations (Bernard, 2018, p. 282). If possible, I also did on-the-spot interviews with the medical professionals or counsellors interacting with me. I would inform them I was researching STIs and hence the idea to get tested.

3.3 Interviews

Interviews are best suited at exploring the "understandings, perceptions and constructions of things that participants have some kind of personal stake in" (Braun & Clark, 2013, p. 81), which was what I needed to investigate the youth's understandings and experiences with their sexual education and sexuality in Denmark. To encapsulate the different perspectives, I had informant interviews and expert interviews. Hence, I reached out to 15 schools, five hospitals, five doctors, three NGOs, a researcher, two institutions, the WHO and the informants (see **Appendix A**). I begin by discussing my informant interviews before continuing to my expert interviews.

3.3.1 Informant Interviews

Informant interviews were conducted in February of 2024. The informant interviews were conducted after document analysis and visits to two STI testing locations. This was done to strengthen my knowledge of the field and allow for shared experiences in the interviews. Many of my informants were obtained through snowball sampling or what Garton & Copland call 'acquaintance interviews' (2010). Given the possibly sensitive nature of the interview, having a sample built through my networks or other informants in qualitative research is perfectly acceptable (Bernard, 2018; Braun & Clark, 2013; Garton & Copland, 2010). I posted my ad seeking informants (see **Figure 2**) on multiple channels (Instagram and specific group chats) and asked informants if they could advertise or knew individuals who would want to participate in the study. Due to the small amount of requests I received, I interviewed all that reached out. As Rimando et al. (2004) highlight in their report, recruitment issues are a common problem for graduate students in qualitative research with no funding, little time and no network. However, barriers are even higher with sensitive topics and gatekeepers to information (such as the schools I contacted) not permitting me access to certain populations (Rimando et al., 2004). Before the interview, I would send out a pre-interview survey which collected demographic information such as age, gender, sexual orientation, ethnicity, and religion (informants were informed they could leave any field blank). My informants ranged from 21 to 31 years of age, with nine identifying as woman/female, one as male and one as non-binary. Six described themselves as heterosexual, three as bisexual, one as queer and one as questioning. My informants were all white Danish individuals, with most of them having no

religion/being atheists, a few mentioning past affiliations to Christianity and two stating Christianity.

One of my roles as a critical feminist is to create space for the subjective experiences, perceptions, feelings, beliefs, and attitudes of the individuals involved in my research. Interviews enable me to do this as they allow for rich and detailed data about lived experiences and perspectives, allow me to talk about sensitive issues, and permit me to guide and probe the data being produced (Bernard, 2018; Braun & Clark, 2013). I contribute by merging different forms and sources of knowledge, facilitating spaces where fruitful discussions can transpire, probing where needed and delving into recurring patterns or themes for causal links.

Figure 2 *Digital ad used to advertise the study*

To achieve this, I chose semi-structured interviews as it affords me control of the interview using an interview guide but likewise allows space for new ideas to emerge (Bernard, 2018; Braun & Clark, 2013; Fletcher, 2017). The flexibility and conversation style of the semi-structured interview also aids in creating the necessary space for my informants to disclose personal information by allowing me to omit, supplement or change the wording and order of the questions in a matter more suitable (C. A. Davies, 2008, p. 106).

In addition, I paid detailed attention to the overall presentation of myself and my environment and to build trust beforehand (Bernard, 2018; Braun & Clark, 2013). My age was likewise an advantage as studies on young individuals and sexuality highlight that trust is more easily built when the researcher is also a young person (Page et al., 2023). I was aware of the power imbalances present and had to balance the identity of a researcher and insider in a way that maintained professionalism whilst simultaneously creating a safe and conformable space. This meant how I dress (casually to lessen power imbalances), the location of the interview (in a study room at Lund University, professional but comfortable), obtaining drinks and snacks (setting a more personal, conversational mood and as a thank you), chatting beforehand (to create ease and letting them get acquainted with me) and starting each interview reassuring my

informants I am here to learn from them and that they have something worth contributing (Bernard, 2018; Braun & Clark, 2013).

The interview guide was likewise structured to build trust and rapport over time; with an opening question asking about their wellbeing to acknowledge and allow my informants to situate themselves, followed by questions that became more personal as the interview progressed (Braun & Clark, 2013, p. 81). Throughout the interview, I deployed different techniques of probing. The standard probe and tell-me-more probe to get more relevant data; the silent probe which gave space for my informant to reflect and divulge and the phased-assertion probe, where I could demonstrate my cultural competence and knowledge gained from previous interviews and have people divulge things, they would not have done otherwise (Bernard, 2018, pp. 169-174). The interview focused on the informants' diverse experience and understanding of sexual education and ensuing experiences in multiple different contexts, letting them talk about what they deem important. If it was not already brought up by my informants, I would at the end ask about STIs and chlamydia before ending it with a closing question, to allow the participants to raise issues that have not already been covered (Braun & Clark, 2013, p. 81).

In addition, due to the threatening nature of some of the questions, where informants might have to share socially undesirable behaviour, I combatted this by highlighting the anonymity of the data, sharing my personal experiences to relate to my informants and have them feel seen, reassuring them of similar findings from others and lastly, formulating things in a judgement-free way (Braun & Clark, 2013, p. 188). Positive feedback was given to me by many of my informants either directly or indirectly through other people that the interviews felt like conversations, that they felt seen, that I was knowledgeable and offered so much of myself which resulted in the open, judgement-free and safer space for things to emerge (things they did not even realise needed space to come out).

3.3.2 Expert Interviews

For the expert interviews, after conducting online research and discussing with knowledgeable individuals, I compiled a list through actor mapping and respondent-driven sampling. Throughout the interviews, if multiple informants kept repeating a certain actor, I would add it to my map and if relevant, reach out to them (Bernard, 2018). This for example led me to reach out to a Danish sexual and mental health organisation and private GPs. I emailed various organisations, hospitals, doctors, schools institutes and researchers informing them about my research and my interest in an interview or chat. From the 33 places I reached out, nine replied

and five agreed to an interview. Most of the schools, organisations, NGOs and institutes I contacted either never followed up or were unavailable to interview (see **Appendix A**). Due to the structure of the Danish healthcare system, medical professionals' contact information was hard to come by. This meant hospitals acted as gatekeepers to my request being submitted to the appropriate actors.

With the experts, I similarly had a semi-structured interview, but as they were experts in differing fields, the interviews would deviate more to accommodate their expertise. Unlike the informant interviews, I would from the beginning mention my initial focus on STIs and chlamydia. Depending on the expert (e.g. medical professional, NGO, etc.), the questions would be tailored to fit the expert field they were representing, whilst some questions stayed the same for all, to allow the questions to be answered from differing perspectives. Hence, when I was interviewing someone from an organisation working with sex education and queer actors, I focused more on the educational content, experiences they had in schools or queer issues. On the other hand, when talking to medical professionals, I inquired more about the demographics and experiences they encounter at the hospitals. All expert interviews were asked why they think there are such high STI rates and what they think the solution(s) could be.

I ended up interviewing three medical professionals (nurses from Bispebjerg and Gentofte Hospital in Copenhagen), a counselling coordinator from a Danish Sexual Health organisation and a representative from RSFU (the Swedish equivalent of Sex og Samfund). I reached out to RSFU as Sex og Samfund did not have the capacity for an interview.

3.4 Ethical Considerations

To do my informants no harm, I followed the Swedish Research Council's ethical considerations and guidelines regarding notifying my informants about the research, consent, confidentiality and the use of the results (Vetenskapsrådet, 2018). I integrate the principles of reliability, honesty, respect and accountability through all aspects of my research design to the best of my ability. Without influencing my informants' answers, I inform them about the aim of the research (assessing sexual health education in Denmark) and my motivations (to understand youth's lived experiences regarding sex ed). In line with my critical feminist stance, I treat my informants as researchers of their own lives who have valid experiences and knowledge I cannot have. Even though I try to minimise the power differences, I am aware of my role as a researcher and theirs as an informant. I am likewise aware of my positionality (a queer, brown, woman doing a master's thesis in sexual health) and how that might impact the conversations I have with my informants.

I use pseudonyms in this paper and anonymise specific information if necessary. All my informants signed a consent form. Separate from the consent form, I also asked permission for the interview to be recorded, to which again all consented. I reminded my informants that they could always stop the interview at any point if they wished to. Regarding the expert interviews, I likewise followed the Swedish Research Council's ethical considerations and guidelines. However, with permission, I disclose the experts' roles and place of work.

3.5 Limitations

The methods had limitations, mostly resulting in access to certain key informants, certain demographics, and my ability to access certain spaces. The schools and healthcare structure were gatekeepers to pupils, teachers, and medical professionals. No school permitted me access, resulting in no observations at school settings, no perspectives of youth under 20 and no teacher's experiences – important perspectives to consider with the matter being researched. Even though I obtained interviews with nurses working at hospitals, I did not gain access to private GPs, someone who a lot of individuals turn to when getting tested. Many organisations failed to respond to my requests for interviews. I contacted their general email because I did not have personal connections to many of these places (WHO, SSI, ECDC). Given more time, building networks and personal connections would be advantageous for accessing key informants (Bernard, 2018). As highlighted by RSFU and the Danish Sexual and Mental Health organisation, who were acquired through personal connections (however, they did not suffice with Sex og Samfund).

As my informant interviews were recruited via acquaintance interviews (Garton & Copland, 2010) or snowball sampling, self-selection occurred as the informants chose to come to me (hence a willingness to talk about the topic) or were encouraged by their friends. This resulted in a quite homogenous group of people. All my informants were white Danish individuals who felt comfortable enough to reach out to me, and except for two people, all identified as ciswomen. Hence, I am aware that I lack BIPOC (Black, Indigenous & People of Colour) voices, voices that are historically more marginalised and lacking in Danish or Scandinavian discourse (Hunter, 2023). Due to the subject matter, it is no surprise that only one male voice was present; issues concerning healthcare, reproductive rights, sexuality, body, and gender are usually taken up by women (Sprague, 2016). Even though more male voices would have had its advantages, this likewise allowed me to give the FLINTA*s a platform to discuss their experiences that are too often not given the necessary space.

The studies, research and statistics I refer to are mainly binary in their gender understanding. Most studies refer to solely men and women, hiding or erasing the experiences of those who do not fall into these categories. I acknowledge the diversity of gender, but I must work with the data I have. If applicable I try to be more inclusive by using terms such as AFAB, FLINTA*, and LGBTQIA+.

Lastly, I do not speak Danish. Even though I have a basic understanding and online translation tools are quite advanced (DeepL, Google Translate), they cannot replace the nuances and experiences lost in the exchange. When making observations, talking to Danes, or analysing resources, I either must translate them or miss out altogether (i.e., exchanges happening at the STI clinics). Nevertheless, even though I do not speak Danish, I have extensive cultural capital and knowledge of the subject matter and of Denmark which allows me to connect with my informants.

3.6 Thematic Analysis

I conducted a thematic analysis on the transcripts from my informant and expert interviews using the software NVivo. I was inspired by Braun & Clarke's (2006) six-phase framework for doing a thematic analysis. A thematic analysis aims to identify patterns and interpret themes in the data that say something interesting or important about the research or issue at hand, rather than just summarising the data(Maguire & Delahunt, 2017). As my research is interested in my informants' experiences, I did an inductive analysis that is driven by the data; coding "without trying to fit it into a pre-existing coding frame" (Braun & Clarke, 2006, p. 12). In step three of searching for themes, I analysed at a semantic level, looking for the "explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said or what has been written"(Braun & Clarke, 2006, p. 13). Once I was done with the semantic level themes and codes, I did a latent level analysis "to identify or examine the underlying ideas, assumptions, and conceptualisations – and ideologies - that are theorised as shaping or informing the semantic content of the data" (Braun & Clarke, 2006, p. 13). Due to the space constraints of this paper, I selected the semantic and latent-level themes that are most relevant to the research questions.

4 Past Research and Literature Review

There is countless research on chlamydia and STIs, ethnographic studies done of schools and clinics, qualitative studies on youth and research on (Danish) sexual education. However, the numbers drastically decrease when you overlap the terms. This further contextualises the need for my study. However, the research done related to aspects of my study gives great insights

into what is already known and what is still lacking (Daly, 2015; Dudgeon & Inhorn, 2004; Fabian-Jessing, 2016; Haste, 2008; Lengen et al., 2010; Narushima et al., 2020; Newby et al., 2012; Sperling, 2021). I start by giving a brief history of Danish sexual education and related events and their healthcare policies. I then continue by discussing the main findings of research done on sexual education and then on chlamydia and STIs.

4.1 Danish Sexual Education and Surrounding Structures

4.1.1 Brief History of Danish Sexual Education (Policy) and Related Events

Sexual health has been part of Danish schools since the early 1900s but only became a compulsory part of primary and secondary education in the 1970s (Wellings & Parker, 2006). It is federally mandated but decentralised, hence government provides the guidelines but does not set a curriculum for educators (R. Goldstein, 2017; Wellings & Parker, 2006). As it is decentralised and not timetabled, it is up to the teachers to decide on the content, hours and implementation purpose (Wellings & Parker, 2006). The mandated curriculum afforded the teachers a lot of freedom, prohibiting only vulgar terminology, pornographic material, pupil counselling and information on how to perform sexual acts (Wellings & Parker, 2006). A group of parents took the state to court against the compulsory nature of sexual education but lost the case (Wellings & Parker, 2006).

In 1956, Sex og Samfund (the Danish Family Planning Association)(DFPA) was established by female doctors to help women with unwanted pregnancies (Sex og Samfund, n.d.). In 1973, abortion on demand was legalised for women over the age of 17 and covered under national health insurance (Manniche, 1983).

In the 1991 curriculum, the discourse changed from illness prevention towards health promotion (Roien et al., 2022, p. 76). The curriculum was also seen as a pioneer in the field as sexual health must now be integrated into all the subjects, students could ask any time and teachers can likewise discuss it anytime (Beaumont & Maguire, 2013). Schools likewise started inviting guest speakers such as sex workers and people living with HIV/AIDS to share their experiences in class.

Until 2005, the curriculum was decentralised and content-based which afforded greater autonomy on curriculum recommendations. However, since 2005, the curriculum has changed towards more neo-liberal education ideals with narrowly defined outcome-based curricula, affording the teachers less autonomy (Roien et al., 2022, p. 78). These tendencies towards centralised, neo-liberal ideals have likewise been reported in Australia, and the UK and echo the US curricula (Bay-Cheng, 2018; Biesta et al., 2017). In the same year, the Danish Ministry

of Health launched a nationwide health campaign to target STIs among 19 – 25-year-olds through multiple forms of media, urging people to test and use a condom (Lengen et al., 2010).

In 2008, Sex og Samfund started campaigning for "Week Six" in February, a week where schools can put sex education on the agenda and Sex og Samfund publishes new material for teachers and pupils. Participation is free and schools have no obligations to join (Roien, n.d.). The school is expected to work with (school) nurses and related social agents like Sex og Samfund, Checkpoint and other sexual educators/organisations to supplement their teachings but this is not mandated. Moreover, where in the past school nurses were a staple of schools and very active in sex ed teachings, with budget cuts and a lack of nurses, nurses are now stretched over multiple schools (Friis et al., 2007).

In 2015, the curriculum changed from a 'tolerance pedagogy' to a discourse of diversity in sexual education. Before 2015, the role of sex ed was to tolerate those deviating from the dominant cis-heteronormative norm, hence a 'tolerance pedagogy' that viewed sexuality through a heteronormative lens, 'othering' those whose sexuality and gender did not line up with 'the heterosexual matrix' (Butler, 2011; Jones, 2011; Roien et al., 2022). The curriculum from 2015 strives to use "postmodern sexuality education discourses articulated through norm-critical pedagogical practices" (Jones, 2011; Roien et al., 2022). This results in a discourse of diversity in sexuality education, encouraging pupils to understand gender, bodies, and sexuality as socially constructed, and to engage in reflexive and deconstructive practices.

In 2020, rape laws changed from forced-based law meaning the presence of violence, threats or coercion being present to a consent-based law, hence sex without consent being rape (Jacobsen, 2020). After an evaluation in 2019 of the subject "health, sexuality and family education", the Finance Act for 2021 was erected that set aside 15 million kroner to target the challenges of insufficient teaching, lack of knowledge and unclear organisation of responsibilities at school of the subject (Ministry of Education, 2021). In 2023, due to complaints from high school students, sexual education was likewise reintroduced in high school and was given 2 million kronor in funding (Moser & Prytz, 2024).

The current curriculum (2020) draws on socio-ecological and the WHO's assumptions on sexuality that are more holistic promoting positive values such as health, wellbeing, inclusion, agency and so forth (WHO, 2023). This entails seeing sexuality as a cultural & societal construction and an implicit assumption that "children and adolescents are intrinsically sexual beings" (Roien et al., 2022, p. 73). Sex ed is still taught under the cross-curricular topic "health, sexuality and family education"; the national curriculum sets the aims and intended

outcomes, but does not provide set content, guidelines or hours (Ministry of Education, 2019a, 2019b).

4.1.2 Standard Healthcare policies

Each Danish citizen is assigned a general practitioner (GP) and will follow them through their life unless they move cities or decide to change GP (Danish Health Authority, 2017). Your GP is your first point of contact and will refer you if necessary. GPs are qualified in matters of birth control and STI tests and will refer you for an abortion with no questions asked.

If you do not want to go to your GP, there are sexual health clinics (Bispebjerg, Gentofte) and certain organisations (Sex og Samfund, Checkpoint) throughout Denmark that likewise offer certain procedures (*How to Get Tested for Sexually Transmitted Diseases*, 2020). STI tests are free of charge and available when needed. However, some places (e.g. Sex of Samfund) require proof of residence in the clinic's city.

4.2 Failing Sexual Education and the Danish Curriculum

I delved into research with different qualitative methods investigating youth's experience with sexual education (Fabian-Jessing, 2016; Garland-Levett, 2017; Haste, 2008; Kim et al., 2019; Narushima et al., 2020; Roien, n.d.; Sperling, 2021). Though each research produced slightly different findings, most had similar themes such as inadequate sexual education, structural discrimination & contradictory messages and educators' inabilities. I then compared those findings with relevant research on the Danish curriculum (Bay-Cheng, 2018; Elia & Eliason, 2010; H. Goldstein, 1998; R. Goldstein, 2017; Moser & Prytz, 2024; Roien et al., 2022; Roien & Gundersen, 2018; Svendsen & Bang, 2018).

Haste (2008) conducted a comprehensive one-year ethnographic study of secondary schools in an area of London. She explores the lived experiences of school staff, sex education specialists and students and explores traditional and non-traditional school settings concerning their Sex and Relationship Education (SRE). Her study highlights findings consistent with other research on students' experiences with sex ed (Dailey, 1997; Ezer et al., 2019; Fine, 1988; R. Goldstein, 2017; Narushima et al., 2020; Shannon, 2016; Sperling, 2021). There seems to be a mismatch between the expressed needs of the students and what is being delivered in the classroom.

4.1.2 Inadequate Sexual Education: Emphasis On Risks Over Positives and Lack Of Explicitness

The first mismatch is inadequate sex ed in the form of emphasis on risks over positives and lack of explicitness (Haste, 2008, p. 22). Pupils express SRE to focus too heavily on the dangers of sexual activity, whilst neglecting the positive and pleasurable aspects. The lack of focus on pleasure and the positive aspects of sexuality is consistent with studies over the last decades (Crutcher, 2012; Fine, 1988; Orenstein, 2016; Rowland, 2020; Schwan & Brenner, 2020; Susie Jolly et al., 2013; Tolman, 1991). SRE likewise fails to address things such as sexual behaviour, emotions, and feelings, instead offering only biological or generalised explanations. These concerns were also brought up by the students in Narushima et al. research, a community-based pilot study in Toronto, Canada that examined the perspectives and experiences of sexual health education among socioeconomically marginalized, racialised, and LGBTQIA+[3] youth (2020, p. 32).The youth (16–24-year-olds) stated that school material primarily focused on abstinence and basic biological aspects of sex, such as puberty and contraception while neglecting topics like sexual pleasure, healthy relationships, consent, and diverse sexual orientations and identities. This limited scope left them feeling unprepared and misinformed, contributing to gaps in their understanding of sexual health and safety.

The current Danish sexuality education curriculum aspires to promote a sex-positive discourse but provides little space for genuinely sex-positive content, often dominated by discussions of challenges, risks, and caution. This lack of pleasure mirrors other studies done on sexual education (Fine, 1988; Rowland, 2020). Or, when sexual pleasure is present, it is framed through rationality and reflection, rather than an embodied sense and sensuality, disconnecting students from their interests and experiences, as it fails to align with their actual needs (Roien et al., 2022, pp. 75–76).

4.2.2 Structural Discrimination and Contradictory Influences

Narushima et al. (2020) study took a socio-ecological approach, allowing them to pay "greater attention to the social, institutional, and cultural contexts of people-environment relations" (Stokols, 1992, p. 7). This revealed the influences of "patriarchal, sexist and heterosexist norms [that] (re)produced dominant discourses" that affected various groups differently (Narushima

[3] Acronym used to describe the community of people who do not identify as heterosexual or cisgender. Lesbians, Gays, Bisexuals, Trans, Queer and/or Questioning, Intersex, Asexual and the + to represent those who identify with a sexual orientation or gender identity not covered in the acronym.

et al., 2020, p. 40). Parents and teachers promoted abstinence, whereas boys felt pressured to have sex to be a man, and girls feared being judged as "sluts" for it. Heterosexual youth took things for granted, whereas LGBTQIA+ youth identified barriers in both educational settings and at home. Many LGBTQIA+ reports mention the heterosexist and homophobic biases present in their everyday settings and the need to rely on the internet for their information (Charest et al., 2016). However, even though media was ranked third as a source of information, the narrative portrayed online differed from the youth's experiences by being hypersexualised and focusing solely on sex and offering little on relationships (Narushima et al., 2020, p. 38).

Haste likewise uncovers the notable gender differences between the pupils, with male and female students having distinct requirements regarding lesson content, classroom dynamics, and teaching approaches (2008, p. 23). Boys, in particular, often struggle to engage in coherent conversations about sex education, suggesting a need for gender-sensitive approaches. Paste writes that "'specialist' sexuality educators, continued to rely on a 'comfort zone' of traditional gender roles and normative heterosexual masculinity in ways that were not just unhelpful but also potentially damaging" (2008, p. 199). SRE programmes likewise struggle to address the needs of Black and Minority Ethnic (BME) pupils, as these students face unique challenges navigating conflicting norms and values about sexuality (2008, p. 23). Haste notes a need for better culturally relevant materials and a broader understanding of these diverse experiences.

On LGBTQIA+ issues, the Danish curriculum includes only a few references to queer[4] individuals. While the language used is gender-neutral, research shows that the lack of explicit representation of LGBTQIA+ individuals and relationships leaves space for interpretation of the dominant norms in society, hence reinforcing the dominant cis-heteronormative narrative (Roien & Gundersen, 2018). Though the curriculum intends to promote inclusivity and diversity, the lack of representation risks reproducing hetero- and cisnormativity, whilst excluding those with sexual and gender minorities (Roien et al., 2022; Shannon, 2016).

In addition, the curriculum claims to represent ethnic, cultural, and religious diversity related to sexuality, but there is an absence of concrete examples and illustrations. This neutralisation of diversity can result in a superficial endorsement rather than a practical implementation of diverse perspectives (Roien et al., 2022). Thus, the curriculum does not fully embrace and reflect the varied backgrounds of students, failing to genuinely represent the diversity it rhetorically supports and potentially harming those pupils (Svendsen & Bang, 2018).

[4] I use interchangeably with LGBTQIA+.

4.2.3 Educators' Abilities

In the Narushima et al. (2020) study, school is rated as the second top information for sexuality education, yet it was majorly deemed as unsatisfactory. Structural discrimination often shone through with teachers or counsellors uncomfortable discussing queers' matters and too many sex-negative values. Haste (2008) also employs concepts of social class and cultural capital to teacher/student relationships and how it benefits those from dominant classes who naturally acquire dispositions aligning with educational expectations, making some pupils feel more at home and facilitating their success. In sex ed, this disparity is evident as those with the 'right' habitus feel more comfortable and validated, while others struggle to engage effectively. Teachers, wielding power through their cultural capital, embody tendencies aligning with the dominant educational culture, influencing SRE effectiveness. Teachers unconsciously perpetuate dominant norms, failing to address students' varied realities. This Haste argues is due to teacher preparedness lacking with teachers avoiding questions or addressing students' concerns by relying too heavily on worksheets and textbooks. Teachers are lacking the support, resources and training (2008, p. 197).

In the Danish curriculum, as sexual education is not mandated, there are no set hours or content for the teachers, and they do not receive training. This is evident in the 2019 evaluation on sexual education where the teachers lack knowledge and are unclear about whose responsibilities sexual education falls under (Ministry of Education, 2021).

4.3 Chlamydia and the Youth

Newby et al. (2012) explore how young adults perceive the risk of chlamydia and identify implications for health education using semi-structured interviews similar to those I conducted. The research looked at young genitourinary patients (16-22 year-olds) in Coventry, England. The main themes that came up were the patients' general lack of awareness about the severe consequences of chlamydia, especially towards females, such as pelvic inflammatory disease and ectopic pregnancy. Instead, the young adults focused more on risks like pregnancy and HIV, perceiving chlamydia as less severe due to its treatability. This aligns with Lengen et al.'s (2010) chlamydia study and Cameron's (2003) research on risk representations, as severity estimates are based on controllability and consequences; hence if an illness could be controlled by treatment and has little (perceived) consequences, it would have low severity. It does not help that doctors do not offer tests or are even unaware of the prevalence of chlamydia (Fabian-Jessing, 2016; Lengen et al., 2010).

Another main theme was the patients' perceived susceptibility to chlamydia. Even though patients were aware of how chlamydia spread, they viewed themselves as less risky when engaging in that behaviour than their friends (Newby et al., 2012). Men often based condom use on their partner's perceived reputation, while women relied on cues like cleanliness and appearance. The low disclosure of infections amongst peers led to a distorted view of the prevalence of chlamydia and hence an underestimation of personal risk. Media likewise influences sexual behaviour, especially on condom use (Lengen et al., 2010).

Lengen et al. (2010) found that with new partners, there is still the fear and myth of condoms impairing function. This was in line with the focus group study with Danish men on chlamydia where the young men had strong attitudes and norms on acceptance towards the lack of condoms and an expectation that protection is a woman's responsibility (Fabian-Jessing, 2016). This results in women blaming themselves when contracting a disease and men blaming their partners and women statistically testing more even though men have more visible symptoms, resulting in changing men's testing rate as relevant for future change (Darroch et al., 2003; Fabian-Jessing, 2016).

Fabian-Jessing (2016) likewise uncovered the role of alcohol and parties with the men in the study claiming that alcohol breaks down barriers to unsafe sex and catalyses sexual encounters, whilst parties create fewer obligations to get to know the partner and have accountability. Moreover, non-committal sex with many different partners, which increases the chances of STIs is acceptable, almost desirable.

These studies highlight the need for improved sexual health education that addresses unhelpful beliefs about chlamydia's treatability and asymptomatic nature, especially the uneven and unfair consequences and assumptions between males and females. Education interventions need to emphasise the severe internal damage chlamydia can cause, challenge superficial judgments about partners' infection risk and personalise the true prevalence of infection. It likewise shows the impact of media, the assumed role of responsibility, the lack of information in both youth and medical personnel and the prevailing myth of condom use. If things are going to get better in Denmark, men have to start testing more and holding themselves more accountable to their sexual health, and the impact that has on others, especially women.

5 Interviews and Analysis

This section will look at how my informants problematise their experiences and the narratives that come up. Though each informant has different experiences and highlights various things

in their interviews, certain themes and issues are brought up by many of the informants. Things such as the very clinical/biological approach of sexual education, the assumptions on prevention and the ways they obtain more information. From all these different themes, I have categorised them into three common narratives: 1) What is sex(uality)? 2) Whose responsibility? 3) Hiding behind progressivity and 4) Breaking out of bodies.

5.1 What is sex(uality)? Teacher-student tensions

My informants kept bringing up their dissatisfaction with the inadequate sex ed they received during schooling similar to what other studies have found (Fine, 1988; Haste, 2008; Narushima et al., 2020). Through the many interviews, it materialised that this dissatisfaction stemmed from a discrepancy between what the students conceptualise as sex and sexuality, and what the teachers do. As the national curriculum is very vague, teachers are left to decide how they understand sexuality. Hence, with this basis, sexuality education was taught according to what the teachers thought seemed necessary. Some students experienced external educators such as Sex og Samfund, but many of them just had their usual school teachers. This section looks at how students conceptualise sex/sexuality, and hence what sexual education should then entail.

Anne, a 31-year-old woman who identifies as bisexual from an urban city in Denmark paints a sense of the coming themes:

> You have some awkward teacher stammering their way through a presentation. I associate it very much with being focused on cisgender heterosexual sex. It's putting a condom on a banana or it's putting a tampon in a glass of water and things like that.

When I asked my informants for their associations to sexuality, many of them refer to sexual orientation, identity and attraction, but likewise to pleasure, consent, an inner experience, appearances or even biological components such as reproductive organs and STIs. Though I never outwardly asked what their understanding of sex is, it was clear from their comments that sex is seen as a very diverse concept that clashes with what was taught in class. Many of my informants complained about their teachers' very limited views on sex and sexuality. Rather than discuss the potential diversity of sex and relationships, teachers just conflate penis-in-vagina (PIV) penetration with sex, "No, I don't feel like we talked about intercourse or how to have sex or stuff like that. Of course, we talked about how to get pregnant. But we didn't talk about that there are all kinds of relationships. It was mainly just general stuff like penis goes into the vagina." (Hanne, 28, she). Mads (21), my male informant from the outskirts of an urban city likewise has a similar experience, "You didn't put the emotional kind of person-to-person thing into it. It's just, this happens when you make a baby kind of thing". And even

though many teachers offered time for open questions, as Nora (25, they) points out, “it was open to us. But because we'd never been taught any other option, it was still very much heterosexual sex.”

Most of the informants point out this very limited understanding of sex and, as Nora, Anne and Hanne point out, left them focusing on “cisgender heterosexual sex” and not discussing the other “kinds of relationship” that are also present. This pushes a heteronormative understanding of sex that reinforces the gender binary and its corresponding sexualities, erasing queer experiences and the different reasons people might be in relationships or have sex with each other (romantic, sexual, platonic, physical etc.)(Butler, 2011). Or as Mette (27, she) comments, “Like how sad to be a young gay boy and be told that your kind of sex is wrong or different or somehow extreme that's such bullshit.”

Agnes (27, she) likewise comments on the set-up of this very heteronormative teaching “everything was kind of between a boy and a girl. And that was how it was set up (…) I don't think there was any focus on like, how do women have sex”. Using only non-queer examples and binary structures did not only limit non-queer people’s understanding but likewise actively harms queer individuals as Nora (25, they) recalls needing to pick a ‘side’ and perform, “which also made me really uncomfortable as a genderqueer person but I just am socialized into like performing cis womanhood. I just decided I was a cis woman and I just performed that for 10 years of my life because it was easier”.

Here, we can see the habitus operating, where the implicit dominant culture (heteronormativity) is being established by the teachers and then later reproduced by the pupils. Heteronormativity and those who adhere to it are being privileged, but this is not made clear. This makes heteronormativity appear like the ‘objective’, ‘ought to be’ norm and a ‘correct’ way of having sex. By the constant repetition of being told sex is PIV penetration (and the individuals doing the actions), this practice is broken into the pupils till they accept this norm, and the patriarchal, heteronormative value is subliminally absorbed into their bodies (Lefebvre, 2004). As the teachers possess a lot of capital, the knowledge and opinions they impart are taken seriously as Christof (he/him) who is in his early 30s and currently a project manager and counselling coordinator at a sexual and mental health organisation highlights, “If [the teachers] take on queer people is that they are (indiscernible) [Danish slur for queers], then it will affect the educational...whatever they teach the kids.” People like Nora, whose identity does not fit the ‘objective’ binary dominant habitus must disrupt the status to simply be, which is difficult and hence why Nora performed a false identity to fit the habitus.

Many participants express dissatisfaction with the too clinical and biological focus in their sex ed classes. Mette, who has lived in many countries and experienced schooling in Indonesia, France and Denmark voices the following:

> Well, this is sex, this is how it works, but it was very penis and vagina sex. There wasn't any talk of oral sex other than you can get sick if you practice oral sex with a sick person. There wasn't any talk of pleasure or setting limits, setting personal boundaries. It was very clinical.

But even with this clinical/biological focus, it was a very tailored focus. Freja (25, she) who comes from rural Denmark and moved to an urban city recalls her anger at finding out important things too late in life, "Things that I have never found in my life before I turned 22-23 and that makes me kind of angry that you know as a part of sexual education you can tell us about puberty but you can't tell us about how common it is to have fungus (…) I feel so disconnected from my own body (…) not able to read myself".

When the teachers discuss the 'dangers' of sex, they solely focus on the biological 'dangers' of pregnancy and STIs. Interestingly, Mads (21, he) talks little of school and attributes what he learns to from home, "I'd say my parents who have given me the most introductions to different things and warnings about certain things". Nevertheless, the education at home likewise revolved around the 'dangers' of sexual health, "it's usually the same thing you hear, right? It's use a condom, don't do it too lightly. The main thing I feel like I've heard all around is just to use the goddamn condom because otherwise, you end up with gonorrhoea and HIV and stuff that you live with for the rest of your life or a baby or child support.". While it is certainly good Mads' family was open to discussing sexual education at home with their child, particularly the importance of condom use, the way he describes his experience also indicates a sex-negative framing, focusing on the dangers and commenting on "don't do it too lightly".

Sexuality is conceptualised as something to fear and something happening at a biological level to the bodies, and no attention was given to the emotional, psychological, and social aspects that likewise encompass it. Nevertheless, even with the biological focus at school or home, the information was still lacking or incorrect as Freja highlights above or 23-year-old Kirsten from an urban city in Denmark remembers how the anatomical diagrams used were not always up to date and wished for "more anatomical stuff that is updated" regarding women's bodies. This is an issue in school textbooks, but even in medicine textbooks where the vulva and corresponding clitoris is not fully explained or anatomically represented as the penis is (Spaulding, 2021). Christof warns about the politicised agenda the politicians have:

> They only focus on the part of biology that they would agree on. So if you want to talk about biology, then you also have to talk about intersex people. But they won't talk about intersex people because that's not a part of their agenda. And it's a problem when it gets political in that way because everyone should have the ability to see themselves in the educational system. And one way to do that is to include you in the educational system. But if you try to diminish or erase queer people also in sexual education, then you end up killing people because they won't feel seen. They will feel ashamed. They will feel wrong. And we keep stigmatizing people. And it's not okay. And it's a major problem.

As Spaulding formulates, there is a "hidden curriculum of gender bias" in medical textbooks that reinforces androcentric bias and sex/gender stereotypes which is an example of the institutionalisation of the patriarchal, heteronormative habitus (2021, p. 6).

The positive, healthy and pleasurable aspects of sexuality were barely discussed. Alma expresses how she was too scared and not informed about the potential enjoyment that comes with getting older and becoming sexual:

> I would have liked some of the positive parts of growing up and getting a sexuality because I think that... I probably got a little scared of it, of the whole world about it. So it would have been nice with some people who told me that it's pretty nice and it's not that dangerous or scary.

As Kirsten exclaims in the interview, female pleasure was not incorporated, "Way, way more sexual education. First of all, quantity more and more and more. And then of course also quality. More about female pleasure and pleasure in general". As mentioned above, because sex was implicitly understood as PIV penetration, this was not always pleasurable for people with vulvas, hence the emphasis on the lack of female pleasure. Agnes describes it as following:

> I think it was just like, I guess, for men, but it didn't really shine through. I think that's also kind of the problem that when we had sex occasions, we thought that was what sex was. So we didn't see it like this is for the men, this was just what we have and then you have to learn for yourself, oh women actually have other things going on (…) so you think that's how it is for everybody and penetration is the best thing in the world and then you're like maybe I'm the one who's the problem and then you learn and figure out that's not what's happening.

Agnes (27, she) had a moment of recognition in the interview when she realised that only recently has the sexual education information she consumes been consciously tailored towards women, with the past sex and discussions she received being unconsciously tailored towards

men. Again, this androcentric bias led to only sex being discussed to be PIV penetration. Agnes and many of the other informants were subconsciously being told this is the sex that they are supposed to be having and enjoying (and felt broken when this was not the case), and only later in life realised that the 'pleasurable' aspects taught in school were not oriented for bodies like her. Being in the habitus, it is hard to recognise what the habitus is as it is the unspoken status quo, even if it does not benefit everyone. Agnes, and many of the other informants (and their partners) were enacting disciplinary control unto themselves during sexual encounters by perpetuating what counts as 'sex'. The repetitive disciplining of the body during sex goes through dressage as they conform their bodies to this behaviour. It took Agnes realising that the status quo is designed for men to realise that she is not the problem, but the dominant culture is. On top of that, not only were topics of physical pleasures missing, but so were the pleasures of being in a healthy relationship.

> What is a healthy relationship? I've been in so many toxic and manipulative and emotionally abusive relationships (…) Just having some discussions about these things to know what the fuck is up and have some role models in terms of romance and love and sex being something that can be good. And knowing what a healthy relationship is. And knowing that it's healthy and loving or not even loving, also just being like, okay, sex can also be for pleasure and for fun. It doesn't have to be to a man and a woman who's super in love (Nora)

As the limited sexual education focused on the scientific and biological processes, almost all participants expressed the lack of information on interpersonal aspects such as "consent and setting boundaries – How to say no and say yes" (Kirsten). As Nora likewise agrees, "bodily autonomy and consent stuff. There was so much of that, that we never got taught. Just in general, just being much more honest about these things, power and balances in consent". When the classes do not examine consent, boundaries and power structures, informants find themselves in uncomfortable situations as they are not prepared for it. As intersectionality highlights, differing intersecting identities have various privileges and disadvantages, as Kirsten comments in her sexual education classes "that space they create is for me so big and so masculine and so difficult to break and I feel that's a conversation we need to have because, for me, I still haven't figured out how to break with that pattern. And with that space that the men take up". When in a situation with a guy, my non-male informants have less power and control. Here, Agnes talks about how, rather than focusing on STIs at such a young age, where that was not relevant to her yet, she would have preferred consent work, as that is applicable in many aspects:

> And understanding that growing up, handling feelings, was way more important when you're a teenager than getting a disease. (…) I think that I would have liked a little bit more about how to actually handle it when you were in situations where you did not feel in control about saying no to a guy that kissed you or in situations. Because you're so young and vulnerable that it's really hard to say no to somebody.

Consent is not only something you exercise in explicitly sexual situations. It is used in everyday life, from agreeing to join your friends for lunch to asking someone to borrow their pen or allowing someone to hold your hand. Consent is an affirmative agreement or permission verbally or through actions that are understood by all. Something applicable and necessary to learn from a young age and a part of sex ed, as many of the informants expressed, including three of the experts. As Sigrid our medical personnel highlights, "The important part is about boundaries and consent. And I think that if we start with that and then move on to the infections because sex is still supposed to be fun and a natural part of life. And it's important not to scare the young people. because then they will also have an unfulfilling sex life during their life, right?"

However, as the sexual education curriculum points are not mandated, it is up to the teachers, as the experts note "one major problem with the Danish sexual education is that it's unregulated" (Christof) and "the laws are mandatory but it's up to the individual teacher in school to how to interpret this law. So, they're supposed to teach the children about health, well-being, gender, body and sexuality but they can choose themselves how to do it" (Maja).

By analysing how the informants understand sex and the sexuality education they received, we can see the discrepancy occurring. Teachers saw sex and hence sexual education from a clinical, risk-based approach and hence, students were missing out on the broad spectrum of what entails sexuality and sexual health such as the interpersonal, holistic and positive aspects of it. So even though the current Danish sexuality education curriculum aspires to promote a sex-positive discourse it provides little space for genuinely sex-positive content, often dominated by discussions of challenges, risks, and caution. This lack of pleasure mirrors other studies done on sexual education (Fine, 1988; Rowland, 2020). Or, when sexual pleasure is present, it is framed through rationality and reflection, rather than an embodied sense and sensuality, disconnecting students from their interests and experiences, as it fails to align with their actual needs (Roien et al., 2022, pp. 75–76). As Peter highlights, "I think it's good also for teachers to think that this is knowledge-based rather than value-based." Because when teachers put certain values, they are reiterating the dominant discriminatory habitus.

5.2 Whose responsibility? Prevention as a woman's issue & men's invincibility

Throughout the interviews, informants and experts repeatedly mentioned negative examples and experiences they had to endure. Whether it was a sexual encounter, an experience at the doctor or the content being taught at school; the narrative was that prevention is a women's issue. Denmark has very strong healthcare with free easy testing, treatment and abortion available. This good healthcare combined with prevention as a women's issue leads to unfavourable consequences such as the matter of protection, teachers' expectations, experiences with healthcare personnel and men's assumption of lack of consequences.

Most of my informants mention an experience where they had to bring up the issue of protection during sex or even argued for it; "Like, if you don't stop them kind of just putting that dick inside of you, they just really think you're on contraceptives" (Kirsten, 23). It starts with men assuming women are on birth control and not asking them and expecting the women to bring it up. This aligns with Fabian-Jessing's (2016) findings that Danish men expect that protection is a woman's responsibility. Agnes recollects how infuriating a sexual encounter can be when broaching the condom question: "it's a lot that's put on your shoulders as a woman. All of a sudden, you come home and they're [the men] like 'oh why didn't you say that then' and they ask, 'why didn't you say anything'". Even when Agnes was the one to bring up the condom question, the men she engaged with would complain about how 'late' she mentioned it. Or some even outright manipulate and lie to my informants, as Nora mentions, "They end up manipulating me into not wearing a condom (…) some of them literally pretend that they go get tested and they never talk about it again". As pupils are not taught about consent and boundaries, Freja (22, she) thinks that "the culture of guys hav[ing] a problem with using condom is still quite alive (…) it's about not being able to say no. Feeling that you're kind of turning down the vibe or taking down the heat if you say that". Christof the counsellor confirms "in our test clinic, we also see a lot of young women who want to have sex with condoms, but that they feel ashamed bringing it up because they will be shamed or the guy would just say, aren't you on birth control?"

These kinds of thoughts were confirmed by Mads (21, he) who mentions, "Like, as a man, if you have the chance and you're like, oh no, I don't have a condom, I think a lot of men will be like, at least in those years in high school where, frankly, all men are rather desperate. I think they'll just be like, ok, I have the chance, we'll take the risk". But it is a risk that the women take as Mads later argues the severity of the risk depends on the choice the woman

makes on the pregnancy. Here, Mads is conceptualising pregnancy as an issue that occurs once the woman decides to keep the pregnancy, rather than an issue both parties are a part of by not using a condom.

As Peter our advisor manager for sexuality education at RSFU confirms, schools and teachers institutionalise and normalise women's responsibility, by perpetuating the habitus and adopting the gendered norms of prevention being a women's issue, "it's also a little bit about the teacher's expectations also. The school's expectations that you put on most girls. (…) I think it is also a kind of old tradition that prevention has in some ways been put on women. (…) there is a kind of perception that it's much easier to influence women than men". This perception is not innate, but the result of the socialisation and ensuing habitus over decades of dressage done onto women and disciplinary power. And it shows, women test more, initiate condom use, explore more and are using more contraceptives. Statens Serum Institut 2022 report states that women are testing twice as high as men are in Denmark (2023). Maja our nurse of four years with two daughters questions, "Is this what we teach our girls? Always to take care of others before taking care of yourself?"

As Nora resolves "some of these men have no shame and have no fear of anything because nothing bad has ever happened to them", an opinion that is also shared by our expert Christof "I think a lot of straight men are used to not thinking about consequences (…) So there's a lack of responsibility". Christof emphasises straight men because of their increased risk of HIV, gay men routinely come in to get tested, which he and the nurses confirm. Peter from RSFU emphasises that "sexuality education can and has to be better in reaching out to boys" because as the data shows women are testing twice as high as men and doing other forms of prevention (Fabian-Jessing, 2016; Statens Serum Institut, 2023). In addition, STIs are only fixable if they are caught in time, and men experience more symptoms than women. This fear and consequences related to sexual health for women and the lack of it for men are based on past experiences and socialisations that mirror the gendered realities and habitus of the everyday lives of men and women. In many aspects of life from sexual to climate to public life, women experience more violence than men (UN Women, 2023). It makes sense that the "no consequence" privilege men have also exists in the sexual health realm.

On top of that, bodies with uteruses experience more consequences due to STIs. When asked what my informants fear most, most of them reply with "pregnancy". Even with the extremely biological risk approach in sexual education, when it comes to STIs, a lot of the informants and experts express how they believe no one knows enough, whether it be symptom-wise or long-term consequences. Nora speaks about themselves "I think like the

whole, I don't think any of us understand the symptoms", whereas Hanne mentions those around her, "not aware also how dangerous" the STIs can be. Experts agree, like Sigrid (she/her), who is 38 years old and has worked 14 years in dermato-venerology and is currently at Bispebjerg, believes not only individuals but likewise doctors do not know enough, especially regarding transmission, "people in general and also their doctors and everybody else doesn't have that much knowledge about the potential ways of transmission that you can get chlamydia and gonorrhoea from oral sex, you can get syphilis from kissing". Due to the AIDS crisis of the past, Sigrid thinks there is a misconception regarding safe sex, "kissing and oral sex is considered safe sex when it comes to HIV and when it comes to pregnancy but not with these bacteria [STIs]". Christof, with five years of experience in the field likewise adds that too little is known regarding testing procedures. When offering sex education classes to the youth in rural areas, he received multiple questions regarding basic information to testing.

In urban centres like Copenhagen or Aarhus, there are testing centres like Checkpoint and sexual health clinics like Bispebjerg. However, in rural areas, testing facilities, external organisations like Sex og Samfund or Checkpoint are not available, which Christof emphasises is a big issue and demonstrates itself in higher STI statistics and migration movement of queers towards urban cities. In rural Denmark, individuals can only get tested by their own GP. Maria and Harriet at Gentofte comment on an issue there, "a lot of people don't go to their GPs because they have a personal relationship with the GP because they've had the GP since they were like babies (…) and the whole family uses the same GP. So they're kind of nervous and afraid that they will get outed with the STD testing". Sigrid from Bispebjerg adds that many of her patients travel far distances to her hospital as "their doctors refused to do" certain tests. For Mette, she feels judged by her GP, even when she does the responsible thing by getting tested:

> Like, I do catch myself. If I go for a check because I've not used a condom, I do catch myself telling her it's because I did use a condom but it broke. Because I feel there is still, like, a level of judgment. I caught chlamydia once from a guy I was seeing, what I thought was exclusively, and he told me he was only seeing me. He was having sex with others, apparently. I could feel something was wrong straight away and I called my doctor up and I was like I need to get checked. And then she was well, it's positive and you need to inform all your partners. And I was like, I only have one partner and she didn't believe me. (…) She was super slut-shaming about it.

For those lucky enough to live in an urban area or did not encounter judgemental medical personnel, testing is viewed as easy, "it's so easy for people to get tested. And to get treatment and it's free. So people are maybe more like if it happens, it happens. Because it's very easy to

get help. (…) Because there's not really a stigma about getting sexual diseases and you know that help is very easy to find. Then it's not that severe for you to get sexual diseases. Just like if I get it, I get it. I don't have a condom. I don't care" (Klara, she, 23). This sentiment of getting an STI as not being a big deal and "you take a pill and it's gone" (Mette, 27) was shared by many informants and experts, but then also cautioned that they felt their peers or patients were not aware of the "dangerous" consequences.

Strides in HIV/AIDS treatment, abortion rights and STI testing are celebrated but then also seen as a factor for individuals to not use protection as cautioned by Maria and Harriet from Gentofte, "everything you can fix, you can take away. The chlamydia, the gonorrhoea, if you get pregnant, you can take it away. In the 80s and 90s, they were so afraid to get HIV because you could die. You can still get these STDs. That is not that funny okay, herpes or condylomas, who wants that? But they are not thinking about it (…) there is a blankness in those young heads". Informants and experts applaud the advancement in healthcare but likewise notice the unintended consequences that arose out of it. To combat this, Christof highlights how in their organisation's sex ed sessions, the educators try to work with the youth, such as encouraging testing rather than shaming the youth into using protection, "We also talked about getting tested as a way of preventing STIs because we know a lot of people won't use a condom or won't use a dental dam. So what is another way to take care of yourself and your partners? That is to get tested, to know your status. And then if you have chlamydia, get treatment."

As the data shows, these kinds of experiences occurring with institutions, doctors, and sexual encounters are repeatedly happening to the women's bodies, it is impounded into them that protection is women's issue and responsibility, over time creating the habitus that 'boys will be boys' and girls are the 'responsible' one. This goes so far that men blame their partners and women blame themselves if something occurs (Darroch et al., 2003). Even though women are already testing more, and men have more visible symptoms, the dominant culture is still blaming women when something occurs and at times penalising them (i.e. slut shaming) and men do not receive the same expectations. All these possibilities of free testing, abortion, and contraception are only band-aid solutions because the habitus and dressage have not changed. Heterosexual men are not making use of the services and do not take responsibility in prevention. Unless we change that culture, no amount of band-aid solutions will improve the STI cases.

5.3 Hiding behind progressivity

Denmark has a narrative of progressivity around sexuality due to historical events, policies and a culture around sex that aim to be more sex-positive and inclusive. Historically, Denmark was the first to legalise pornography and same-sex unions, and made sexual education compulsory and legalised abortions in the 1970-80s (Gade, 2010; Garrett, 2016; H. Goldstein, 1998; R. Goldstein, 2017). The current sexual education curriculum strives to incorporate values such as well-being, inclusion and agency and views sexuality as a cultural and societal construction with the assumption that "children and adolescents are intrinsically sexual beings" (Roien et al., 2022, p. 73). 88% of men and 73% of women consider having a good sex life important and their reasons for sex are diverse from enjoyment (51% of men and 39% of women), emotional intimacy (40%), orgasm, emotional confirmation, pursuing well-being and release of tension. Only 0.7% report doing it due to partner pressure (Frisch et al., 2019).

I asked my informants their thoughts on this narrative of progressivity and was met with ambivalent feelings. They highlighted the issues of being seen as progressive, Denmark's relation to queerness, the assumptions adults have and the urban and rural divide.

Many of my informants acknowledged the accepted nature of casual sex, sexuality and queer identities in Danish culture, but highlighted the limit of its understanding and pride, as Anne (31) mentions, "Like, I think here we kind of also pride ourselves a little bit. Which sometimes becomes a problem, right? Because we think we're more progressive than we are (…) I think there's sometimes a disconnect. Between, again, how we also envision ourselves to be. And then how we actually act. But from where I'm standing, it does seem like there's space for talking about sexuality in a way that I think is generally quite healthy". Mette (27) builds on this commenting:

> I feel like it wants to be more progressive than it actually is (…) Like, it kind of insists on its own progressiveness without actually putting in the work. Your general man will be like, oh, I don't mind gays, I don't care at all. Like, people should do whatever they want. I just don't want them to hit on me. Or it's like, why would they do that? So it's also, like, regarding sex, it's very, I'd say it's a relatively sex-positive society, at least in Copenhagen. I think in most of Denmark, Casual sex is very much a part of, like, youth culture and of culture in general.

Klara (23) continues on this tension between acceptance of others but not of themselves,

> There is definitely respect and I think people feel like you're [queers] just as welcome and it's just as well what you're doing. But I think there's still these societal norms that

> people themselves want to live up to. So like it's fine, you can break the norms, you can do whatever and also maybe they're kind of impressed, yeah, you go. But then it's still like, oh, I still want to exist inside of this bubble.

Nora (25), who is queer argues following, "we're allowed but we can't be too proud or too loud about it, we're welcomed but we can't be too drastic and there are no queer exclusive spaces because that would be reverse discrimination. There's a lot the mainstream has to be comfortable with you, (says ironically) but the mainstream is so progressive that it's not a problem right?". Here, Nora notes the tension they experience being a queer person in 'progressive' Denmark. The perception of the progressive habitus did not match what my informants felt is the real lived experience, especially for queer individuals.

Informants like Mette, Anne, Klara and others felt that Denmark had a too high image of itself, which ultimately harmed itself due to the assumptions that come with it, and the lack of momentum that then occurs, Freja comments, "I'm quite opposed to the version that other countries have of Denmark. (…) And, you know, people have this romanticized image of Denmark being this ideal country. And I think that affects the way that they see us also in sexuality, progressiveness, everything. And I think that it's really hurtful, both for the Danes themselves, because we in general tend to believe that we are one of the best societies in the world." This internalised progressivity seems to affect the sexual education the pupils learn, with not a lot of depth happening as the teachers assume the students already know enough, "We didn't learn about like sexual health really (…) There was very much an assumption that most of us were sexually active".

Kirsten theorises this pride of being ahead hindered talks of certain issues due to fears of making it shameful, "There was so much lack of information (…) because everyone was very aware of not making any of it shameful. I think there's just a lack of awareness of STIs and I think the culture is we're so sexually progressive that we can't talk about the consequences". Nora adds on, "because there's a culture of no shame then there's also no information about it, so no one fucking knows and then it's just become so normalised that everyone gets chlamydia once in a while but that shouldn't be". This value of not making sexual stuff shameful was so ingrained, that it took an unfortunate turn that mistook vulnerabilities or negative consequences as something shameful, rather than just a part of sexual health. It went so far that getting chlamydia was part of the norm, possibly even a sort of dressage that having a Danish sexual life is part of. The teachers seem to have enacted disciplinary power to police themselves on what they would teach to be in line with 'progressive Denmark', which for them meant not discussing the negative consequences, in fear of being sex-negative.

My informants are a mix of both rural and urban areas in Denmark. Many who have moved to urban cities like Copenhagen note the difference in progressivity between their old rural places and their current urban environments, "In Copenhagen, they are really, really open-minded. You can really feel that they are a bit more woke than you are in Aalborg". Freja (25), also from a rural town notes that the progressivity of places like Copenhagen should not be confused with the entire Denmark, or as Agnes puts it, "I don't know how representative the Danish society is of Copenhagen". This is an issue that Christof our counsellor who is from a mid-sized urban city highlights:

> If you live in the rural part of Denmark then my theory is maybe you will not get the most norm-critical Sex & Samfund educational material. Then it will be one hour with your math teacher like me (…) it creates a gap between the largest cities and the outskirts of Denmark and we can see that a lot of queer people move from the smaller towns into larger cities because they found it easier. And it's a problem. Because all students should get the same equal good education. So it shouldn't be regarding how rich your parents are or how big the city is".

He then continues to advocate how more resources need to be given to smaller cities and towns to help focus on creating safer spaces in schools, so one can live in those places the way Christof can in Copenhagen. Another issue he highlights relates to the negative effects patriarchy has on men through *toxic masculinity* which is a set of attitudes, norms or stereotypes that are associated with or expected of men that harm men and society as a whole such as hyper-competitiveness, individualistic self-sufficiency, sexism, misogyny and much more (Sculos, 2017). "We also see young men that feel pressured to act a certain way sexually or behave or maybe have sex in some way that they don't want to have sex. But the society has told them that this is a manly thing to do, and you have to do that" (Christof). In addition, he mentions concerns of stigmatized and undocumented sexual assault towards straight men, "it's unbelievably shameful to be a straight man and to have experienced sexual assault because you will be questioned about it. (…) but as a society, we haven't created a safer space for straight men to open up about their feelings in general but especially not when it's regarding sexual assault". In his line of work, he experiences the struggle these men have in coming out with abuse. From little boys, men have experienced dressaged over and over again that showing vulnerability is weak for a man, they have been penalised and that value is so ingrained into them that they are now struggling to speak up on assault.

As my informants and experts voice, Denmark, or better said Copenhagen is progressive in some sense, but its reality is far from what it believes it is already at. This notion

of progressivity seems to hinder change, as it stops people or institutions from putting in the work. Progressive also depends for whom, are you in Copenhagen or the outskirts? Are you queer or straight? Did your teachers assume things of you and hence undertaught you? There is also a misperception that talking about risks and negative consequences equals making sexual health matters shameful. Men likewise bear a burden with toxic masculinity manifesting to hinder them from speaking up.

5.4 Breaking out of the bodies: Seeking alternatives

Even with all the different norms, rules, institutions and education that are creating the habitus that prevention is a woman's issue and that sexual health is understood through a biological heteronormative understanding, there are different ways individuals are breaking out of their bodies and changing the rhythms that have been impounded into them. This is through talking to friends, professionals or seeking out TV shows, books and podcasts. However, not all the informants can break out of their habitus as easily.

Most of my FLINTA* informants mention how they would seek alternative information sources or heavily talk to friends regarding matters of sexual health. Even though it feels like it reinforces this notion of sexual health being a women's issue, the information they seek would be contradictory to what they learnt in school or through socialisation up to that point. Talking to friends and coming across alternative information empowered many of the informants by making them feel less alone, giving them "acknowledgement that it's normal" (Klara, 23), realising the issues they share, and giving them the courage for future situations (Agnes, 27); findings like Schwan & Brenner (2020) research on a peer-to-peer sexual education for AFABs. Anne (she, 31) who identifies as bisexual shares,

> a lot of my understanding of sexual health and my own sexuality and stuff comes from talking with my friends. It's a lot of peer knowledge. Talking through the lack of knowledge that we all kind of share. At least a lot of my friends tell me similar experiences that they had with sex at school. And sharing our good and bad experiences with sex. And learning from that and kind of learning together.

Nora (they, 25) feels it is validation and a form of protection against unsafe situations:

> I've started recently being more open about it with my friends and the others who are sleeping with cis men (…)To be like no actually that wasn't okay and I have a lot of friends who've had similar experiences and they also didn't think that was okay, so now we can come together and be like no, because there's a lot of gas lightings cis het men out there. At some point, you start at least observing what they're doing.

Similarly, through connecting and sharing similar experiences, Agnes can better advocate for herself,

> Some of the best bonding I have ever had with women has been about sex and sexual health. Like have you tried this, this sucks or the guy did this and what the fuck happened and you're like I tried the exact same thing. This experience of talking to women who just understand you. I think a lot of it is in that positive experience and that learning that you really bond over this and then I think a lot of self-discovery and also it has been something that has been talked about more in the media (…)Because in a way, they're [men] selfish all the time. And when you were a teenager, you didn't even like the guy. It was just, I didn't want to be rude, it would be a little bit uncomfortable, don't want to step on his toes. And now you're just like, get out. And I'm really happy that I learned that but it's been a long process.

To undo years of dressage that has been formed out of decades of habitus is going to be "a long process", but through comradery, my FLINTA* informants are feeling more comfortable in their bodies and identity, better able to take care of themselves and slowly change the narrative about prevention only being a women's issue and start holding men and others accountable to undesirable behaviours. By discussing the experiences and actions the FLINTA* informants do to themselves, they are better able to uncover the disciplinary power they were unconsciously enacting in the first place and the way men have encouraged it.

Moreover, for my queer informants, friends and the media were some of the only spaces where they could feel represented or seek out information like Anne mentions above or Nora notes, "the Danish stuff has been very heteronormative so I've just kind of given up on it. It's mainly just conversations with friends and then Instagram". Multiple informants brought up (new) norm-critical shows they would seek broadcasted on the state channel that deals with issues of (trans)diversity and sex-positive content. TV shows have been shown to change attitudes and inspire action (Green et al., 2024). Helle (22, she) who comes from an urban city mentions the inspiration she found in role models in these new critical media spaces, "we've had like so many strong voices. We have a Danish columnist called Emma Halden. And she was first sexually abused and then she did some activism around that and he's been working on the consent form(…) She's the coolest person I know".

Whereas my FLINTA* informants were breaking out of their bodies, my male informant sadly did not seem to experience the same. I recall how different my interview with Mads (21, he) was because I needed to clarify questions that none of the FLINTA* informants needed. This highlighted to me how different his experiences were from theirs because the

lived experiences are what allow my AFAB informants to similarly understand the question. On the matter of confiding in friends, Mads questioned the purpose because for him, talking with friends meant sharing "how we have sex with our girlfriends" and "that's kind of disrespectful". Later on, he adds, "I never felt like I had the urge to be like yeah hey I have issues". Mads claims that he would only talk to his friends once an issue has been fixed. When asked if he sought out alternative information, he replies you only seek information if you have an issue which he did not have. A patriarchal habitus does not only harm women but also men. Similar to what Christof mentions above, Mads has been conditioned and gone through dressage that showing weakness or vulnerability is undesirable or even condemned, hindering him from properly confiding in his peers and discussing the ways my FLINTA* informants can. Discussions that allowed my FLINTA* informants to break out of their disempowering stance on sexual health. This is an issue Peter from RSFU emphasises and why he feels sex ed needs to target young boys more:

> In some way, you see sexuality as a very male thing. It's the sex drive and the biology of sex and all has been very much connected to men. But at the same time to talk about it. It hasn't seemed so manly, it's not within the masculinity norm. So when it comes to health and especially sexuality in relationships, that has been a field for women(…) because sexuality is also sometimes so much connected to masculinity. We'll talk about also difficult things there or to be vulnerable. That is also to reduce your masculinity. And to talk about difficulties of warming [for sex]. They will also say something that you are not a real man or something like that. These things are not so strong anymore but it's still there.

Many of the experts highlight the need to change boys' narratives and understanding. This heteronormative, patriarchal dressage is harming them, but unlike the girls, they have less capabilities to break out of their bodies. For Helle (22), it helped her to go "into environments which are more structural critical" and "understanding what patriarchy really does". As the effects of patriarchy on women are more evident, it is harder to notice the effects of patriarchy on men, and thus how to break out of it.

Access to alternative resources in the form of media and friends needs to continuously be developed as they allow individuals to break out of the patriarchal heteronormative habitus. Media's capabilities need to be acknowledged and used to its advantage. Currently, FLINTA*s are using these resources more. This should continue to be encouraged but likewise find ways to target boys to use the resources.

6 Personal Experiences in the Field

Unlike the Danish youth I interviewed, I did not go through the habitus and dressage of Danish society. Nevertheless, I am still part of and affected by the patriarchal society, hence my body has also learnt how to navigate and be forced to absorb the habits and norms of that society. What there is to observe does not only exist for Danish people, and an outsider perspective can uncover things that my informants might not realise through distance and perspective as I was not shaped by the prevailing value systems (Naaeke et al., 2010). I have structured the STI clinics in the order I visited them to give you the reader a sense of how I experienced them. I first provide thick descriptions and then an analysis.

During my participant observation, I did not ask people's pronouns as it did not seem appropriate or relevant in the moment (e.g. the front staff at the various clinics, the individuals in the waiting room). However, whilst writing the thesis, I realised how heavily I rely on pronouns. This is a limitation on my end, especially as I acknowledge the diversity of gender identities and the fact that people's pronouns are unknowable unless asked. When possible and relevant, I try to use gender-neutral terms or descriptions (clerk, male-presenting etc.). This does not solve it, but it is me working with the data I do have.

6.1 Bispebjerg Hospital

Located on the Bispebjerg Bakke hill, Bispebjerg Hospital serves around 400,000 of the capital's inhabitants (Bispebjerg Hospital, n.d.). Due to its 1908-1913 construction date, the complex is a series of individual, red-bricked buildings hosting a department, or multiple departments spread across the buildings' multiple floors. The hospital complex is huge covering multiple roads and bus stops and is currently being expanded. The hospital forms a part of the Copenhagen University Hospital.

Figure 3 *A view of Bispebjerg's complex of red-bricked buildings*

One does not need a CPR number to come and use Bispebjerg's free STI Clinic. Due to this, a lot of people, including tourists and those not registered in Denmark or Copenhagen, use Bispebjerg's services. The website says testing (not treatment) can even be done anonymously. Their popularity or lack of staff is evident in the booking process, where I waited 22 minutes

for a call that lasted less than a minute. Bispebjerg takes 50-80 calls and receives around 70 patients daily. As they are a hospital with medical professionals, they can test for everything (blood samples and swabs).

My visit

I arrive at the Bispebjerg hospital complex through one of its many entrances. All the signs are in Danish and after some searching, I find the STI department located on the 1st floor of a building. I follow the Danish signs and enter through the white swinging double doors. There is a big sunny waiting room ahead and more signs; to the right another department and to the left a sign for the STI clinic, written officially in Danish and then improvised on a piece of paper in English. This is the first English sign I come across, clearly signalling the use of their services by non-Danish speakers. In the hallway, there is a makeshift counter with a bell and a sign that says drop-in hours are closed. I ring the bell and a friendly Danish male-presenting clerk does my registration.

Figure 4 *The STI clinic waiting room at Bispebjerg with the makeshift sign on the left*

I arrived before my appointment time am told to wait in the waiting room. There are three other male-presenting, middle-aged individuals on their phones, reading a magazine or just sitting there. The waiting room is semi-circle in shape and feels spacious due to the sunny windows. The basic colour scheme is white and sterile, as often associated with medical places, but the lighting, plants and wooden furniture used are more inviting and welcoming compared to other hospitals I have visited.

I am called in earlier than I anticipate and am brought to a room where two female-presenting medical personnel are waiting. The hospital must be matching patients to same-sex doctors, hence why I was called up before others in the waiting room. There is a hospital bed in the back corner, a sink, a mirror, a curtained booth next to it and a desk with a computer and chairs by the door. One personnel is sitting in front of the computer and the other is sitting across from her on the table. I sit between the two of them on the short side of the table. Once I am seated, the woman on the computer starts asking me standardised questions and inputting

them in. Her partner sits across from her listening. Hence, I assume the doctor is the one on the computer and the other the nurse. Some questions and looks I receive from the doctor make me feel uncomfortable. For example, questions regarding my nationality, or the confused, slightly judgemental look about my relationship status and sexual partners.

After the questioning, the doctor tells me what I will be tested for and the nurse talks me through the mouth swab by the sink. I do my vaginal swab in the curtained booth with little instructions from the nurse. This left me confused and nervous and I ended up accidentally hurting myself. After, I wash my hands and sit down to get my blood drawn. As the nurse draws my blood, I ask them both questions regarding who uses their services.

They answer my questions openly mentioning the many tourists who use their facilities, and the visits from the young (many under 25 years of age and even under 18 years) and the old (over 60/70-year-olds). Once my blood is drawn, they tell me that my results will come online on MinSundhend[5] and that I am responsible for calling them to discuss the results. The whole thing lasts only a few minutes, with more time spent in the waiting room. I pass by the waiting room and see a new middle-aged male-presenting individual. I am done and out of the hospital before my official appointment time.

Analysis

The waiting time was long but I had the privilege of being able to wait for an appointment. The long call times might deter many potential patients from even booking a test, hence the first barrier to testing. However, their ability to provide services without a CPR or anonymously is a crucial service for marginalised groups, foreigners or those who need it. Nevertheless, the website said anonymous treatment is not possible, but during an interview with medical personnel, they said they were able to provide that if necessary, which highlights the individual agency against institutional practices. However, this is not common knowledge.

The Danish signage reflects the dominant culture that caters to Danish speakers, creating barriers for non-Danish speakers such as tourists and foreigners like me. This is even though a fifth of Copenhagen's population as of 2021 are foreigners (born in another country) and in 2023 they received over 6.5 million tourists (UrbiStat, n.d.; VisitDenmak, 2024). This linguistic exclusivity reinforces the existing social hierarchies and privileges within the healthcare system that are reproduced through institutional practices. However, it is the

[5] Danish phone application for their citizens with an overview of and easy access to the healthcare system and their health information (*MinSundhed*, n.d.).

individuals who fight back against the dominant habitus as seen through the makeshift English signs and their need to translate things on the go.

The waiting room's stylish design contrasts with the typically sterile environment of hospitals. This welcoming atmosphere can be seen as an attempt to mitigate the anxiety associated with hospitals and/or STI testing. The people present in the room reflect the demographics the nurse mentions, men who have sex with men. Gender dynamics appear quickly when patients are matched with their same-sex medical personnel. While this approach might be intended to ensure patient comfort, it also reinforces traditional gender norms and expectations about conventionally binary standards in medical contexts, which can be uncomfortable for genderqueer[6] individuals. I was by far the youngest person in the room and the only FLINTA* presenting individual. I did not feel represented and felt a little out of place, something I can imagine the FLINTA* Danes and the youth could experience, affecting their likelihood of coming back.

However, like many other hospitals, the structured routine at Bispebjerg was one I knew too well. The structured routines—such as registration, waiting, and testing processes—serve as forms of dressage. These are practices that train patients like me in the socially acceptable conducts, norms and values of a hospital and its healthcare system; values such as efficiency, docility and respecting authority. These values failed me when I experienced discomfort and confusion during the vaginal swab but was too afraid to ask for more guidance. Even though I felt something was off, it was hard to break out of the patterns so instilled in me. This could have started the association in me that testing equals pain.

In addition, I felt judged when my relationship status did not match the doctor's habitus of relationships. I was then further discriminated against when asked about my nationality. When asked, I replied with "German" (my German ID was scanned at registration, so it was not for recording purposes). She proceeded to ask if that is where I was born, implying I am not 'naturally' German. This was racially insensitive, enforcing the belief that race is real and tied to a nationality, rather than a social construct. Throughout my whole life whenever I told people where I am from, people have always questioned my answers, not convinced or refusing to believe I could be 'truly' German. Over a quarter of Germans are BIPOC (Federal Agency for Civic Education, 2024; Klein, 2023), yet I am still getting questioned if that is "where am I really from". I have many mixed German friends (German-Polish, German-English, German-Italian etc.) who do not get questioned like me because they are 'racially seen as white' and

[6] Someone whose gender identity does not correspond to the conventional binary gender standard.

that is the 'race' linked to being German. I wondered if the doctor only asked me this due to my brownness or if she asked everyone, making the nationality question redundant. If the goal was to inquire about the countries I have spent time in (for example due to increased STI cases in certain regions), the question could have been formulated more appropriately (e.g., what country were you born in or have spent time in). Incidents like this make me feel uncomfortable and impact my willingness to return to get tested, similar to my informants' retellings of negative experiences.

Lastly, the requirement for patients to check their results and give the hospital a call places the responsibility of surveillance and self-discipline on the patient, pushing individuals to internalise disciplinary power and regulate their behaviour according to institutional expectations. I did not feel seen as an individual, but rather as another body to be catalogued and forgotten. Furthermore, if I did have an STI but did not check my results, I risk further spreading an STI.

The barriers (call time, accessibility) and negative instances (discrimination, pain) I experienced impact my likelihood of coming back to get tested or recommending Bispebjerg's services to others. It does not matter if the negative instance occurred due to the structures of the hospital (call time) or due to an individual (the doctor), I now associate the occurrences with getting tested at Bispebjerg the. The lack of representation in the patients and appropriate questionnaire also alienates me from the place. The dressage I have experienced in healthcare combined with the way of doing in Bispebjerg resulted me in having negative experiences that could have been avoided with the proper care and guidance. The clinic's practices, while inclusive in some aspects, also reflect and perpetuate broader societal hierarchies and norms. By understanding these dynamics, we can better address the intersectional challenges and power structures within healthcare settings, ultimately working towards more equitable and inclusive healthcare services that encourage people to return.

6.2 Sex og Samfund

Sex og Samfund (English translation: Sex & Society) is also known as the Danish Family Planning Association (DFPA). Founded in 1956 by a group of female doctors who wanted to help those with unwanted pregnancies in Denmark, it has now grown to fight for the sexual health and rights of all people in and outside of Denmark (Sex og Samfund, n.d.). In addition to creating educational material for youth and adults, it also offers 'The Contraception and Counselling Clinic' for those residing in Copenhagen.

Figure 5 *Entrance to Sex og Samfund's Clinic & Counselling*

Not as centrally located as the other two locations, the Sex og Samfund clinic is in a nondescript building nestled between a hip café and gym on Amager. It is on the second floor of the building shared with various other offices. The clinic offers advice on sexually related topics, performs certain STI tests (none that require a blood test) and provides various contraception possibilities. However, only citizens who reside in Copenhagen can use their services, which is automatically verified when you provide your CPR number. The person I booked my appointment with was patient and informative during the call, ensuring me their service is what I need.

My Visit

Located not so far from the beach in an area with new development, the neighbourhood has a very different vibe to Bispebjerg with its tall, glass and concrete buildings. Inside the building, the clinic has its door open with a sign indicating who they are (see **Figure 5**). Though there are a few more colours present compared to the hospital, the flat is very sterile in its colour scheme. Space-wise, it is tiny compared to Bispebjerg. When I come, there are three mid-twenties individuals sitting in the hallway. Two are sitting together on the sofa; judging by the body language, I think they are a couple.

I pass the individuals and come across an unattended counter on the left. Behind the counter are two rooms with people in them. After a few minutes, a female-presenting clerk checks me in. She hands me a laminated instruction sheet (see **Figure 6**), self-swabs (oral and vaginal) and tells me to use the bathrooms at the end of the hallway. With the instruction sheet, a private space (the bathroom) and no one waiting on me like at Bispebjerg, I take my time doing the vaginal swabs, not hurting myself in the process.

Once I am done, I return the vials to the clerk at the counter. She makes me reconfirm my CPR number and Danish address and informs me the results will come in seven to 10 days. Unlike Bispebjerg, if the results are positive, they will give me a call. Either way, I can check my results online on MinSundhed. I am in and out of the clinic within minutes.

Analysis

The location in the modern, gentrified neighbourhood signifies a different socio-economic context, potentially affecting the clientele that comes to them. The clinic's shared entrance helps maintain anonymity. The furniture in the clinic such as the couch creates a more intimate and less institutional atmosphere compared to Bispebjerg, but also evidence of the type of funding they have, which is mirrored in the services they provide and who are entitled to them (swabs for officially registered Copenhagen residents). Access to the clinic's services is restricted by legal and bureaucratic mechanisms, privileging those with certain capital (Copenhagen legal residency).

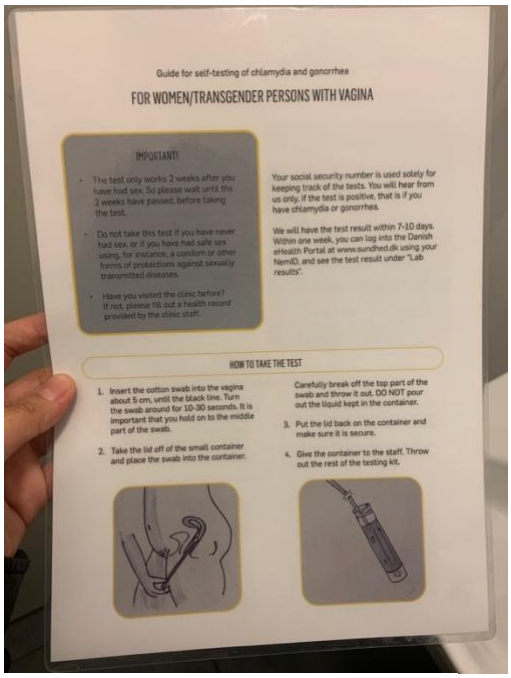

Figure 6 *Instruction sheet for self-swabs (vagina side)*

The space features colours not typically associated with a hospital (yellow) and highlights the organisation's colour scheme and its younger target group. This was reflected by the young individuals waiting and made me feel like this place was more suited to me than Bispebjerg. It felt reaffirming seeing young people there too.

The individual self-swab process at Sex og Samfund contrasts significantly with my experience at Bispebjerg. The laminated instruction sheet with inclusive language and the availability of a private bathroom decreased the stress and time pressure I experienced at Bispebjerg. However, I was aware there were only two bathrooms and I was occupying one. This privacy and autonomy were a more patient-centred approach that reduced the power imbalance between healthcare providers and patients and allowed me to feel less anxious and have a better sense of control over my body. Nevertheless, I did not feel like I could talk to anyone. My experience there contrasts starkly with the informative call I had when booking the appointment. Even though there was no waiting time, the structure was still quite similar, register, test, leave. Even though I was on my own time, I still felt a sense of urgency and lack of care. I could do my test but the clinic did not give me space to ask questions, discuss issues or ask for advice, something that my informants likewise seek.

Even though calling Sex og Samfund was quick and informative, the limited services they offer, the need for a Copenhagen CPR and its distant location are factors that influence me

from returning. Sex og Samfund left me with mixed feelings due to a tension I experienced. On one hand, they try to provide supportive patient care to the youth (inclusive instruction sheet, informative call, outreach on positive results, young people at their clinic), yet they are operating within a habitus with dispositions and values that prioritise efficiency and cost-effectiveness in healthcare (lack of personnel, availability for only registered Copenhagen residents). When coming across Sex og Samfund online or in education materials, it is clear their values are inclusive, empowering, sex-positive and youth-centred. However, these values fail to come across at their clinic, as the dominant norms and values have not been explicitly changed, leaving the habitus and usual dressage of the patients to play out. This shows how having values differing from the dominant culture is not sufficient to change the dominant culture. Unless the dominant dispositions and norms are explicitly tackled, individuals' dressage and disciplinary power will keep them in line with the existing habitus and contribute to insufficient care.

6.3 AIDS-Fondet Checkpoint

The AIDS-Fondet (English translation: AIDS Foundation) was founded in 1985 to tackle AIDS in Denmark during the global AIDS pandemic (AIDS-Fondet, n.d.). Now, as the cases of AIDS have gone down, AIDS-Fondet has expanded its aim and services to focus on other related issues such as Checkpoint. Checkpoint is the AIDS Fondet's testing and counselling services. Checkpoint is a supplement to the public health service and is targeted towards those who most often get STIs or who struggle to get access to public testing services (AIDS-Fondet, n.d.). On their website, they list the target groups they cater to (youth between 15-29 years, LGBTQIA+ individuals, people living with HIV and those from Africa, Asia, South America, or Eastern Europe or who have had unprotected sex with someone from those places). This was also reiterated on the online form when you book an appointment.

Like Sex og Samfund, they offer gonorrhoea and chlamydia tests (which require a CPR number as they are sent to the labs) and HIV, syphilis and hepatitis C tests which can be done anonymously and without a CRP number. Checkpoint was created by the target groups who need them; hence they work closely with the environments in which their target groups find themselves. This was evident in their services, which I will delve into below.

My Visit

Checkpoint is located ten minutes away from the central station (by foot), making it the most central of all three places I visited. Located on the 4th floor, the building and the entrance are hidden in a courtyard, hence not viewable from the street. The signs are limited, so it is tricky

Figure 7 *Entrance to AIDS-Fondet's Checkpoint*

to find the first time. As I had been there with Copenhagen Pride, I knew what to look for. The building hosts many offices, amongst them being LGBT+ Danmark, located on the two floors below Checkpoint. On the floors where LGBT+ Danmark is present, there are rainbow garlands wrapped around the handrails by the stairs, creating a very welcoming and queer-friendly atmosphere as I walk up towards Checkpoint.

This colourful aesthetics continues as I enter Checkpoint, making it very distinct in comparison to the other two testing centres. As I enter, a banner clearly states the target groups they cater to. I fit into the two they advertise, so I feel right here. The waiting room is stylish and cosy, mirroring the aesthetics of a hip Copenhagen café with its lamps, various sitting possibilities and warm colours. When I arrive, eight people are waiting, except for one, most of them are male-presenting in their late 20s and early 30s. In one corner, a clerk is sitting on a computer next to a tray with free coffee and water. Behind the counter, Checkpoint's facilities continue. In another corner, there is an assortment of stickers, condoms, pens and QR codes to scan. I walk up to the clerk and tell her of my appointment. She shows me to the QR code which brings me to an online questionnaire I need to fill out.

Many of the questions are like those asked by the doctor at Bispebjerg. However, unlike at Bispebjerg, their questions were norm-critical and appropriate, giving me explanations along the way whilst never assuming or offending me. Compared to the discriminatory questioning I experienced at Bispebjerg, at Checkpoint, the questionnaire asked if I was born or have had sex with people from certain regions (they provided a list including Southeast Asia). When I clicked on Southeast Asia, the form informed me that this area has higher levels of hepatitis C, hence why the test might be suggested.

I submit my questionnaire and wait. As I wait, two walk-ins come by. Staff from the back room constantly come up to grab stuff from the reception and their patients from the waiting

Figure 8 (Left to Right) *Checkpoint's main waiting room, Second waiting room, Testing cubicle.*

room. Like the people waiting, the staff are young and hip, though mostly male-presenting. Some are gender-neutral presenting, and some are BIPOC.

Finally, I am called up by a male presenting staff. He takes me into a private room with a desk and computer, and two comfy armchairs by the window. He points us to take a seat by the armchairs. Once we are seated, he starts by asking me a lot of personal questions like "how I am", "what brought me here", "what I am doing" and so forth. We talk a lot about me and any questions I might have before getting into the testing procedure. Unlike the other clinics, there is no feeling of being rushed – I feel seen as a person. Nevertheless, I feel bad taking so much of his time.

After he answers all my private questions, I am given an oral, vaginal and anal swab, which I inquire about, and he tells me is not given to everyone but customised based on the answers to the online questionnaire. Using props, he shows me how to do the tests and then brings me out to the second waiting room where the testing cubicles are located. I am told to take my time with the self-swab and to drop my swabs in a box before leaving. I am in total there for one hour, with half an hour spent on counselling and the rest spread between waiting time and swabbing myself.

Analysis

Checkpoint is the most centrally located of all the clinics with the building hidden in a courtyard. This gives the visitors privacy but does not allow for any foot traffic, which means you need to know they exist there. Through their targeting of specific groups of people (and hence receiving funding for these purposes), they acknowledge and are committed to the

unique needs of marginalised populations and exemplify how healthcare can be more inclusive and responsive to diverse/intersectional experiences.

As you enter the building, there is a queer-friendly welcoming atmosphere reinforced through cultural symbols such as the rainbow garlands and the existence of multiple queer organisations in one building. The warm, colourful and stylish waiting room, reminiscent of a hip café, contrasts with sterile medical environments, contributing to a physical environment designed to convey inclusivity, comfort and community. There are free amenities like coffee, stickers, postcards and condoms, but not dental dams (condoms for vulvas). The banner at the entrance highlights its target group making me feel acknowledged and welcomed. The clientele in the waiting room reflects that with the majority being young.

The use of a QR code further highlights their young clientele and the questionnaire used is norm-critical, avoiding assumptions and using inclusive language, recognising the diversity and experiences of the patients. Checkpoints' questions sought the same information as Bispebjerg, yet they provided context, more racially sensitive wording and were respectful of people's identities and sexualities. The diversity and youth of the staff match their target group, enhancing the comfort, understanding and trust of the patients as they see themselves reflected in the staff. Even without meeting the staff, I am more inclined to return due to the atmosphere of the space and the many clients similar to me.

The friendly and unrushed interaction with the staff member during my appointment emphasises their patient-centred approach. The in-depth conversation I had before the testing procedure demonstrated an understanding of the holistic nature of healthcare which made me as a patient feel seen as an individual and not just a case to be processed. This kind of approach is in line with feminist care ethics that emphasises relational and empathetic care (Superson, 2017). Alone this individualised chat beforehand urges me to want to return for any issues or advice I might need in the future. Nevertheless, I felt bad because it went against all the conditioning and dressage I have experienced in healthcare. This lack of 'efficiency' and holistic approach was not the norm I associated with the medical field or experienced in the other two locations. So even though I had a much better experience, I experienced guilt as it was the norm I was trained to experience with healthcare, something I would need to routinely work on to break out of.

The individualised swab tests based on the questionnaire highlighted their understanding of personalised care tailored to individual risk factors. The testing cubicles gave me even greater comfort and autonomy than the Sex og Samfund one as their sole purpose was

for testing (separate bathrooms available) and I could just deposit my swabs behind without having to confront anyone.

I came to get tested, but in the end, left with counselling I did not even realise I needed. Checkpoint's decor, the clients, the questionnaire, the diversity of counsellors, the counselling and the unrushed testing experience are all reasons that made me want to return. Unlike at Sex og Samfund, Checkpoint's values match the ways of doing at the clinic. It is evident that they consciously worked against the dominant norms and dispositions to provide a form of healthcare differing from the dominant habitus. Nevertheless, due to my dressage and disciplinary power, I experienced guilt as my body is not used to being treated this way. I felt bad taking up so much time and having so many questions. With repetitive visits, I could dressage myself to align with Checkpoint's values and decrease the disciplinary gave I have on myself. Checkpoint's approach to sexual health service shows how targeted, inclusive, norm-critical, holistic healthcare can be done and how they better serve marginalised populations. They exemplify how healthcare can be inclusive, respectful and empowering when consciously addressing the dominant culture.

7 Conclusion & Applicability

Is chlamydia seen as cool within the youth? Not exactly. What is happening is a lot more complex and shows what occurs when the symptoms of a problem are being treated, rather than the root of the issue.

Both school-based sexual education and how the people around my informants (teachers, family, doctors, friends) dealt with matters regarding sexual health left a significant impact on my informants. What they learnt in class was often inadequate, biological, non-holistic and non-interpersonal. On top of that, it was very heteronormative and patriarchal, aimed at a specific type of body. The interactions they experienced were likewise similar, which I also had a taste of in the clinic visits.

All this inadequacy or unfair treatment was not obvious to my AFAB informants back then. Only now, after slowly (and still in the process of) breaking out of their dressaged bodies through alternative resources and talking to friends do they realise the injustice and insufficiency they experienced. Unlearning things they have come to believe as 'normal' is a difficult and tedious process as their bodies have gone through years of dressage, and the habitus decades. The habitus my informants are in is informed by a hegemonic patriarchal, heteronormative discourse that is value-oriented (i.e. whose responsibility, whose pleasure etc.), generating dispositions towards FLINTA* and marginalised people that if unexamined,

can lead to further exacerbating and reproducing the issues of prevention as simply a women's or queer issue. The habitus veils the dominant patriarchal, heteronormative culture, and means defying it to go against the status quo.

The sexual education that AFAB individuals received left them vulnerable whilst simultaneously putting a lot of responsibilities on their shoulders. The power structures and disciplinary power in sexual interactions created an unfair double standard and veiled under the disguise of progressivity, people in authority struggled to talk about difficult but important matters. Important matters such as protection, consequences, consent and boundaries. That combined with the healthcare possibilities and sexual openness may have contributed to some Danes no longer fearing STIs. Getting an STI or knowing someone who had it is part of their sexual culture and is seen as inconsequential and easy to treat. However, the consequences of having an STI are often not properly understood and the consequences and testing rate are not equally distributed between individuals. So, even though healthcare provides accessible services (testing, abortion, contraception), they tend to be used more by women than men.

Moreover, many of the clinics do not create a safe, inclusive, empowering space that makes one want to come back, even if their values say otherwise, as little conscious work has been done to change the dominant cultures, norms and dispositions of the place, permitting people to fall onto their disempowering healthcare dressage and disciplinary stance. Though these healthcare developments (free testing and treatment, abortion) are good and necessary, they are only band-aid solutions if the root problem is not properly addressed. By this, I mean tackling the root of responsibility and accountability regarding prevention and aftercare.

Like healthcare, sexual education has an element of dressage. The teachings subliminally get absorbed into the body through rhythms over time, which is then reinforced outside the teachings through everyday interactions in the habitus. All this access to testing, contraception etc. are necessary and valuable, but they are not changing the fundamental rhythms of how bodies are forced to learn and operate the norms in our heteronormative, patriarchal society. The dressage, which is informed and reinforced by the habitus and aided by disciplinary power still has a very non-holistic understanding of sexual health, prevention and aftercare as a women's issue, queer issues are not real issues, and progressivity means we do not probe uncomfortable topics. If we want lasting solutions and not only band-aid ones, we need to change the norms and rhythms taught into the bodies, which will in the long-run, change the habitus.

Sexual education in Denmark is shaped by heteronormative and patriarchal values. Key tools such as consent and comprehensive, inclusive material are missing from their education.

As a result, students may lack essential skills and inadvertently adopt harmful norms and values. The healthcare system is likewise influenced by the same detrimental values, impacting those who use its services. While sexual education and the healthcare infrastructure are not the sole causes of rising STI rates, they may contribute by reinforcing certain behaviours and attitudes, particularly among AFAB individuals, minimising the risks and treating people to different standards. These unjust dispositions are not inherent to human nature but are the products of dressage, discipline, and patriarchal, heteronormative discourse and can be challenged and transformed through critical engagement and unpacking. Part of the problem is the learning and internalisation of normative dispositions through education, healthcare and family, which can be disrupted through the very same means. To address this, I have developed specific recommendations.

Regulated sexual education laws

As many of the experts have mentioned and the informants' experiences highlight, there needs to be regulated sex education laws, like there are for subjects like maths or science. This means the number of hours dedicated to it, the materials to be used and finding a teacher qualified to teach it. The varying qualities and quantities vary from school to school, and even more between rural and urban cities. Sexual health education needs to be taken more seriously and hence not just a subject that can be taught by anyone.

Currently, too much influence is placed on the teacher one receives. Sexual education should not be value-based, but knowledge-based. A maths teacher is good for maths, but not necessarily for teaching sexual health education which requires a completely different skill set and sensibility. Teachers need to be taught appropriate pedagogical skills to accompany the content they should teach.

Re-prioritising in sexual education

There are so many points within sex ed that need changing or improving, from talking about pleasure, how we talk about risks and safer sex to how we talk about bodies. I highlight three of the most important points, 1) underlying patriarchal values 2) consent and boundary setting and 3) queer themes. Number one is more on a broader level and not only applicable to school, but too many narratives and discourses in school, at the doctor, at home or with friends is that sexual health is a women's issue, and men are not accountable to the same double standards. Whether it is testing, contraception, or simply who discusses and worries about sexual health. Men are likewise subject to toxic masculinity and unable to seek help. This is why we need

qualified educators who do not reinforce these harmful norms and values but can rather create an inclusive, judgement-free, empowering space.

Many unfortunate instances seem to stem from lacking interpersonal skills in setting boundaries and asking for consent. Without the tools and awareness, individuals are struggling to uphold their boundaries whilst others are not creating safer spaces for people to properly consent to. Paired with the patriarchal habitus, this creates dangerous situations due to unfair power dynamics. For example, needing to convince someone to use a condom or to take a test. With proper interpersonal skills, individuals can stand up for themselves and create safer spaces for people to genuinely express their desires and boundaries because consenting only counts if the person would have felt comfortable saying no.

Queer topics are currently still treated as an extra category (if even) and need to rather be integrated into everyday teachings as the diverse spectrum of what individuals can do or be. The current understanding of sex is not only heteronormative but mainly benefits men. This relates to education needing to be knowledge rather than value-based. Queer themes are not something institutions or people in authority should debate about but made known so individuals can make their own informed choices.

Health clinics & testing

Healthcare institutions need to make a conscious effort to change the dominant cultures and norms of their place to combat the dressage and disciplinary power the individuals and personnel bring into the interactions. They likewise need to be aware and change the discriminatory and non-inclusive ways of doing by working with people from these groups (changing the questionnaire, language of signs). They need to embrace the "Nothing About Me Without Me" way of doing. A slogan from the South African disability rights movement to communicate the idea that no policy, rules, procedures, regulations etc. about any population without explicit input from that population (Zelmer, 2019). To combat STIs in the long-run, clinics need people to have a good experience to want to return or recommend them.

As Christof emphasises, testing needs to be seen as a normal part of a sexual life. Rather than only focusing on getting individuals to use a condom, institutions and education need to recognise this unwillingness and focus on normalising testing. Remove the shame associated with testing, educate the consequences (especially on AFAB bodies), push non-queer men to test and make it more accessible and part of their healthcare routine. Currently, when men who have sex with men (due to increased HIV risks) get PrEP (preventative HIV medication), they are automatically tested for HIV and STIs giving them a testing routine. AFABs often get tested

when at their GPs or gynaecologists. Straight men do not have the same testing possibility; hence institutions need to instil more routine as straight men are currently testing the lowest.

This routine can be connected to their normal GP visit, or through education that pushes men to be more accountable and to seek testing. As evidence shows that GP is not the ideal tester for some, sexual health clinics, testing centres or even at-home tests need to be more advertised, especially in rural areas where currently GPs are the only options.

8 References

Agénor, M., Lett, E., Ramanayake, N., Zubizarreta, D., Murchison, G. R., Eiduson, R., & Gordon, A. R. (2023). Racial/Ethnic Differences in Sexually Transmitted Infection Testing Among Transgender Men and Nonbinary Assigned Female at Birth Young Adults in the United States: a National Study. *Journal of Racial and Ethnic Health Disparities*, *10*(6), 2900–2910. https://doi.org/10.1007/S40615-022-01467-4/TABLES/3

AIDS-Fondet. (n.d.). *Checkpoint - About Us*.

American Academy of Pediatrics. (2024). *The Importance of Access to Comprehensive Sex Education*. https://www.aap.org/en/patient-care/adolescent-sexual-health/equitable-access-to-sexual-and-reproductive-health-care-for-all-youth/the-importance-of-access-to-comprehensive-sex-education/

Anderson, E. (2020). Feminist Epistemology and Philosophy of Science. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Spring 202). Metaphysics Research Lab, Stanford University.

Anderson, R. M. (2013). Positive sexuality and its impact on overall well-being. *Bundesgesundheitsbl*, *56*(2), 208–214. https://doi.org/10.1007/s00103-012-1607-z

Archer, M. S. (2020). *The Morphogenetic Approach; Critical Realism's Explanatory Framework Approach* (pp. 137–150). https://doi.org/10.1007/978-3-030-26114-6_9

Askew, J. (2007). Breaking the taboo: an exploration of female university students' experiences of attending a feminist - informed sex education course. *Sex Education*, *7*(3), 251–164. https://doi.org/10.1080/14681810701448051

Bay-Cheng, L. Y. (2018). Critically Sex/ed: Asking Critical Questions of Neoliberal Truths in Sexual Education. In L. Allen & M. L. Rasmussen (Eds.), *The Palgrave Handbook of Sexuality Education* (pp. 343–367). Palgrave Macmillan.

Beaumont, K., & Maguire, M. (2013). *Policies for Sexuality Education in the European Union*. https://www.europarl.europa.eu/RegData/etudes/note/join/2013/462515/IPOL-FEMM_NT(2013)462515_EN.pdf

Bernard, H. R. (2018). *Research Methods in Anthropology: qualitative and quantitative approaches* (6th ed.). Rowman & Littlefield.

Bernard, H. R., & Gravlee, C. C. (2015). *Handbook of Methods in Cultural Anthropology* (2nd ed.). Rowman & Littlefield.

Biesta, G., Priestley, M., & Robinson, S. (2017). Talking about education: exploring the significance of teachers' talk for teacher agency. *Journal of Curriculum Studies*, *49*(1), 38–54. https://doi.org/10.1080/00220272.2016.1205143

Bispebjerg Hospital. (n.d.). *About Bispebjerg Hospital*.

Bourdieu, P. (1977). *Outline of a Theory of Practice*. Cambridge University Press.

Bourdieu, P. (2001). *Masculine Domination*.

Braun, V., & Clark, V. (2013). *Successful Qualitative Research: a practical guide for beginners*. Sage.

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Butler, J. (2011). Gender trouble: Feminism and the subversion of identity. *Gender Trouble: Feminism and the Subversion of Identity*, 1–236. https://doi.org/10.4324/9780203824979

Cameron, L. D. (2003). *Conceptualizing and Assessing Risk Perceptions: A Self-Regulatory Perspective*.

Charest, M., Kleinplatz, P. J., & Lund, J. I. (2016). Sexual health information disparities between heterosexual and LGBTQ+ young adults: Implications for sexual health. *The Canadian Journal of Human Sexuality*, *25*(2), 74–85. https://doi.org/10.3138/cjhs.252-A9

Chiseri-Strater, E. (1996). Turning In upon Ourselves: Positionality, Subjectivity, and Reflexivity in Case Study and Ethnographic Research. *Ethics and Representation in Qualitative Studies of Literacy*, 115–133.

Christianson, M., Lalos, A., Westman, G., & Johansson, E. E. (2007). ``Eyes Wide Shut'' — Sexuality and risk in HIV-positive youth in Sweden: A qualitative study. *Scandinavian Journal of Public Health*, *35*(1), 55–61. https://doi.org/10.1080/14034940600812943

Crenshaw, K. W. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *U. CHI. LEGAL F*, *139*.

Crutcher, E. E. (2012). *The Pleasure Gap: A Sociological Analysis of Evaluating Female Pleasure in Pornography*. University of California.

Curtiss, C. R., & Weinbach, R. W. (1989). Sexually Transmitted Diseases: Responses to a Sexist Problem. *Affilia*, *4*(4), 68–80. https://doi.org/10.1177/088610998900400405

Dailey, D. M. (1997). The Failure of Sexuality Education. *Journal of Psychology & Human Sexuality*, *9*(3–4), 87–97.

Daly, L. K. (2015). *Making Space for Young People's Voices: Adolescent and Clinician Perspectives on Clinical Encounters for Sexual Health*. The University of British Columbia.

Danish Health Authority. (2017). *The Danish healthcare system*. https://www.sst.dk/en/english/publications/2017/The-Danish-healthcare-system

Darroch, J., Myers, L., & Cassell, J. (2003). Sex differences in the experience of testing positive for genital chlamydia infection: a qualitative study with implications for public health and for a national screening programme. *Sexually Transmitted Infections*, *79*(5), 372–374. https://doi.org/10.1136/STI.79.5.372

Davies, C. A. (2008). Reflexivity and ethnographic research. In *Reflexive Ethnography - A Guide to Researching Selves and Others* (2nd ed.). Routledge.

Davies, C., & Robinson, K. (2010). Hatching Babies and Stork Deliveries: Risk and Regulation in the Construction of Children's Sexual Knowledge. *Http://Dx.Doi.Org/10.2304/Ciec.2010.11.3.249*, *11*(3), 249–262. https://doi.org/10.2304/CIEC.2010.11.3.249

De Klerk, V., Klazinga, L., & Mcneill, A. (2007). The Habitus of the Dominant: Addressing Rape and Sexual Assault at Rhodes University. *Agenda: Empowering Women for Gender Equity*, *1*(74), 115–124.

De Schryver, A., & Meheus, A. (1990). Epidemiology of sexually transmitted diseases: the global picture. *Bull World Health Organ.*, *68*(5). https://pubmed.ncbi.nlm.nih.gov/2289300/

Dielissen, P. W., Teunissen, D. A. M., & Lagro-Janssen, A. L. M. (2013). Chlamydia prevalence in the general population: Is there a sex difference? A systematic review. *BMC Infectious Diseases*, *13*(1), 1–10. https://doi.org/10.1186/1471-2334-13-534/TABLES/3

Dudgeon, M. R., & Inhorn, M. C. (2004). Men's influences on women's reproductive health: Medical anthropological perspectives. *Social Science and Medicine*, *59*(7), 1379–1395. https://doi.org/10.1016/j.socscimed.2003.11.035

Elia, J. P., & Eliason, M. (2010). Discourses of Exclusion: Sexuality Education's Silencing of Sexual Others. *Journal of LGBT Youth*, *7*(1), 29–48. https://doi.org/10.1080/19361650903507791

European Centre for Disease Prevention and Control. (2024). *Chlamydia. Annual Epidemiological Report for 2021*.

Ezer, P., Jones, T., Fisher, C., & Power, J. (2019). A critical discourse analysis of sexuality education in the Australian curriculum. *Sex Education*, *19*(5), 551–567. https://doi.org/10.1080/14681811.2018.1553709

Fabian-Jessing, K. (2016). *Holdninger og normer til seksuel adfærd og klamydia blandt unge mænd i Danmark – et kvalitativt studie*. Aalborg Universitet.

Federal Agency for Civic Education. (2024). *Population with a migrant background*. https://www.bpb.de/kurz-knapp/zahlen-und-fakten/soziale-situation-in-deutschland/61646/bevoelkerung-mit-migrationshintergrund/

Fine, M. (1988). Sexuality, Schooling, and Adolescent Females: The Missing Discourse of Desire. *Harvard Educational Review*, *58*(1), 293–300.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: methodology meets method. *International Journal of Social Research Methodology*, *20*(2), 181–194. https://doi.org/10.1080/13645579.2016.1144401

Foucault, M. (1978a). Domain. In *The History of Sexuality* (pp. 103–114). Pantheon Books.

Foucault, M. (1978b). Method. In *The History of Sexuality* (pp. 92–102). Pantheon Books.

Foucault, M. (2008). "Panopticism" from Discipline & Punish: The Birth of the Prison. *Race/Ethnicity: Multidisciplinary Global Contexts*, *2*(1), 1–12.

Friis, K., Ekholm, O., Hundrup, Y. A., Obel, E. B., & Grønbæk, M. (2007). Influence of health, lifestyle, working conditions, and sociodemography on early retirement among nurses: The Danish Nurse Cohort Study. *Scandinavian Journal of Public Health*, *35*(1), 23–30. https://doi.org/10.1080/14034940600777278

Frisch, M., Aalborg Universitet, Statens Serum Institut, Projekt SEXUS, Statens Serum Institut (Afdeling for Epidemiologisk Forskning), & Aalborg Universitet (Sexologisk Forskningscenter, K. I. (2019). *Sex i Danmark : nøgletal fra Projekt SEXUS 2017-2018*. Statens Serum Institut.

Gade, R. (2010). Art, Sexuality and Images: The legalization of pornography in Denmark. *Performance Research*, *15*(2), 23–28. https://doi.org/10.1080/13528165.2010.490425

Garland-Levett, S. (2017). Exploring discursive barriers to sexual health and social justice in the New Zealand sexuality education curriculum. *Sex Education*, *17*(2), 121–134. https://doi.org/10.1080/14681811.2016.1233396

Garrett, C. (2016). *Continually Striving for Sexual Equality in Denmark*. The Cross Section. https://crosssection.gns.wisc.edu/2016/09/06/continually-striving-for-sexual-equality-in-denmark/

Garton, S., & Copland, F. (2010). 'I like this interview; I get cakes and cats!': the effect of prior relationships on interview talk. *Qualitative Research*, *10*(5), 533–551. https://doi.org/10.1177/1468794110375231

Gillespie, L. (2019). *Pierre Bourdieu: Habitus*.

Goldstein, H. (1998). Legal abortion in Denmark during the past 25 years: aspects of public health and ethics. *The European Journal of Contraception & Reproductive Health Care*, *3*(3), 155–159. https://doi.org/10.3109/13625189809051419

Goldstein, R. (2017). *Sexual Health Education: A Comparison Between Denmark and the United States*. https://ir.lib.uwo.ca/undergradawards_2017https://ir.lib.uwo.ca/undergradawards_2017/18

Green, D. P., Eko, R., Ong, L., Paskuj, B., Godfrey, A., Garg, A., & Rea, H. (2024). Changing minds about climate change in Indonesia through a TV drama. *Frontiers in Communication*, *9*, 1366289. https://doi.org/10.3389/FCOMM.2024.1366289

Haraway, D. (1988). Situated Knowledges : The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies*, *14*(3), 575–599. https://www.jstor.org/stable/3178066

Harden, K. P. (2014). A sex-positive framework for research on adolescent sexuality. *Perspectives on Psychological Science*, *9*(5), 455–469.

Haste, P. (2008). *Tackling the "difficult" subject: An ethnographic exploration of sexual learning in secondary schools*. Goldsmiths College, University of London.

Hedley, P. L., Hoffmann, S., Lausten-Thomsen, U., Voldstedlund, M., Bjerre, K. D., Hviid, A., Krebs, L., Jensen, J. S., & Christiansen, M. (2022). A Nationwide Observational Study of Chlamydia trachomatis Infections in Denmark during the

COVID-19 Pandemic. *Acta Dermato-Venereologica*, *102*, adv00704. https://doi.org/10.2340/actadv.v102.2324

Herlitz, C., & Ramstedt, K. (2005). Assessment of Sexual Behavior, Sexual Attitudes, and Sexual Risk in Sweden (1989–2003). *Archives of Sexual Behavior*, *34*(2), 219–229. https://doi.org/10.1007/s-10508-005-1799-5

How to get tested for sexually transmitted diseases. (2020). Peech. https://peech.dk/en/blogs/sexsygdomme-og-praevention/guide-til-at-blive-testet-for-konssygdomme

Hunter, E. L. (2023). *Black Racial Isolation: Understanding African Diaspora Subjectivity in Post-Racial Denmark*. University of California.

Jacobsen, H. (2020). *The long road to a consent-based rape law in Denmark*. Amnesty International. https://www.amnesty.org/en/latest/news/2020/12/the-long-road-to-a-consent-based-rape-law-in-denmark/

Jones, T. M. (2011). Saving rhetorical children: sexuality education discourses from conservative to post-modern. *Sex Education*, *11*(4), 369–387. https://doi.org/10.1080/14681811.2011.595229

Jørgensen, M. J., Maindal, H. T., Christensen, K. S., Olesen, F., & Andersen, B. (2015). Sexual behaviour among young Danes aged 15-29 years: A cross-sectional study of core indicators. *Sexually Transmitted Infections*, *91*(3), 171–177. https://doi.org/10.1136/sextrans-2014-051814

Jupp, V. (2006). The Sage Dictionary of Social Research Methods. In *SAGE Publications*. SAGE Publications.

Keedle, H., Schmied, V., Burns, E., & Dahlen, H. G. (2019). A narrative analysis of women's experiences of planning a vaginal birth after caesarean (VBAC) in Australia using critical feminist theory. *BMC Pregnancy and Childbirth*, *19*(1). https://doi.org/10.1186/s12884-019-2297-4

Kendall. (2022). *STI vs STD — What's the Difference?* Planned Parenthood. https://www.plannedparenthood.org/blog/sti-vs-std-whats-the-difference

Kim, G., Ram, M., Taboada, A., & Gere, D. (2019). A Qualitative Evaluation of Impact and Implementation of a Theater-Based Sexual Health Intervention in Los Angeles High Schools. *American Journal of Sexuality Education*, *14*(3), 269–291. https://doi.org/10.1080/15546128.2019.1579137

Klein, H. (2023). *„Wir wollen marginalisierte Perspektiven in Deutschland sichtbar machen“*. https://blog.wikimedia.de/2023/12/21/wir-wollen-marginalisierte-perspektiven-in-deutschland-sichtbar-machen/

Kolb, A. (2022). Do's, Don'ts, and the Rhythms of the Urban Everyday. *TDR: The Drama Review*, *66*(2), 81–100.

Leander, A. (2009). *Habitus and Field*.

Lefebvre, H. (2004). *Rhythmanalysis: Space, Time and Everyday Life (Elden S. & Moore G., Trans)*. Continuum. (Original work published 1992).

Lengen, C., Jäger, S., & Kistemann, T. (2010). The knowledge, education and behaviour of young people with regard to Chlamydia trachomatis in Aarhus, Denmark and Bonn, Germany: Do prevention concepts matter? *Social Science and Medicine*, *70*, 1789–1798. https://doi.org/10.1016/j.socscimed.2010.01.048

Maguire, M., & Delahunt, B. (2017). *Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars.* * (Issue 3). http://ojs.aishe.org/index.php/aishe-j/article/view/335

Manniche, E. (1983). [History of induced abortion in Denmark from 1200 to 1979] - PubMed. *Josanpu Zasshi = The Japanese Journal for Midwife*, *36*(10), 842–847. https://pubmed.ncbi.nlm.nih.gov/6759731/

Ministry of Education. (2019a). *Fælles Mål for sundheds- og seksualundervisning og familiekundskab*.

Ministry of Education. (2019b). *Vejledning for sundheds- og seksualundervisning og familiekundskab*.

Ministry of Education. (2021). *15 millioner kroner skal styrke seksualundervisningen i folkeskolen*. https://www.uvm.dk/aktuelt/nyheder/uvm/2021/apr/210421-15-mio-kr-skal-styrke-seksualundervisningen-i-folkeskolen

MinSundhed. (n.d.). Retrieved August 19, 2024, from https://play.google.com/store/apps/details?id=dk.sundhed.minsundhed&hl=en&pli=1

Montgomery, H. (2008). *An Introduction to Childhood: Anthropological Perspectives on Children's Lives*. Wiley-Blackwell.

Morantes-Africano, L. (2023). Queering habitus: interrogating heteronormative dispositions that reproduce inequalities towards sexual minorities. *Research in Post-Compulsory Education*, *28*(2), 241–259. https://doi.org/10.1080/13596748.2023.2206708

Moravec, L. (2022). Dressage Performances as Infrastructural Critique: Mike Kelley and Yvonne Rainer's Dancing Horses. *Dance Chronicle*, *45*(1), 57–78.

Moser, K. S., & Prytz, S. B. (2024). *Sexual dannelse / Sexual bildung and Sex education in Denmark and Sweden*. https://nordics.info/show/artikel/sexual-education-in-denmark-and-sweden

Naaeke, A., Kurylo, A., Grabowski, M., Linton, D., Radford, M. L., Naaeke, A. ;, Kurylo, A. ;, Grabowski, M. ;, & Linton, D. ; (2010). *Insider and Outsider Perspective in Ethnographic Research*. *9*, 4–16. http://docs.rwu.edu/nyscaproceedings/vol2010/iss1/9

Narushima, M., Wong, J. P. H., Li, A. T. W., Bhagat, D., Bisignano, A., Fung, K. P. L., & Poon, M. K. L. (2020). Youth perspectives on sexual health education: Voices from the YEP study in Toronto. *Canadian Journal of Human Sexuality*, *29*(1), 32–44. https://doi.org/10.3138/cjhs.2019-0049

Newby, K. V., Wallace, L. M., & French, D. P. (2012). How do young adults perceive the risk of chlamydia infection? A qualitative study. *British Journal of Health Psychology*, *17*(1), 144–154. https://doi.org/10.1111/j.2044-8287.2011.02027.x

Orenstein, P. (2016). *Girls and Sex: Navigating the Complicated New Landscape*. Harper.

O'Toole, O. (2021). Habitus, Culture, and Human Sexuality. Notions of Consent in the Sexual Habitus. *Zeszyty Pracy Socjalnej*, *26*(2–3), 81–90. https://doi.org/10.4467/24496138zps.21.006.15078

Page, A., Cense, M., & van Reeuwijk, M. (2023). Working with young peer researchers in sexuality studies: benefits, challenges and lessons learnt. *Sexual and Reproductive Health Matters*, *31*(1). https://doi.org/10.1080/26410397.2022.2152550

Philpott, A., Knerr, W., & Boydell, V. (2006). Pleasure and prevention: when good sex is safer sex. *Reprod Health Matters*, *14*(28), 23–31. https://doi.org/10.1016/S0968-8080(06)28254-5

Piróg, M., Grabski, B., Jach, R., Zmaczyński, A., Dutsch-Wicherek, M., Wróbel, A., & Stangel-Wójcikiewicz, K. (2022). Human Papillomavirus Infection: Knowledge, Risk Perceptions and Behaviors among SMW and AFAB. *Diagnostics 2022, Vol. 12, Page 843*, *12*(4), 843. https://doi.org/10.3390/DIAGNOSTICS12040843

Raymond, N. M., & Hutchison, A. N. (2019). A Pilot Test of the Effectiveness of an Integrated Sex Positive Education Program. *American Journal of Sexuality*. https://doi.org/10.1080/15546128.2019.1584870

Redmond, S. M., Alexander-Kisslig, K., Woodhall, S. C., van den Broek, I. V. F., van Bergen, J., Ward, H., Uusküla, A., Herrmann, B., Andersen, B., Götz, H. M., Sfetcu, O., & Low, N. (2015). Genital Chlamydia Prevalence in Europe and Non-European High Income Countries: Systematic Review and Meta-Analysis. *PLOS ONE*, *10*(1), e0115753. https://doi.org/10.1371/journal.pone.0115753

Ribeiro, C., & Facciolo de Camargo, A. M. (2003). *La educación sexual en lo cotidiano de la escuela*. https://www.researchgate.net/publication/28062601_La_educacion_sexual_en_lo_cotidiano_de_la_escuela

Rich, A. (1980). *Compulsory Heterosexuality and Lesbian Existence*. http://www.journals.uchicago.edu/t-and-c

Rimando, A., Brace, M. M., Christiana, A. M., Fowles, R. W., Davis, T. L., Martinez, T. L., & Sealy, L. M. (2014). The Qualitative Report Recruitment in Qualitative Public Health Research: Lessons Learned During Dissertation Sample Recruitment. In *The Qualitative Report* (Vol. 19, Issue 4). http://nsuworks.nova.edu/tqr

Roien, L. A. (n.d.). The Danish Experience: Introduction to Health and Sex Education in Denmark, Teaching Methodologies. In *Sex og Sa*.

Roien, L. A., Graugaard, C., & Simovska, V. (2022). From Deviance to Diversity: Discourses and Problematisations in Fifty Years of Sexuality Education in Denmark. *Sex Education*, *22*(1), 68–83. https://doi.org/10.1080/14681811.2021.1884060

Roien, L. A., & Gundersen, M. de la M. (2018). *Normkritisk seksualundervisning: Mangfoldighed, trivsel og anti-diskrimination i skolen*. Hans Reitzels Forlag. https://pure.au.dk/portal/en/publications/normkritisk-seksualundervisning-mangfoldighed-trivsel-og-anti-dis

Rowland, K. (2020). *The Pleasure Gap: American Women and the Unfinished Sexual Revolution*. Basic Books.

Russell, H. (2015). *16 Ways Denmark Wins At Sex*. BuzzFeed. https://www.buzzfeed.com/helenrussell/reasons-danes-do-sex-best

Schaefer, E. (2014). “I’ll Take Sweden”: The Shifting Discourse of the “Sexy Nation” in Sexploitation Films. In *Sex Scene: Media and the Sexual Revolution*. Duke University Press. https://doi.org/10.1353/book.69056

Schwan, A., & Brenner, L. (2020). *A Path to Sexual Authenticity Holistic female centred sexual education with an action research approach*. Leuphana University Lüneburg.

Sculos, B. W. (2017). Who’s Afraid of ‘Toxic Masculinity’? *Class Race Corporate Power*, *5*(3). https://doi.org/10.25148/CRCP.5.3.006517

Sex og Samfund. (n.d.). *Sex og Samfund - About Us*.

Sex og Samfund. (2023, November 13). *Danish young people once again break their own record for chlamydia - see how widespread the disease is in your municipality*.

Shannon, B. (2016). Comprehensive for who? Neoliberal directives in Australian ‘comprehensive’ sexuality education and the erasure of GLBTIQ identity. *Sex Education*, *16*(6), 573–585. https://doi.org/10.1080/14681811.2016.1141090

Sinka, K. (2024). The global burden of sexually transmitted infections. *Clinics in Dermatology*, *42*(2), 110–118. https://doi.org/10.1016/j.clindermatol.2023.12.002

Spaulding, S. H. (2021). *The peacock in the room: confronting the hidden curriculum of androcentrism and gender bias in undergraduate biology education* [University of Louisville]. https://doi.org/10.18297/etd/3647

Sperling, J. (2021). Comprehensive sexual health education and intersex (in)visibility: an ethnographic exploration inside a California high school classroom. *Sex Education*, *21*(5), 584–599. https://doi.org/10.1080/14681811.2021.1931834

Sprague, J. (2016). *Feminist Methodologies for Critical Researchers* (J. A. Howard, B. Risman, J. Sprague, & V. Rutter, Eds.; 2nd Edition). Rowman & Littlefield.

Statens Serum Institut. (2022). *Number of chlamydia infection cases in Denmark from 2010 to 2022 (in 1,000s)[Graph]*. https://www.statista.com/statistics/1067959/number-of-chlamydia-infection-cases-in-denmark/

Statens Serum Institut. (2023). *Chlamydia 2022*. https://en.ssi.dk/surveillance-and-preparedness/surveillance-in-denmark/annual-reports-on-disease-incidence/chlamydia-2022

Statista. (2022). *Sexually transmitted diseases in the Nordics*.

Stone, N., Ingham, R., & Gibbins, K. (2013). "Where do babies come from?" Barriers to early sexuality communication between parents and young children. *Sex Education*, *13*(2), 228–240. https://doi.org/10.1080/14681811.2012.737776

Superson, A. (2017). Feminist Ethics of Care. In A. Garry, S. J. Khader, & A. Stone (Eds.), *The Routledge Companion to Feminist Philosophy* (pp. 540–555). Routledge. www.routledge.

Susie Jolly, Andrea Cornwall, & Kate Hawkins (Eds.). (2013). *Women, Sexuality and the Political Power of Pleasure*. Zed Books.

Svendsen, S., & Bang, H. (2018). The Cultural Politics of Sex Education in the Nordics. In L. Allen & M. L. Rasmussen (Eds.), *The Palgrave Handbook of Sexuality Education* (pp. 137–155). Palgrave Macmillan.

Tolman, D. (1991). Adolescent girls, women and sexuality: discerning dilemmas of desire. *Women & Therapy*, *11*, 55–69.

UN Women. (2023). *Facts and figures: Ending violence against women*. https://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures

UNESCO. (2023). *Comprehensive sexuality education: For healthy, informed and empowered learners*. https://www.unesco.org/en/health-education/cse

UrbiStat. (n.d.). *Maps, analysis and statistics about the resident population: Municipality of Copenhagen*. Retrieved August 12, 2024, from https://ugeo.urbistat.com/AdminStat/en/dk/demografia/stranieri/copenhagen/20368667/4

Vetenskapsrådet. (2018). *Conducting ethical research*. Vetenskapsrådet. https://www.vr.se/english/applying-for-funding/requirements-terms-and-conditions/conducting-ethical-research.html

VisitDenmak. (2024). *Turismen i dit område*. https://www.visitdenmark.dk/corporate/videncenter/turismen-i-dit-omraade

Walby, S. (1991). *Theorizing Patriarchy*. Basil Blackwell.

Wellings, K., & Parker, R. (2006). *Sexuality Education in Europe − A Reference Guide To Policies and Practices*. http://www.euro.who.int/Document/RHP/SexEd_in_Europe.pdf

WHO. (2010). *Developing sexual health programmes A framework for action*.

WHO. (2018). *International technical guidance on sexuality education An evidence-informed approach*. www.unesco.org/open-access/terms-use-ccbyncnd-en

WHO. (2023). *Comprehensive sexuality education*. https://www.who.int/news-room/questions-and-answers/item/comprehensive-sexuality-education

WHO. (2024). *Sexually transmitted infections (STIs)*. https://www.who.int/health-topics/sexually-transmitted-infections#tab=tab_1

Williams, D. J., Prior, E., & Wegner, J. (2013). Resolving social problems associated with sexuality: Can a "sex-positive" approach help? *Social Work, 58*(3), 273–276.

Zelmer, J. (2019). Nothing About Me Without Me. *Healthcare Policy = Politiques de Sante*, *14*(4), 6–9. https://doi.org/10.12927/HCPOL.2019.25861

Informant Interviews

Agnes (2024-02-08). Interviewer Annastassia Schwan

Alma (2024-02-14). Interviewer Annastassia Schwan

Anne (2024-02-01). Interviewer Annastassia Schwan

Freja (2024-02-08). Interviewer Annastassia Schwan

Hanne (2024-02-06). Interviewer Annastassia Schwan

Helle (2024-02-07). Interviewer Annastassia Schwan

Kirsten (2024-02-05). Interviewer Annastassia Schwan

Klara (2024-02-06). Interviewer Annastassia Schwan

Mads (2024-02-08). Interviewer Annastassia Schwan

Mette (2024-02-04). Interviewer Annastassia Schwan

Nora (2024-02-09). Interviewer Annastassia Schwan

Expert Interviews

Christof (2024-03-01). Interviewer Annastassia Schwan

Peter (2024-02-21). Interviewer Annastassia Schwan

Harriet (2024-04-04). Interviewer Annastassia Schwan

Maja (2024-04-05). Interviewer Annastassia Schwan

Maria (2024-04-04). Interviewer Annastassia Schwan

9 Footnotes & Appendix

1. Reel: A short video on Instagram.
2. FLINTA*: A German abbreviation for Females/Women, Lesbians, Intersex, Non-binary, Trans and Agender people with the asterisk representing all non-binary gender identities.
3. LGBTQIA+: Acronym used to describe the community of people who do not identify as heterosexual or cisgender. Lesbians, Gays, Bisexuals, Trans, Queer and/or Questioning, Intersex, Asexual and the + to represent those who identify with a sexual orientation or gender identity not covered in the acronym.
4. Queer: I use interchangeably with LGBTQIA+.
5. MinSundhed: Danish phone application for their citizens with an overview of and easy access to the healthcare system and their health information (*MinSundhed*, n.d.).
6. Genderqueer: Someone whose gender identity does not correspond to the conventional binary gender standard.

Appendix A. Stakeholder Outreach

Who	Type	Status	Additional Information
Various Doctors	Doctors	No follow up	
Amager	Hospital	No follow up	
Bispebjerg	Hospital	Interview	Nurse from Dermatovenerology (14 years)
Frederiksberg	Hospital	No follow up	
Gentofte	Hospital	Interview	Nurse from Allergy, Skin and STI Department (20 years)
Gentofte	Hospital	Interview	Nurse from Allergy, Skin and STI Department (4 years)
Righospitalet	Hospital	Unavailable	
European Centre for Disease Prevention and Control (ECDC)	Institute	Not possible	
Statens Serum Institut	Institute	No follow up	
RSFU	NGO	Interview	Advisor Manager in Sexuality Education (24 years)
Sex og Samfund	NGO	Unavailable	

Sexual & Mental Health Organisation	NGO	Interview	Project manager & counselling coordination (4 years)
The World Health Organisation (WHO)	Organisation	No follow up	
PhD candidate	Researcher	Unavailable	
Various schools in and around Copenhagen	School	No follow up	
P6 Lund	Student Union	No follow up	
Various Informants	Youth Informant	11 Interviews	