A Different Mirror:
Understanding negative sexual health outcome among Dutch Black women by using an Intersectional framework to look at ethno-gender stereotypes

A Master’s thesis done as part of the Amsterdam Master’s in Medical Anthropology 2005-2006

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Amsterdam: May - August 2006
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Thanks

This study could not have been completed without the advice and support of my supervisor, Dr. Eileen Moyer. Thank you, Eileen for your insight, time and encouragement from the beginning to the very end.

My special thanks also goes to various members of the AMMA team. Sjaak Van der Geest, whose teaching helped me realize I do my best work when I’m faced with the toughest challenges. Peter Mesker, for dealing with crisis intervention during my adventures in Amsterdam. Trudy Kanis, for her good humor and support.

I would like to thank the AMMA ladies: Nipa, Hana, Paschaline and Veta. Without the sambal dinners, endless cups of tea, and late night chats I might not have survived this year sanely.

Finally, I am deeply grateful for the opportunity to study Medical Anthropology, which would not have been possible without the support of my parents. This is knowledge and a perspective I will always cherish and never lose.
Preface: Check Boxes and Re-Education

"How come you always have a sexy year-round tan?" This was a line I heard frequently while growing up from my friends at my suburban high school in the Midwest (of the United States). It would not be until later, when I found myself outside of that environment, where I questioned why it was that the color of my skin or the Asian look of my eyes that determined my sexiness. That short one sentence question summarizes the frequent experiences I have had whereby, because of my gender combined with my "ethnicity", people have turned me into a sexual object, completely ignoring my culture, education, lifestyle or any other aspect of my identity.

While I spent the majority of my life, sixteen out of twenty-two years, in an international environment, I spent my "growing up" years in the northern suburbs of Chicago where having five non-white kids out of a high school class of almost one thousand was considered diversity. I grew up in a setting where women complained about being harassed by Mexican landscapers, feeling uncomfortable around black men in public spaces and thinking Asian men were too effeminate to be attractive. In school we learned about racism but believed it was a thing of the past (and the South). Experiences with diversity was mostly limited family and the media; both situations taken out of the greater context of society. It was not until I came to university in Boston did I start to notice, "Hey, people think I’m Asian, Mexican, Alaskan, Brown, etc."

When applying to universities in the U.S. one is usually asked to check a box for ethnicity: Caucasian always being at the top, then African American, Asian, Native
American, Pacific Islander and Other. I always chose randomly different “ethnicities”, an American version of a friendlier term for race, for fun, but I had always thought of myself as a non-race. In the case of Boston College I think I chose “Pacific Islander”. It had a sunny, less stigmatised feeling. Looking at that decision alone, even if I was not fully conscious of it, I had already adjusted my life – the way I acted, the decisions I made, the way I approached people – based on the stereotypes and stigmas that came with my experience of being labelled and identified by how I look.

At university, where I was considered a minority student because of my “Pacific Islander” box-checking habit, I discovered that race-based stereotyping and discrimination transcends class and time. I realized that thoughts such as “I hope he’s not talking to me because he thinks I’m exotic” censored the way I interacted with people. Of course, it is possible to think I am over-reacting and people are not run by such preconceptions. But the number one question I get when meeting someone for the first time is “Where are you from?” Which I try to answer with, “I’m from here.” Then comes the second most popular question, “No, where are you originally from?” Sounds perfectly fine, right? But, think of how ridiculous it would sound if I insisted on asking a white American or European where they were from, making them give me the details of their Irish/German/Norwegian/etc. heritage until I have been able to pin a satisfactory identity onto them. My educational path has been inspired by my experiences of stigma, stereotypes, and discrimination and its consequences on being a woman and an active participant in society.

As an exploration of society’s tendency to categorize and label people, for my Bachelor’s degree I studied visual communication and did a lot of research on the
portrayal of Asian women in film. I talked to women about how these stereotypes affected their everyday life involving relationships, friendships, career, etc. I found that discrimination and stereotypes created by society not only plays a large role in women’s experiences, but also that there is little academic attention paid to this relationship. Unfortunately, the discussion of the relationship between media and its influence on behaviour is lengthy and too large to incorporate into this study. Yet, for my Master’s I wanted to continue the theme of exploring how the two most silenced groups in Western society, people of color and women, are portrayed and what the impact on health is.

I decided to do my Master’s in the Netherlands so that I could take the opportunity to “explore” my Dutch heritage. The first cultural realization I encountered revolved around the Dutch concept of “tolerance”. I discovered that, instead of tolerance towards integration and acceptance, the Dutch idea referred more to not rejecting people for the sake of economic interest. This ideal of “tolerance” created an environment where, from the political arena all the way down to everyday conversations, discussion of anything race related, including race-based discrimination, was sucked into a vacuum of non-existence. Dutch society has a narrow but widely shared image of its history and the way that the Dutch public views itself is reflected in its conversations and actions. For instance, during fieldwork for this project I often went for runs through Oosterpark to gather my thoughts. I discovered a sculpture entitled “Shared Past, Common Future” hidden in a wooded corner of the park. It struck me because in the very back, in the shadow of a powerful female figure breaking into open space, is a little girl with pigtails attached to a group of people by a rope around her wrist. I later learned this was the National Monument
of the History of Slavery. During its opening in July of 2002, where Queen Beatrix was present, security refused admittance to the “common people” who were not allowed to see or participate in the unveiling. Only after the Queen had left did the “descendents” have the opportunity to inaugurate the monument themselves. Paradoxically, many Dutch people have told me, “Oh we don’t have racism here, it’s not a problem”. It surprises me that there is little attempt to address the lack of discourse in this area when on the everyday level the experience of race/ethnicity is obvious. This research is an attempt to explore this empty space, as well as introduce an anthropological perspective to medicalized sexual health. This project seeks to share stories that invite people to view the reflection of Dutch society from a different mirror.
SECTION I: BACKGROUND

Chapter 1: Introduction

1.1 A need for sexual health research that gives voice to Dutch women of color

*Ethno-racial stereotypes and sexual health*

Racially geared gender stereotypes of women of color, through stigma, embodiment and other factors, influence women’s lived experiences. Since racial and gendered stereotypes are based on how a person looks, they can transcend the class and culture of the receiver. Amsterdam and other urban settings of the Netherlands are areas where women of color, as immigrants, tourists, locals, etc., are subject to stereotypes regardless of their personal history. Their health, whether physical, mental or social, is partly dependent on how people perceive and in turn act in relation to them and how women interpret this. In the Netherlands there is a discrepancy in sexual health outcome; however, most Dutch literature targets ethnic groups as “social problems” (e.g. Why do Surinamese women have so many unwanted pregnancies? Why are Antillean men so sexually violent?) and what can be done to “fix” these groups. Issues of sexuality and sexual health are often attributed and isolated to intrinsic cultural values of these ethnic communities. Further, most of the small amount of research done involving the Dutch urban community treats it as a group of immigrants or outsiders. This suggests that people who have been born and raised in the Netherlands but are not part of the Dutch-termed “autochthonous” demographic are often not identified as Dutch, which in turn leads to deficiency in information and research involving this particular group.
Dutch people of color only discussed as immigrants

Dutch literature categorizes people of color, for example the Surinamese community, as a STI high risk group, but it is not clear if this applies to everyone within that group, including first and second generation. Youth who have grown up in Dutch culture? Non-migrant workers who have not travelled back and forth between countries? Dutch literature of studies on sexual health does not have a lot of information of what the sexual health concern within targeted communities is. Most of the information regarding sexual health in the women and men of color demographic is a comparison study between Surinamese, Antillean, Turkish and Moroccan immigrant groups. It shows whether something is greater or less than another group. From this information it seems that public health deals with sexual health of people of color from an outside perspective, categorizing everyone together as immigrants and addressing them as a problem group whose practices are either due to intrinsic cultural values or a threat to the general Dutch population. An arena is missing in the Dutch political and academic world to discuss Dutch people of color. There is even a lack of vocabulary to distinguish the difference between an immigrant and a Dutch person of African descent. Without these essential tools, sexual health of Dutch people cannot fully be explored.

Research to explore the gaps

This research works in the context of a lack of vocabulary in Dutch society to address black women as Dutch women. It hopes to introduce a different perspective for analysing the discrepancy of sexual health outcome for people of color in the Netherlands. It aims to accomplish this through exploring the role that social constructions of gender and ethnic identities have on shaping a healthy experience of
sexuality and womanhood for young women of color in the Netherlands. First I will describe the methodology, explaining the study type, variables, themes, and sample. After a look at current literature on sexual health of people of color in the Netherlands, I will explain how consequences of patriarchy, racism, etc. are intensified where multiple identities intersect, such as in being a woman and of color and how this perspective can be applied to sexual health. In the presentation of data I will examine conversations with young Dutch black women about their experiences and understanding of sexual health to gain insight into the tools needed to address the negative sexual health outcome of Dutch women of color. Then from these conversations I will illustrate the main ethno-gender stereotypes in Dutch society. Finally, I will discuss the implications these stereotypes have for sexual health and conclude with recommendations.

1.2 Objectives and Research Questions

This research, in a broad sense, aims to explore how the history of race, class, and gender inequality in the Netherlands has affected the way that women of color experience and understand sexual health. The research expects to gain insight into health-related and popular discourses of race/ethnicity in the Netherlands and whether there are differences between what is talked about in the formal arena (according to the literature) and what is experienced informally (according to conversations with informants). It intends to realize the implications racially geared gender stereotypes have for sexual health of women of color. Finally, through this, it hopes to gain insight gained into why there is a discrepancy in sexual health outcomes between ethnic groups in the Netherlands.
General objective:
Identify aspects of racially geared gender stereotypes that are connected to the experience and understanding of sexual health for women of color in Amsterdam.

Research questions:

- Is there increased poor sexual health for women of color in Amsterdam, if so how is it conceived, experienced, and explained in current discourses? (Addressed in literature)
- Is there a relationship between racially geared gender stereotypes and health outcome for women, if so in which direction and to what degree is the relationship affected (positive/negative)?
- Do stereotypes/perceptions impact women’s experience with and ability to negotiate safe sex, express sexuality, interact with intimate partner, utilise health care, etc?

1.3 Crucial Terms

Women of color: Since women of color are in fact globally the majority, I choose not to use the term ethnic or minority women. The word “minority” in itself also implies subjugation and inferiority.

Ethnic Minority & Immigrant Groups: I use these terms instead of using “people of color” when referencing literature in the discussion above because these are the terms used in the sources.
Race/Ethnicity: I am using these together because with reference to the American context it seems that they are used interchangeably. Ethnicity seems to be the “politically correct” way of using race. Although in the academic world the concept of biological hierarchy based on race is meant to be a thing of the past, in society this concept still exists. In the Dutch context there is a lack of discourse on race/ethnicity. The non-white community is still discussed as immigrant groups regardless of how many generations have lived in the Netherlands.

Black woman: This is the term used by informants to describe themselves (versus woman of color, ethnic minority, etc.) and I will use it when referring to the informants. I will use women of color when referring to a general population.
Chapter 2: Methodology

2.1 Study Type, Variables, Data Collection Techniques

Study Type and Research Design

This research is an exploratory study for several reasons. First, the available resources and time constraints of a six-week fieldwork period limit the study to exploratory research. To my knowledge of Dutch literature little to no research has been done on this specific field. Although there is a great deal of research on migrant health, not much focuses on sexual health outcomes for Dutch women of color, particularly on the relationship between societal forms of racism and sexism. Since this link has not been identified in the academic and possibly public arena this study is limited to being exploratory. The purpose of this study is to identify if there is a relationship between racially geared gender stereotypes and health outcomes: what this relationship is; and finally how, through an intersectional perspective, this information can be used to explain the disparity in sexual health outcome.

The research design is mostly qualitatively focused. Quantitative data from other research is utilized to place the qualitative information in the context of Dutch society.

Variables

There are numerous variables and themes involved in this research relating to the problem under study. Since the aim is to show that the experience and impact of stereotypes and discrimination transcends categories such as class, age, nationality, etc my independent variables were limited to:
• Women
• People of color (this definition was left open for the participants to define)
• Residents of an urban environment (Amsterdam, Rotterdam, Leiden)
• Grew up in the Netherlands (in order to discuss race/ethnicity outside of the
  migrant forum participation was limited to those
  born or raised – from 4 years old – in the Netherlands)
• Age (Between 20 and 26)

Themes

Sexual lives are difficult to understand without an idea of the larger context. There are many themes, such as family dynamics, religion, and economic and educational circumstances, which shape the context of women’s experiences of sexuality. The dynamic interplay between these aspects can be lost when stories are fragmented to accommodate a label ascribed to a certain woman: therefore themes were identified during and after the field work process without categorizing the women. The main themes entering into field work that were related to the research problem were:

• perceptions of larger issues in society relating to race, gender and sexuality
• racially based gender stereotypes as perceived by women of color
• race/ethnicity and its relation to sexuality and intimacy
• positive/negative sexual health outcomes

Data Collection Techniques

I created a website to spread information and gain informants (Appendix A). I conducted a series of semi-formal interviews following a prepared topic guideline (Appendix C). Though I would have liked to have conducted a series of focus group
discussions as well, this proved to be impossible due to time constraints. Throughout the period of research I also made efforts to participate in as many informal discussions on topics related to the research with relevant informants whenever possible and conducted several key informant interviews with members of the GGD and Dutch government to frame the research as a whole.

2.2 Sample

In an attempt to explore the universal nature of racial and gender discrimination the sample of women came from diverse backgrounds, limited only by age, gender, ethnicity, and location (urban environment). Although when recruiting informants my request was for women of color, in the end all the informants identified themselves specifically as black women. Nine women, selected according to the variables already discussed, were interviewed about topics following the themes of sexuality, intimacy and relationships. The first few contacts were initially chosen from a series of responses to bulletins posted in online communities (Appendix B). The rest were found through snowballing. Their pseudonyms, location and age are as follows:

- Daniella, Leiden, 21 years old
- Dee, Amsterdam, 20 years old
- Dior, Amsterdam, 25 years old
- Kati, Rotterdam, 21 years old
- Lili, Rotterdam, 22 years old
- Lizzy, Rotterdam, 26 years old
- Nina, Amsterdam, 23 years old
- Mo, Rotterdam, 22 years old
- Pepa, Amsterdam, 22 years old
2.3 Ethical Considerations

Informed consent was obtained from all participants through the provision of a description of the research (research is for academic purposes, and the data collected is part of a masters thesis project for the AMMA program) and the study’s risks and benefits. This was made available through a brief oral presentation and statement on the website which was circulated to make sure the informants had a clear understanding of the nature of the research and the methods used. They were informed that they had the authority to choose not to include comments as part of data and did not have to give information to questions with which they did not feel comfortable with. All participation was voluntary. All identities of individuals, whether in interviews, discussions, or observation, are kept anonymous through the use of pseudonyms and the disguise of further details where necessary.

2.4 Problems, Setbacks, and Issues in the Field

Several unforeseen problems were encountered during fieldwork. First, I had wanted to undertake content analysis of Dutch media following the theme of racially geared gender stereotypes. However, at the beginning of the study, I soon realized that an analysis of media was too large of a project. I decided that solely talking to women and discussing their experiences with identity and sexuality was sufficient to bring out the impact of sexually geared gender stereotypes, even if it did not allow me to identify the source of those stereotypes and labelling as the media. Also, it took longer than expected to find participants for focus group discussions and in turn informants for in-depth interviews. Originally, recruiting was attempted through personal contacts, however, many responses from Dutch acquaintances involved answers such as, “Oh...I don’t know those kind of people,” or “Well, why don’t you try the red
light district”. It seemed that the main perception of women of color among Dutch people (and non-Dutch residents) was that these women were either criminals or prostitutes. There was an attempt to recruit at the university, however, fieldwork began during the end of year exam period and many possible informants were busy with studying. Additionally, following the exam period, the Netherlands experienced warm, beautiful weather for the first time in about eight months, and many informants disappeared to the beach. Furthermore, many friends and colleagues who showed enthusiasm for helping find contacts, make a documentary, translate interviews, etc. (when they thought I was researching Dutch hip hop), dropped out when the topic changed to women of color and stereotypes. Another hurdle was dealing with was being Dutch, but not really. When first meeting people many were distracted with fully understanding what it means to be a Dutch expatriate. If I was going to analyse who they were and their thoughts, it was only fair that they had a full understanding of whom I was. Finally, many potential participants were excited about the topic and found it interesting; however they did not want to participate themselves. Due to ethical considerations the conversations with these women cannot be included in this research; however they were used to gain a general picture of the discussion on ethnicity, sexuality and sexual health in the Netherlands. Since the informants were of the same age group and had similar social interests as me it was difficult to maintain a professional perspective. A common occurrence was that I would find an informant and she would talk about the topic as a friend but would be offended that she was “just a research subject” and that my interest in what she had to say was not genuine. However, the set backs were taken as a learning process on how to do fieldwork and although the original work plan had to be modified greatly, informants were found and the results will be discussed here.
Chapter 3: Background Information

Before getting into the discussion of stereotypes and sexual health outcome, the following sections will give some background information on the research topic. I will first summarize current information available in Dutch literature on sexual health in the Netherlands and discuss the disparity in sexual health outcome. Then I will introduce a social science paradigm that will provide a different perspective on health than the biomedical model. Following this chapter will be the presentation and discussion of data.

3.1 “Immigrant” Women in Dutch Discourse on Sexual Health

Sexually Transmitted Infection

In order to detect potential disease outbreaks within the Dutch population in time the Netherlands has implemented a revised (based on a previous model) surveillance system for STIs. Since, 2003 STI testing, diagnosis and treatment have been registered at STI testing clinics and municipal health departments (GGDs). It includes notification data of hepatitis B and the data of laboratory surveillance of gonorrhoea, genital Chlamydia and syphilis. Information of diagnosis and treatment of STIs by general practitioners is also included into the network.

Since 1995 (Van de Laar 2003) there has been a rise in the number of detected infections. This however, does not necessarily imply increased incidence rates. The National Institute for STI and AIDS Control in the Netherlands (SOA AIDS Nederland) attributes this growth to three factors: “there has been more testing,
certain tests have been improved so that they are detecting more and more, and – especially in certain active networks – people have started to practice less safe sex” (SOA AIDS). Chlamydia is the most common STI, with 60,000 infections each year. According to RIVM (the National Institute for Public Health and the Environment), young people have a greater risk of acquiring an STI due to “a complex interaction of behavioral, biological and social factors. They are more at risk because they tend to have a higher number of partners and more concurrent partnerships than older age groups. They also tend to use less condoms than older groups” (van de Laar 2003: 77). More specifically, young women accounted for 66% of all female chlamydial diagnoses, 67% of gonorrhoea, 55% of genital warts and 45% of genital herpes diagnosed in 2003 (van de Laar 2003: 78). These numbers imply that young women in the Netherlands bare a large part of the burden of sexual ill health.

The Hidden Unwanted Pregnancy Issue

The number of teen pregnancies rose from 1996 until 2001 but has been decreasing since 2002 (Garssen 2004). Unwanted teenage pregnancies are not identified as a public health concern in the general Dutch population; therefore there are not many programs to address the issue. However, in research done in Amsterdam, pregnancy of 14 to 19 year old girls occurred more often in Surinamese and Antillean girls than in Dutch girls. In the age group of 14 to 16 it was 3.7 times more than Dutch girls. In the age group of 17 to 19 it was 4.1 times more (Stuart 2002). The number of teen pregnancies is significantly higher among what literature calls ethnic minority women than among Dutch women (Vogels 2002).
In 2000, 8 out of 1000 women had an abortion in the Netherlands. Sixty percent of those women were ethnic minorities. From that group about thirty percent had Surinamese or Antillean backgrounds. Among Surinamese women, 39.2 per 1000 had an abortion compared to 8.0 per 1000 of Dutch women (Rademakers 2002). This information suggests that certain women of color, Surinamese and Antillean, have more unwanted pregnancies than the majority of Dutch women. However, Stuart (2002) also claims that second generation immigrant teens have similar birth and abortion rates to native Dutch girls. There is no clear indication whether or not second generation children of immigrants are included in studies involving the immigrant population. Where it is made clear, they are only remotely identified as Dutch in a small note that relates their similarity to the general Dutch population. It is evident, from interviews with public health professionals and literature readings, that this information on unwanted pregnancy among Surinamese and Antillean women is often used to create “problem groups”. For example, in a conversation with an education coordinator at the GGD I asked whether there were any areas in which they would like to have more research done. He responded by explaining that the Netherlands in general does not have an unwanted pregnancy issue except with young Surinamese and Antillean women. He explained that this is a real problem group and they would love to find out how they could “fix” it.

Universal National Sexual Health Programs

After the emergence of HIV/AIDS in the 1980s, the Netherlands developed several safe sex campaigns. “Lang Leve de Liefde” (Long Live Love) was developed in the late eighties by the SOA-Bestrijding as a reaction to HIV/AIDS. It involved open talk where teachers discussed not just the biological aspects, but also the norms and values
of sex. Currently nearly all secondary schools provide sexual education, and more than half of primary schools address sexuality and contraception. As a result there has been an increase in students buying condoms and using them (SOA AIDS Nederland). The safe sex campaign reached the entire primary target group in 2003 and successfully dispersed knowledge about STIs (SOA AIDS Nederland). Some additional national projects include “Islam and Sexuality”, a program associated with www.maroc.nl that brings sexuality into open discussion. The media also serves as an open dialogue. Frequently one observes advertisements on the TV or on posters of STI consequences targeted at youth. Another program called “The Love Box” involves young volunteers that go to discos and teach condom use to their peers. “Uma Torf” is an intervention specifically aimed at Creole Surinamese, Antillean and Aruban women. It involves gender and culture specific group education about HIV and STIs.

**Mainstream Discussion of Sexual Behavior among Immigrant Groups**

Academic and political discourse about Dutch people of color categorizes them as immigrants instead of addressing them separately or as a part of the Dutch population. Often issues of sexual health are attributed to cultural factors that are specific to the immigrant groups under study. The following examples of research in safe sexual behavior among immigrant groups demonstrate the phenomenon in Dutch literature to isolate experiences of people of color from and to measure them against the norm set by the general Dutch population.

This example explores the tendency to use ethnicity based on countries as categories and using “autochthonous” as a norm. In 2000, a comparative study between Dutch
and ethnic minority (Turkish, Moroccans, Surinamese and Antilleans) youth on safe
sex and condom use found that Surinamese and Antilleans have more difficulty with
using a condom with a new partner compared to the Dutch (von Bergh 2000: 5). This
correlates to a study on high-risk sexual behavior among immigrant groups in
Amsterdam that concluded it should be kept in mind when addressing sexual health
that immigrant men use condoms less frequently with women of their own ethnic
group than with Dutch women (Gras 2001). Surprisingly however, in the von Bergh
study, Surinamese and Antilleans differ the least out of the identified immigrant
groups from the Dutch. This example demonstrates how there is no discussion or
distinction of class influence, level of integration, first generation immigrant or born
and raised Dutch.

This example explains how Dutch literature uses culture as an excuse for poor sexual
found that young women who grew up in the Netherlands were familiar with STI
prevention and condom use. However, in contrast to Dutch culture, the Creole-
Surinamese culture has a taboo on talking about sex and sexuality. Usually, very little
sexual knowledge is passed from parents to children, and there is little discussion of
contraceptive use. This deficiency of discussion leads to lack of knowledge and few
communication skills (in respect to negotiating condom use). In addition, gossip and
reputation play a significant role in creating a stigma of distrust with condom use.
Gender roles, especially “Machismo”, play an important part in the negotiation of safe
sex in Creole-Surinamese couples. In interviews with women, men’s role was
described as extremely sex oriented. Often the more children by different women and
the more women a man has had sex with the more “manly” he is (Brouwer 2003: 53).
In these two studies are examples of how the Netherlands does not have the tools for discourse based on race/ethnicity. The first study shows how the Dutch use countries to categorize ethnicities in discussions about sexual health. This relates to the general lack in vocabulary to address issues of discrimination based on race/ethnicity. The second study illustrates how culture of the target group is held responsible for poor sexual health outcome, rarely are other factors examined.

The Unexplained Discrepancy in Sexual Health Outcome

Research claims that there are significant sexual health discrepancies between, what literature refers to as, the Dutch and the ethnic minority (often combined with immigrant) population in the Netherlands. However, what are described as immigrant youth, especially second generation, have the least difference out of migrant groups with the Dutch on sexual knowledge. The Surinamese and Antilleans also speak Dutch and therefore have easier access to information. In addition, educational programs such as “Long Live Love” are implemented in all secondary schools. The Dutch safe sex programs are quite extensive and universal, therefore equal amount of information is available to children who grow up in the Netherlands (despite literature’s tendency to categorize second generation immigrants as non-Dutch). Much of the available literature and research on migrant sexual health implies that culture is mainly responsible for the status of poor sexual health in certain ethnic groups. However, if cultural perspectives on sex and access to safe sex information are fairly similar, it can be assumed that non-Dutch culture, as suggested by literature, is not the source of poor sexual health outcome; rather it must be related to other societal, economic or political factors (such as racial/ethnic and gender discrimination)
in the Netherlands. This suggests that there is a need to identify Dutch people of color as a demographic separate from immigrants and address how the popular Dutch attitude towards race/ethnicity has shaped experiences of sexual health. The most important question that has not been answered yet when it comes to research of discrepancies in sexual health outcome between ethnic groups (without using "culture" or socio-economic status as an excuse), is why there is such a divide.

3.2 A Different Perspective: Using social science to understand health

The Cost of Gender Hierarchy

In society there is an undeniable gender hierarchy. Often constructions of gender roles are determined by "natural" tendencies of maleness or femaleness (Rossi 1994). Testosterone legitimises violence, hence suggesting that men "can't help it". The "ideology of supremacy" objectifies subjects and naturalizes the distinction between subject and object (Connell 1995:83). In this model, women are objectified and often sexualised. This construction of sexuality is substantially what makes the gender division be what it is, male dominant (MacKinnon 1979: 130). This hierarchical gender related power dynamic influences how men and women view themselves and how they are treated by others within the culture (Stamler & Stone 1988: xiii). Hence, power dynamics influence how someone entering an arena is treated regardless of that person’s personal culture.

Creating the Other

The familiar anthropological concept of dirt as matter out of place applies not only to matter but people as well. In human relationships, difference is threatening. The concept of the Other has long been part of anthropological history. “Othering” in the
context of early anthropology and society today uses distance and difference to reconfirm one’s own normalcy. The Other is often depicted as categorically and intrinsically different. This difference leads to the potential for hierarchical and stereotypical thinking. The consequences of this in reference to gender can be detected in that “a man represents both the positive and the neutral, as indicated by the common use of man to designate human beings in general; whereas woman represents only the negative, defined by limiting criteria, without reciprocity” (McCann 2003: 33). A simplified but common example can be seen in the familiar stereotype that women are more emotional than men; combining this with the concept that all women are the same and using men as the standard of normalcy leads to hierarchical implications for women’s decision making capabilities.

*Introducing Intersectional Theory*

The cost of “othering” for women of color means that the level of otherness influences frequency, experience and consequences in situations such as discrimination and violence involved in gender hierarchy. Hence, racism enlarges cleavages among women and sexism divides women and men of color. While these two forms of discrimination, sexism and racism, are clearly related, they are also qualitatively and dynamically distinct (Sidanius 2000). In 1970, as part of a wave in radical feminist writings, Francis Beale introduced the concept of “double jeopardy”. Her hypothesis suggests that women from subordinated ethnic groups are acutely aware of their dual social identities, and therefore will also suffer from a double dose of discrimination, one based on gender and the other on ethnicity (Beale 1970). She suggested that black women in the West represent the “low man on the totem pole”. This is a reference to the man or woman who is in the worst social and economic
position. She proposes that by looking at the “low man on the totem pole” one can begin to understand the composition of oppressive forces weighing upon various peoples. At the time the position of the women’s liberation movement in the U.S. held that gender exploitation and discrimination was a product of a cultural process. Beale suggested fighting capitalism, as she claimed discrimination was an economic process. “Double jeopardy” focused on the economic disadvantage facing black women (in the U.S.). Beale’s Marxist analysis was typical of the day, arguing that the subjugation and subordination of women and people of color was a by-product of capitalist ideology and function. Non and neo-Marxist scholars contend that class is not a product of racism and sexism; it is rather an independent source of another form of oppression. Race, gender and class based oppressive forces cannot be separated from each other because they are experienced simultaneously. Most research on discrimination has focused on either race or gender separately, ignoring the unique location of women of color. Recent years has seen the welcomed development of an interactive model, expressing the interlocking nature of racial and sexual systems of subordination. Intersectional theories focus on the interactive effects of race, gender and class and claims that discrimination becomes institutionalised over time, reproducing if left unchecked (Collins 2000).

Intersectional analysis claims that women of color (and of lower class positions) are affected by greater forms of institutional and individualized oppression (Crenshaw 1993). The word oppression in Crenshaw’s explanation may seem a bit strong in a Dutch context; however it is important because it brings to light the multiple ways in which race, class, gender, sexuality and ability impact women’s agency in society. The intersectional model describes a junction of “roads as the axis of subordination”
and "traffic as the dynamics of subordination". The "cross-roads" where patriarchy, racial hierarchy and vehicles of discrimination, such as race, gender, class and global economic forces, meet are where marginalized women are located. Intersectional analysis aims to reveal different identities, exposing the different types of discrimination that occurs as a consequence of the combination of these identities. Intersectional analysis suggests that multiple markers of difference (e.g. gender, race, class) interrelate and all play a role in discrimination. For example, a woman’s experience of violence cannot be solely attributed to the fact that she lives in a highly masculine society: other factors need to be taken into account. According to intersectional analysis, women of color experience intensified incidents of gender discrimination (Crenshaw 1993).

**Studying the Target’s Perspective**

Much literature on discrimination and prejudice comes from the perspective of the perpetrator or "majority" population. However, in situations such as sexism and racism, women and "minorities" act as active agents who choose and influence the situations they are in. Simply because people are labelled as victims does not mean they do not have agency. Research involving women, minority members, or other targets of discrimination mostly positions women as the object of prejudice or as those who react to other people’s prejudices (Shelton 2000). Janet K. Swim & Charles Stangor (1998) introduced the concept of doing stereotype, prejudice and discrimination research from the “target’s perspective”. They argue that it is important to gain the “target’s perspective,” not as an object merely receiving an action, but as the subject creating or experiencing a situation. “One obvious benefit of including the target’s perspective is that it offers a more complete understanding of the
interpersonal and inter-group aspects of prejudice, stereotyping, and discrimination" (Plous 2003: 21). It also produces information about the consequences of exposure to discrimination. Research suggests, for example, that the discrimination black people experience is associated with self-reported ill health, lower psychological well-being, and the number of bed-days away from work (Williams, Yu, Jackson, & Anderson 1997). When looking for recommendations, “one additional benefit of considering the target’s perspective is that it can suggest effective ways to reduce prejudice, stereotyping and discrimination” (Plous 2003: 22). The “target’s perspective” gives a more complete understanding by gaining the insiders view, giving insight into consequences of discrimination on health, and suggesting a means to reduce negative experiences with stereotypes. More importantly, it gives agency to target groups. Janet Swim and Charles Stangor explain further that not only do studies from or on the “target’s perspective” improve the quality of research on discrimination, prejudice and stereotypes, but it “gives a voice to target groups, validates their experiences, helps pinpoint their unique strengths and weaknesses, and can potentially increase empathy for the targets of prejudice in today’s society” (1998: 6).

Implications for Sexual Health

Relating this to medical anthropology, one must examine the implications that characterizations based on race/ethnicity and gender have for sexual health. Most literature on this topic analyses the relationship between gender stereotypes and sexual health outcome. Research looking at the consequences that ethno-gender stereotypes have on healthy experiences of sexuality and womanhood is limited. Steele (1997) offers the concept of “stereotype threat” and argues that when a person
is presented with a task and made aware of a stereotype applying to his or her character it negatively impacts achievement. Steele uses examples of how women perform poorly on math exams if they are made aware of their gender before taking the test. Steele claims that the presence of the gender stereotype of women not being good at math influences their ability to make correct decisions on the math exam. This can be applied in theory to women’s decision making when it comes to sexual health. For example, if a woman of color is exposed to the stereotype of poor sexual decisions, such as promiscuity and unsafe sex, the “stereotype threat” would impede her ability to make a successful healthy sexual decision.

Intersectionality provides a lens through which to view sexual health outcome disparities. While there is a great amount of literature in each of the three areas of race, gender and class influence on health, few studies analyse the simultaneity of their impact on health (Schulz 2005). Intersectional analysis can also provide insight on the macro level: illustrating how systems of capitalism, racism and patriarchy interact with race/ethnicity, gender and class identities (Duffin 2005). This perspective is important for establishing the social and historical context of health disparities which cannot be explained by each factor individually. Further discussion of the relationship between stereotype and sexual health using the intersectional model will be discussed in Chapter Six.
SECTION II: PRESENTATION OF DATA

Chapter 4:  
Sistah Talk-A different view on Dutch sexual health discourse

To study negative sexual health outcome for people of color in the Netherlands, certain tools are necessary. I will bring up three points that are of concern when joining the discussion on sexual health for women of color in the Netherlands. First, to be sure that the discussion is on the same topic, there needs to be an understanding of how the target group defines sexual health. Secondly, I will illustrate how there is a tendency to use culture as an explanation for poor sexual health outcome. Finally, I will explain how it is necessary to address Dutch black women in a category separate from immigrants living in the Netherlands in order to fully address their sexual health concerns.

4.1 Sexual Health: Pleasure within her framework of values and comfort

Recent years has seen an expansion of the concept of sexual health from a focus on reproductive well-being and disease prevention to a broader integration of sexual well-being into physical, emotional, cognitive and social aspects of health (Lewis 2004). A working definition of sexual health, offered by the WHO, is an example of this:

Sexual health is 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).
Such broad definitions obscure the goal in sexual health research and bring up questions such as, “Which sexual health?” “One single umbrella definition of sexual health free from socio-cultural, historical and personal contexts is probably impossible” (Lewis 2004: 2). Too narrow of a definition, such as simply focusing on the physical aspect of sexual health, implies the possibility to attain a single, natural, normal sexuality. This suggests that sexual health is a static concept and that it does not adjust nor shift across culture and time.

Understanding the difficulty in using such a broad definition, I allowed the informants to define what sexual health means for them. Gathering information from the conversations I found that concepts of sexual health could be divided into two categories, described by Linwood Lewis (2004) as preventive sexual health and eudemonic sexual health. He defines preventive sexual health as the public health oriented domain mainly concerned with prevention of disease. It mostly addresses sex related behaviors that are “defined as challenges to public health because of the negative consequences associated with these behaviors...for example, adolescent pregnancy is considered a threat to public health because of possible physical harm to the adolescent and infant” (Lewis 2004: 225). Hence the focus is on the threat to public health because of possible physical danger rather than psychosocial consequences. This is the type of sexual health discussed in the first chapter that the Dutch public arena refers to. Eudemonic sexual health on the other hand is the attainment of sexual pleasure specifically integrated within the broader context of one’s life, within a guideline of certain morals (Lewis 2004: 225). It often involves discourse of sexual function and dysfunction, typically looking at social and cultural aspects of dysfunction rather than medical and organic aspects. Whereas sexual
Responsibility in preventive sexual health is the protection of society, in the
eudemonic point of view it is more private and relational.

The research discussing poor sexual health outcome in the Netherlands is mostly
preventive based, as in numbers of infections, unwanted pregnancies, etc. etc.
However, when asked about sexual health most of the women with whom I talked did
not automatically think of the preventive perspective. Although those concerns were
not far from their minds, the more immediate sexual health matter was something that
could be described as “comfortable sexuality”. The informants talked less of physical
health risks in the context of sexuality and more of the level of comfort and security
they feel with their current sexual lifestyle.

I feel comfortable with my sexuality. I have had experiences with
other women, not really sexual intercourse, but threesome. I know I
am straight though. Being comfortable with my sexuality is something
I work on. I always ask myself questions about why I like this, or why
I don’t like something (Daniella).

When discussing experience with bad or poor sexual health, informants would refer to
earlier in their lives, a period most associated with not being comfortable with
themselves or made decisions based on insecurities. Kati explains here how lack of
understanding leads to fear and what would be considered poor “sexual health” by her
definition.

I was about twelve, when I first started exploring myself. I had to put
things together myself. At first I didn’t understand what was going on
with my body sexually, when puberty came...Then I started
understanding it. Which means I got to know it, which ultimately
meant that I was ok with it. But as with everything, if you don’t
understand something you fear it, or you can’t be comfy with it until
you do.

Bringing in eudemonic discourse, the focus for informants is on the cultural and social
aspect of sexual (dys)function. Here Lili explains her definition of sexual health:
It differs for each person. For me sexual health is about keeping myself healthy, while doing what I like doing. I have had experiences that weren’t pleasurable but those were the ones I was too young for to even have a say in it. Ever since I became old enough I’ve made it an issue to only do as I please.

Here Lili hints at bad experiences from when she was younger. She discusses health from the perspective of pleasure. From the above examples, when informants are referring to experiences of bad sexual health they talk about the absence of pleasure or comfort. The informant’s first thoughts on sexual health are not based on a biomedical model, rather one that is based on pleasure within the bounds of their value system. Sexual health is more than, actually completely different from, information about safe sex and preventing unwanted pregnancy. This is where social science, such as anthropology, lends a hand to getting a better picture of health because it examines it from outside the biomedical model. This is essential to note because when examining sexual health outcome for Dutch people of color it is important to understand what they define as sexual health. Also through this definition it is possible to examine the relationship between black women’s understanding of sexual health and their experience of stereotypes.

4.2 Culture as the Culprit: Sexual debut and values related to sexual health

In regard to sexual health and sexually transmitted infections, there is a strong emphasis on delaying sexual debut. Early sexual intercourse is frequently associated with a higher number of lifetime sexual partners and consequently, a higher risk of contracting sexually transmitted infections. Therefore voluntarily delaying sexual debut is of key importance in the prevention of sexually transmitted infections and the promotion of long term health (Stantelli 1998). I discussed sexual debut with
informants in the context of getting an idea of their perception of risk for themselves. Also to understand what concerns (if sexual health was included) they had in making the decision to delay or have sex. Along this thread the concept of virginity and its meaning was brought up, which ties back to the eudemonic perception of sexual health described earlier. Moreover, it demonstrates how essential it is to get away from the tendency in Dutch literature to refer to culture and lifestyle paradigms, using individual failure or inevitable consequences to explain poor sexual health outcome.

Rather than choosing to delay sexual debut because of risks for pregnancy or STIs, for most informants the decision focused on whether having sex would fit appropriately into their lives.

The first time I had sex was my third year in college. I think I would have done it earlier, but I just never had the opportunity. It wasn’t like I was waiting or anything (Daniella).

In high school I didn’t really feel like having sex. I was distracted with other things, studying maybe. I just wasn’t interested. I think sex to me was also not just casual, it had to mean something. I also had a lot of guy friends and I saw how they talked about girls after they had sex. I didn’t want them talking about me like that. I guess it’s a double standard. Virginity was something I wanted to and chose to keep. I wanted to experiment when I got out of high school which was after I was 18 (Dee).

Daniella and Dee’s stories are examples of how the decision to have sex happened according to whether sex had an appropriate place in their lives. The following example shows another perspective on sexual debut.

I had my first boyfriend in high school. After we had been dating for a while the subject of having sex came up. It was my first time and I didn’t know what to do. You know, it’s such a big topic at that age. I didn’t really have a lot of self-confidence so I felt like it was something I had to do. To feel wanted or perhaps because I felt I needed men. I did end up having sex with him, but he really loved me and I knew he wouldn’t leave so I was comfortable with it (Lizzy).
Informants' decisions to have sex were not related to knowledge of risks to preventive sexual health. Also, testimonies from informants demonstrate that values of sex and decisions vary among Dutch black women. Dutch research imposes inescapable intrinsic cultural attributes to women of color in relation to their sexual decisions and behaviour, such as, not being able to make proper decisions because of certain values about sex and communication. However, according to this sample of women, sexual experiences and decision making among Dutch black women are diverse. Furthermore, sexual debut does not always happen due to individual failure or inevitable consequences.

4.3 Disputing the Categories: Cultural claims of poor sexual health outcome

Earlier, one of the problems identified with researching sexual health of Dutch people of color is that in the Netherlands categories of ethnicity are based on countries and, from these groupings, cultural values are used to explain problems. In order to explore the experience women have with access to sexual health information, I asked about how they first learned of sexuality and sexual healthiness. Most informants described having to learn it themselves. For example, Kati describes learning about sex from the television:

I learned about sex from TV. I watched lots of it. I grew up on TV. But then I started noticing a lot of stuff. Then I came across a porn and I went to look and that's where everything kind of fell together. No one talked to me about it before, so I didn't know about AIDS or how to get pregnant.

When asked about their first contact with information about sex and sexual health several began with describing having to learn about it independently outside of the home.

Sex was something we didn't really talk about at home. Maybe it has to do with my parents' upbringing, but we barely even talked about
having your period. I actually went to look for answers about sex in
books, and my friends of course. I had some friends that went through
puberty before me and they were doing things before me. So I'd
always ask them (Daniella).

I didn’t learn about sexuality from my family. I learned it from outside
the home, my friends mostly. My mom didn’t feel comfortable talking
to us about sex things, not even about having periods (Dee).

I didn’t learn anything about sex from my mom. I used a condom
when I had sex for the first time, but because it was the guy’s idea
(Lizzy).

I was very curious and was always reading about stuff. Mostly, I
learned from my friends though. I learned a little bit about sex from
my mom. I should’ve learned more, but it was mostly just regular stuff
parents tell their kids. Like don’t let him get in your pants, don’t get
pregnant, you know? It was never formal talk (Dior).

This relates to the background information given in Chapter Three where Dutch
discourse on sexual health involving people of color often attributes negative sexual
health outcome to intrinsic cultural traits different from the general Dutch society.
Relating back to the Brouwer (2003) study, the lack of condom use and in turn higher
number of STIs and unwanted pregnancies was credited to the cultural practice of not
speaking about sex at home. However, as shown in testimonials from informants, this
does not mean there is a lack of access to information nor that there is an absence of a
forum for discussion about sex outside of the home. Hence, claiming that the cultural
feature of not having a dialogue about sex and sexuality at home cannot be held solely
accountable for the lack of condom use.

Eventually informants revealed that they did learn about sex in school through sexual
education courses. Kati explains, “I had to put things together myself. But I did learn
stuff in school. At first I didn’t understand what was going on with my body sexually,
when puberty came. I was like what the hell is going on? Then I started understanding
it”. Where Kati explains having to teach herself until having a sexual education course
in school, Dee, “learned from outside the home” though she admits, “We did have a sexual education course in school though”.

The Netherlands has widespread education programs about sexual health and all informants did have access to information through school. When reflecting on discovering sex and sexuality, although parents are not usually considered as a resource, informants’ have access to information or dialogue in books or through peers. Looking at this information gives insight into the difficulty in using categories that do not distinguish between immigrants and Dutch black women. It can be seen that experiences of first contact with information about sexual health cannot be divided into categories of immigrants. Although Dutch literature about immigrants, people who have not lived their whole lives in the Netherlands, may be accurate, the experiences of Dutch black women are unique from those documented in research about immigrants. Also, the cultural traits of immigrants that Dutch literature claims leads to poor sexual health outcome cannot be applied similarly to Dutch black woman. The vocabulary and concept of Dutch black women needs to be recognized in Dutch discussions in order to fully understand the sexual health concerns and consequences of this group of women.
Chapter 5:  
“You’re Pretty for a Black Woman”  
Revealing Dutch Ethno-Racial Stereotypes

Two terms often used with the word stereotype are discrimination and prejudice. Discrimination involves putting group members at a disadvantage or treating them unfairly as a result of their group membership. Prejudice involves a prejudgement, usually negative, about a group or its members. “It is not merely a statement of opinion or belief, but an attitude that includes feelings such as contempt, dislike, or loathing... Where prejudices lurk stereotypes are seldom far behind” (Plous 2003: 3). American journalist Walter Lippman coined the metaphor of stereotypes as “pictures in the head”. He explained, “Whether right or wrong, imagination is shaped by the pictures seen... consequently, they lead to stereotypes that are hard to shake” (Lippman 1922). Currently it refers to fixed preconceived generalizations, or often overgeneralizations, about members of a group (Plous 2003). Such generalizations can be positive, such as women are nurturing, however mostly they are negative and static. They are usually applied whenever a group is depicted or portrayed in such a way that all its members appear to have the same characteristics, attitudes or life conditions (Sprafkin 1988). Stereotyping, prejudice and discrimination are distinct from one another despite the fact that they are often experienced together. In this research, to keep it focused, conversations concentrated on experiences with stereotypes. In this chapter I will explain how the informants, despite their diverse background, were all labelled as black women. Then, from their experiences I extract four stereotypes of black women in the Netherlands which fall into two categories, the
hyper-sexual “exotic other” and the asexual “pathetic other”. Finally, I describe the two directions in which Dutch black women identify with stereotypes.

5.1 “African, Caribbean, They’re all alike”: Figuring out Dutch Stereotypes

During fieldwork I discovered that women of color in general tended to be categorized as black women. For example, Nina whose father is Hispanic (from Curacao) and mother is half Dutch and half Indonesian considered herself a black woman. When I asked her why, she explained that it was because that was what the Dutch people called her. She went further to explain:

The stereotypes don’t differ much if they’re black women from the Antilles, Suriname or Africa, cause they’re mostly the same. Just like white women, you put them in a group...in general. People do distinguish between Surinamese, Antillean, whatever Black women but only if they get to know them. Otherwise you see them on the street, they’re all the same.

Identification based on group rather than individual is related to what psychological studies (mostly dealing with eyewitness identification of criminals) call cross-race identification or own-race bias. In studying stereotypes it is also called the out-group homogeneity effect. It explains that when we encounter someone from a different group we process them at the group level. We code the face in our memory under the category black or white, and not under the category of someone with, for example, a round face, brown eyes and a small nose. The perception of out-group (“them”) members is that they are more similar to one another than in-group members (“us”) are. An example can be seen in the phrase, “They are all alike, we are diverse”.

It was surprising that according to the testimonials of the informants and conversations I had with Dutch people that the “they’re all alike” phenomenon had, what I identified as, such a broad spectrum of people put into a general category of
being “black”. For example, I had conversations with some Dutch Master’s students at the University of Amsterdam and I asked about where there were good places to go out at night. They wanted to know what I was looking for and I gave them a few names of places that I had been to and they responded by saying, “Oh, you mean black music?” and went on to explain with hesitancy that “it’s full of those kinds of people”. I was surprised because I was simply looking for places that did not have techno. I did find these places and they have a diverse atmosphere. Perhaps the Dutch students made this statement because they did not know it is a meeting place for people of different backgrounds, or they were classifying everything unfamiliar into one category. The “other” music scenes and its audience were all categorized into one group of being “black”. This study, since it is from the target’s perspective, does not incorporate the viewpoint of the general Dutch population. However, I did use these casual conversations to determine that although my informants had such diverse backgrounds (Surinamese, Antillean and Ghanaian descent) it would not take away from the validity of the stereotypes of black women I identified in conversations with informants.

5.2 “Exotic Other” or “Passive Other”: Stereotypes of Dutch Black Women

A large part of academic literature on gender and ethnic stereotypes regarding women of color focuses on black women (women of African descent as opposed to other ethnic groups such as Asian women). They are often contrasted with white women who are meant to represent models of self-respect, self-control, modesty and even sexual purity. Black women are often portrayed as innately promiscuous and more connected with nature as well as uncivilized. These themes are also present in the conversations I had with informants. They can be broken down into two categories.
The first are characterizations of perpetually sexually available black women and the second are completely nonsexual beings. In both situations the character’s existence is dependent on men, either as part of fulfilling their identity or in order to demonstrate a failure. Although these characterizations are put into two groups, they are not independent from one another. Often the characters shift and mix depending on the context. The four stereotypical black women characters are presented separately in the following discussion; however, they are often experienced by the same woman simultaneously or at different levels at different times.

**Hyper-sexual “Exotic Others”**

*Forbidden Fruit*: *An exotic taste for your pleasure*

The first stereotype that had an over-arching presence was that of the exoticized woman. In conversations with informants about dating and intimacy the exoticizing of their identities came up the most often. Although the topic of discussions dealt with race/ethnicity and gender, there was little conversation about interactions with black men or women. Some informants had experiences with other women, but all of them identified as heterosexual. Also, as all the informants lived in cities, the focus of their discussion on dysfunction concentrated on experiences of living in a diverse environment. The informants explain how in these settings, the label exotic is often encountered.

A lot of men seem to have this odd fascination with non-white women. As if white's an invisible race, a norm. I don't know if it's left over from war times or it's a taboo sexual thing or what. The most common things I hear "So, what are you?" "I have this thing for black chicks..." "You know, I've never dated a black girl before..." And it confuses me because I was born here, I act like any other Dutch girl, I tried to break every black stereotype, but for some reason the only part I can't easily change, the way I look, has given men some notion that inside I am excitingly different or forbidden fruit or something (Pepa).
My first serious boyfriend, when I was 16, was this hip-hop white guy who, for a long time, I couldn’t figure out why he wanted to date me or found me attractive. Eventually he admitted to me he was attracted to my exotic beauty, something that I would eventually hear all the time when I started going to bars and clubs (Jo).

Jo and Pepa both describe experiences of being sexualised based on the label of the exotic other. This hyper-sexualization influences aspects of their lives, such as relationships. The exotic label sexualises black women, turning them into merely sexual objects. This stereotype trivializes a woman’s identity into an object of desire. Pepa explains further how “a simple thing” like being a “forbidden fruit” objectifies her identity. “A simple thing like that makes me a "what" instead of a "who" and gives guys permission, though I've never been abused or even treated badly or anything, to show me off to their friends like a possession”. She describes how this “exotic” stereotype makes her feel like a possession. The exoticization of black women minimalizes their identities so that they are sexual objects. This also implies a dependency on men because this characterization does not exist on her own without a male counterpart.

“Sex Beast”: Perpetually sexually available

This characterization similar to the “forbidden fruit” suggests that a black woman is always sexually available. She is a hyper-sexualized and predatory woman. She is often depicted dressed in animal fur, with little clothing, or other exotic adornments. Literature attributes the origin of this character to either plantation patriarchy, in relation to stereotypes in the Americas or 17th Century white European travels to Africa. In plantation patriarchy, the rape of the slave woman by the slave owner had three purposes: economic, to increase the number of slaves, sexual, to relieve sexual desires, and power, to show dominance (Frankenberg, 1993). Describing the black woman as an aggressive woman was an explanation for and justified the sexual
relationship between the slave owner and the slave. It is also believed that this character came from European travellers who brought back stories of African women dressed in little clothing—misinterpreting them as lewd and sexually hungry.

Informants listed some examples of Dutch stereotypes of black women: the terms “lust driven”, “promiscuous”, “wilful” and “sex beasts” came up frequently. Along with having an exotic label the informants tended to encounter this stereotype the most often. When I asked Lili about what it meant to be a black woman she explained, “I am a black woman, and an Antillean one at that. So, I must be the promiscuous type and eager to satisfy any dick coming my way”. Lili goes further to explain her observations based on her personal experiences:

When people see my pictures they tend to get lustful feelings or think, ‘Well she has a pretty face and her body isn’t that bad. I’d like to fuck her”. Then they actually go to talk to me and seem to be amazed that I actually have something to say and that I sometimes have received a higher education than them.

Here Lili explains that people are “amazed that I actually have something to say”. Her description of how black women are perceived in Dutch society implies that they are seen as objects of desire or simply sexual beings compared to white women which are considered the norm. An example of this can be seen from a conversation I had with an environmental anthropology student here in Amsterdam. When discussing our research projects, I was explaining the terms allochthonous and autochthonous and the relationship to sexual health outcome. She became confused and asked, “Wait, you mean the white people have a negative sexual health outcome?” I clarified for her that it was the people of color who experienced the poor sexual health outcome. She then responded by saying sarcastically, “Oh okay, good. I was going to say, oh what disgrace it would be to the Dutch if the white people were running around having lots
of sex”. This example illustrates how people of color are perceived by the Dutch public as innately promiscuous and sex driven. However, since the white population is used as the norm, in this situation stereotyped as having less sexual activity, people of color become a pathologized group. Black women are put in the position of the Other and in turn made abnormal because of their gender, but this identity is intensified by race-based stereotypes.

**Asexual “Pathetic Others”**

*Kaffer*: Comic relief gangster

Stereotypes claim that a black woman’s identity revolves around her sexuality. If she is not a hyper-sexual being then she is completely devoid of sexuality. The first character of this kind that appears in the descriptions of informants is a wise-cracking, emasculating woman who is often imagined with her hands on her hips, swaying her head from side to side while exchanging insults with someone. She is very in charge; everything that the Single Mother, the following character, is not. Because of her role as emasculator (she is often assumed to be in a verbal dual with a black male), she cannot exist independent of a man to duel with.

Nina explains her experience with being typecast as this character:

> My white friends always say that we don’t hide in expressing ourselves. So if they piss us off they’re in real trouble. Cause we’ll give it to them good. People say we’re loud. Or they call us kaffers, it’s like street oriented people. So if you see a black girl on the street and she’s “street”, like gangster or whatever, that’s what it is.

Unfortunately, despite the dominant traits of this character, she is never taken seriously. It is only perceived as comedic or entertaining. Similar to the “exotic other’s” dependence on men, since this character needs to have a person to exchange
insults with, which is usually a man, her existence is also determined by a male presence.

"Single Mother": A failed mother and woman

Although most of the age group that I talked to did not personally experience this stereotype, they mentioned it as another common generalization. This character originally is the docile, loyal yet untrustworthy favourite aunt or grandmother. She is usually imagined as desexualized and overweight. She is not the wise cracking “passive other” described previously, in fact she is often assumed to have no education and a low level of intelligence. Lili explains, “I get underestimated a lot. Being a woman, and black, people often assume I’d be talking with an accent, aren’t smart, don’t know anything that’s worth something”.

This stereotypical character also takes on the form as the irresponsible mother. She is the failed mother because she spends too much time away from home working. For example Dior, who was the only parent of my informants, explained:

I ended up having a baby when I was seventeen. When I got pregnant it was an accident. The guy was someone I was seeing. He didn’t really force me to have sex, but I didn’t really want to have sex, because we didn’t have a condom. But now I’m studying something that’s a passion, but I still get people treating me like I’m a sort of drop out. If they’re not talking about me ditching my kid at home to go class they’re saying I’m never going make it anyway.

This single mother character that Dior talks about is stigmatised as deviant because it challenges assumptions of the patriarchal family which Dutch society is used to. Since Dutch households are usually identified as male headed, it suggests that women headed households are failures. In this case, where previous stereotypes depended on
men, the “Single mother’s” independence of a male character is socially justified by suggesting she is a failure.

5.3 Recognizing the Reflection: Seeing or Not Seeing Herself in Stereotypes

The trend that appeared in general responses to experiencing and living with these stereotypes could be put on a scale with two extremes. On the one end are women who embody stereotypes. They allow themselves to fulfil the image that is expected of them. On the other side of the spectrum are women who do not see themselves in the stereotypes at all. These are women do not connect or identify with stereotypes of black women.

The first extreme found in how informants deal with stereotypes was through adjusting behaviour to follow the label. For example, in reference to being the “forbidden fruit”, Kati describes, “I have a huge struggle with this “exotic fetish” thing because on the one hand, I absolutely hate being objectified and now have a policy against talking to or dating any guy who tells me he “has a thing for brown girls”. On the other hand, it beats feeling unattractive because of my race. Sad that those are the only two options, huh?” Kati’s general attitude towards dating in a diverse environment is that the solution is in allowing the exotic characterization to label her at the risk of being unattractive. Nina, while describing the general Dutch population comments that, “Dutch people are judgemental. Everything’s about looks. The cuter you look the better you get treated. Looks matter for meeting new people and friends. Guys are really judging of a girl. Looks still go a long way.” Nina describes herself as insecure based on the image she is meant to fulfil. She explains that she acts like a “kaffer” although she does not feel like one.
On the other end are women who do not identify with Dutch stereotypes of black women and in turn they do not alter their behaviour to match or combat the labels. For example, Lili describes how she does not associate with society’s characterization of a black woman:

I get underestimated a lot. Being a woman, and black, people often assume I’d be talking with an accent, aren’t smart, don’t know anything that’s worth something. But I’ve decided not to let that work against me, but for me. This way they never see me coming. I’ve grown used to it and started using it as an advantage instead of something that’s holding me back. I won’t let the way people perceive me get in the way of what I want.

Lili admits she uses people’s misconception as an advantage for herself because she does not recognize herself in the stereotypes. Dee explains the misunderstanding of black women in Dutch society, “I don’t think the Dutch understand black women’s sexuality. Because all the images they have of “black women” aren’t what most of us are really like”. Society’s labels of black women either define who they are inaccurately or suggest how they should be using the general Dutch population as the norm. The response to this is that Dutch black women react in various ways, on one end either embodying the stereotypes or on the other completely rejecting them.
Chapter 6: Discussion - Implications Stereotypes Have for Sexual Health

Chapter Four introduced data from conversations on sexual health. Here this information will be used to discuss the necessity for new devices to analyse sexual health in the Netherlands. Then, the impact of stereotypes, introduced in Chapter Five, on sexual health will be discussed at two levels. The first is the individual, which will be analysed with the data from informants’ conversations about how they relate to stereotypes of black women. The second will be a discussion using intersectional analysis to demonstrate the influence of structural factors on sexual health outcome.

6.1 Introducing New tools to Dutch Sexual Health Discourse

The Dutch sexual health forum is lacking the tools, available in social sciences, necessary to discuss sexual health of Dutch people of color. The Netherlands is well known internationally for its politics of tolerance; however, this has created a political and academic environment allergic to racial or ethnic discourse. To avoid discussions of discrimination related to race, categories are created based on countries. However, this color-blind perspective takes away the opportunity for addressing problems and perspectives specific to Dutch people of color. It is important to identify Dutch women of color in a separate category from immigrant women. The request to create a separate category of Dutch black women should not be confused with attempting to identify race as biological or genetic, but rather, as a social construction. Race in this context needs to be conceptualised as “relations between groups rather than as something that people of color ‘have’ and whites do not” (Shulz 2005: 6). By moving past the use of race as an “atheoretical and ahistorical category” research can
contribute to identifying the underlying causes of racial disparities in health. Explicitly theorizing race as a social construct persuades researchers to examine how processes of racialization are linked to economic, social, and political circumstances that influence health outcomes (Daniels & Schulz 2005).

This project involves Dutch informants from diverse histories, backgrounds, and experiences. However, outwardly towards the Dutch society they are categorized as either “immigrants”, “Surinamese”, “Antillean”, and “African”. Rarely are they recognized as Dutch women. Gail Wyatt who, standing in a hotel lobby waiting for her husband was mistaken for a prostitute, is a published author and well known researcher of the impact of gender and race stereotypes on sexuality. She claims that there is a disparity in sexual health because in studies pertaining to sexual health outcome a diverse “majority” sample is chosen, whereas a sample of mostly poor black women is selected to represent the “minority ethnic group” (Wyatt 1980). She emphasizes that women of color have diverse experiences with sexuality just as other ethnic groups have diverse experiences; however, “few explorations have examined middle and high SES ethnic minority samples” (Wyatt 1980: 226). When Dutch research focuses on immigrant labels to identify the source of health discrepancy, it loses important information that can be gained from recognizing the role of race/ethnicity as a determinant along with class and gender identities.

Using the perspective of the separation between preventive and eudemonic sexual health, Lewis (2003) suggests that people of color are seen as, what he calls, more dysfunctional due to an imbalance in studies. “The focus on preventive discourse suggests a problem. The historical juxtaposition of racial and ethnic minority status
and sexual health related research...strengthens the association between problems in sexual health and minority groups” (Lewis 2003: 4). This focus on “problem minority groups” creates (fictional) dysfunctional sexualities which ignores the diversity of sexual experiences. Again, the emphasis is on understanding that not all Dutch black women are immigrants; therefore, their experiences and understanding of sexual health need to be addressed separately. Also, labelling research as sexual health of immigrant women, knowing that Dutch women of color are included in this category, provides an inaccurate picture of sexual health outcome for Dutch black women.

The Dutch aversion to addressing issues of race/ethnicity also creates an opening to use culture as an alibi. Cultural and lifestyle explanatory models, which allude to notions of culture of poverty and deviance, are problematic. “Alleged cultural traits, behaviors, or beliefs, frequently implicitly or explicitly considered to be associated with racial groups, are often seen as constant, unchanging, and independent of social and historical processes” (Shulz 2005: 4). By focusing on “immigrant” issues, instead of attending to the impact of the intersection of race/ethnicity, gender, and class identities, lifestyle explanatory models easily use culture as an excuse for a divide in sexual health outcome. Such paradigms position the cause of health disparities within individuals or groups rather than in sets of social relations (Shulz 2005).

6.2 Identification/Alienation: Individual level consequences for sexual health
When talking about experiences of sexuality and intimacy with a sexual health theme, conversations with informants focused on dysfunctional experiences. Attached to dysfunction, in experiences such as dating, were ethnic or racial stereotypes. The stereotyped portrayal of women of color in Dutch society creates characters that are
sexualised based on racial stereotypes. These characterizations often form the basis of how the public perceives and in turn interacts with women of color. "Once activated, stereotypes can powerfully affect social perceptions and behaviour...it appears that when stereotypic representations of behaviour are activated, relevant behaviour also becomes activated" (Wheeler & Petty 2001). The previous chapter explored the way informants felt or have experienced ethno-gender stereotypes, in this section the potential consequences the relationship black women feel with these stereotypes will be discussed.

One implication of negative images is the idea of "stereotype threat". "People who are stereotyped face a burden: the threat that their behaviour will confirm a negative stereotype...Stereotypes can also become self-perpetuating when stereotyped individuals are made to feel self-conscious or inadequate" (Plous 2003: 21). This burden is known as "stereotype threat". The fear of reinforcing negative stereotypes hampers the ability to succeed. It can create anxiety and impede performances on a variety of tasks (Steele 1997). For example, when Asian girls are made aware of their ethnicity they perform better on math tests, however when made aware of their gender they do poorly (Plous 2003). Another concept close to "stereotype threat" is "self-fulfilling prophecy". It is a self-confirming apprehension that one’s behaviour will verify a negative stereotype. Experiencing stereotypes creates a risk of confirming a negative label about one’s group as a self characteristic. As an individual is constantly exposed to negative images of his or her ethnic group, this person will begin to internalise the same social and personal characteristics of the stereotype (Steele 1997). The informants who tend to embody stereotypes of black women have the risk of
fulfilling a negative stereotype. For example, if society portrays black women as promiscuous hyper-sexualized beings, this creates a norm that women will use.

On the other hand, if women do not identify with stereotypes they may become unaware of risk. For example, in the first chapter it was described how women of color experience higher STI and unwanted pregnancy cases which is attributed to unsafe sex practices. There is a danger if Dutch black women do not identify with a group that is at risk and in turn do not adjust behavior because they feel safe. For example, informants are aware of HIV and STI risks for certain ethnic groups. If they view the risk group as, for example, perpetually sexually available black women, they do not connect with the risk because and she does not share this characteristic therefore does not feel concerned.

6.3 Institutional Implications: Applying Intersectionality to health disparity

Analysing the disparity of sexual health outcome from the perspective of Intersectionality acknowledges the malleability of race, gender, and class as socially constructed categories and places the sexual health experience of women of color in a social and historical context. This perspective is useful for understanding and gaining new insight into the disparity of sexual health in the Netherlands. The relationship between Intersectionality and sexual health will be explained further in the following section.

In order to use intersectional analysis, one must examine the labels of Dutch women of color because, along with concentrating on structural, political, historical, and locational factors, intersectional analysis stresses the importance of the ways social
groups and individuals are represented – the ways they are perceived and depicted in society at large and the expectations associated with these depictions (hooks 1992). Direct consequences of these stereotypes are numerous; the following examples name a few. The labels of “Forbidden Fruit” and “Sex Beast” create doors for justifying and instigating sexual exploitation, since these women are depicted as perpetually sexually available. The “Single Mother”, as a woman with no sexuality or intelligence, risks being overlooked in times of need. For example, having sexual harassment claims going unnoticed because, as opposed to where sexual advancements would be justified in the case of aggressive hyper-sexualized characters, it is more difficult to believe that a man would desire an asexual woman. In the case of the “Kaffer”, claims of sexual abuse would be overshadowed by her reputation for deception, lying and lack of loyalty. The impact on sexual health can be seen from these examples. Dominant representations of people of color build on and elaborate stereotypes that become the rationale for the differential treatment of groups and individuals (Arcia, Skinner, Bailey & Correa 2001).

The four stereotypes identified demonstrate not only how society sees Dutch black women, but they also reflect power dynamics, display identities based on sexuality, and create categories of the Other. When black women’s identities are dependent on men it illustrates the power dynamics, specifically the gender hierarchy, in Dutch society. This impacts the amount of public influence women of color have. Hofrichter (2003) explains that differences in combined health status become unbalanced when they are systematic and unjust, which is a result related to a lack of political power. In addition, gender mainstreaming, the imposition of a gender norm, applies not only to differences between women and men, but also to differences within women. This
blocks out the diversity in women, especially women of color. By homogenizing women of color, as shown in Chapter Four, the specific sexual health needs and risks of Dutch women of color are overlooked.

The obsession with the exotic, creating and maintaining women of color in the position of the Other, portrays Dutch black women as categorically and intrinsically different. For example, when women of color are often seen as exotic enough to be sexual, but not white enough to be taken seriously in relationships, careers, etc. The position of the Other is reinforced when white women are used as the standard of sexual health. By localizing the cause of health disparity within groups, it suggests that there is “something innately pathological about that group, reinforcing their essential physical inferiority in the modern world” (Daniels & Schulz 2005: 115).

Furthermore, Daniels and Schulz explain (2005) that generalizations about the Other obscure social processes that create inequality, contribute to stigmatization of racialized groups, and allow whiteness to remain invisible and uninterrogated. These identities of gender and race are factors that intersectional theory claims enhances the experience of systematic institutional and structural marginalization, which consequently impacts health due to unequal access to resources and other factors of marginalization.

Intersectional theory explains that people of color are affected by greater forms of institutional and individualized oppression. When looking at sexual health in the Netherlands, it is important to realize that the disparity in outcome for people of color is produced by more factors than just immigrant status. Although this research focuses on the interplay between gender and racial identities, Schulz (2005) asserts that
economic status is more of a factor than race/ethnicity or culture in access to health services. "Patterned, persistent inequities [in health] are due primarily to failed political struggles and power imbalances, not ad hoc events, individualized failure, or the inevitable consequences of modern society" (Hofrichter 2003: 1). Intersectionality suggests that significantly reducing disparities in health requires fundamental changes in underlying social structures. In order to solve the disparity in sexual health outcome in the Netherlands, the scholarly and political arena needs to recognize identities, especially that of socially categorized race, and place them in a social and historical context.
7.1 Conclusion: Wrapping up Stereotypes and Sexual Health

The combination of race and gender statuses leads to both unique problems and perspectives for women of color. This project was inspired by the realization that sexual health literature demonstrates racial/ethnic disparity in sexual health outcome; however, it fails to explain the reason for it. Often researchers report ethnic group differences in risk behaviours with a tendency to blame underlying cultural differences as the source rather than providing empirical research into reasons for such "cultural" differences. To blame the prevalence of teenage pregnancy or STIs in women of color on laziness, promiscuity or other "cultural" reasons overlooks important historical and structural factors in the Dutch experience. By having a color-blind view of history, details leading to the explanation of the sexual health situation of Dutch people of color are disregarded.

Racial disparities in health must be understood in the social and historical contexts within which they are produced. Dutch women of color have a unique and different history from immigrant women living in the Netherlands. These identities need to be recognized in scholarly and political conversations, as the decisions made in those levels have an impact on sexual health for Dutch women of color. Bringing sexual health experiences of Dutch women of color into public discussions will have an impact on sexual health. As Tricia Rose states in *Longing to Tell*, "Simply having a collection of such stories may help counter the powerful distorted representations that
abound... the sheer diversity of experiences and ways of thinking that emerge from even a mere twenty or so stories will prevent a monolithic, objectifying reading of all black women” (2003: 8-9).

The inclusion of humanities, such as anthropology, to health research enriches understanding of health through intersectional practice as opposed to normalizing medical intervention. Perhaps through a anthropological lens it will be realized that an adjustment to better sexual health outcome may not necessarily rely on more access to information about sexual health but rather policies that, for example, restore black family structure, build employable skills, and other moves to rectify the imbalance created by the intersection of race, gender and class identities. Dutch research needs to devote attention to a historical analysis of race/racism in the Netherlands. Viewing the shared past from a different mirror will create the opportunity to contextualize the experience of sexual health for women of color and better address the disparity in health outcome.

In review, the main objective for this study was to identify if racially geared gender stereotypes have a relationship with sexual health outcome. Then to analyse what the relationship is to the experience and understanding of sexual health for women of color in Amsterdam. Finally, to determine how this information can be used for further steps.

The main findings of this study are:
- Dutch black women do not initially think of the medical or physical aspects of sexual health. They are more concerned with the psychosocial facet; the understanding and comfort with one’s own sexuality. Positive sexual health is
identified as “comfortable sexuality”. It is determined by having or seeking pleasure that fits within one’s lifestyle and framework of values. A social science perspective helps identify this and use it towards a better understanding of health.

- Although there is a tendency to attribute poor sexual health to cultural factors, such as lack of communication, Dutch black women have other forums for sexual health dialogue. Hence, the culture of immigrants cannot be applied to culture of Dutch black women. The concept of Dutch black women (and women of color) must be added to Dutch discussions, especially in the scholarly and political network.

- Dutch black women are subject to stereotypes, identified as either the “exotic other” or “passive other”, which sexualise or desexualise their identities, creating characters that have no depth beyond sexuality, are objectified, and have no agency. This has implications for sexual health because according to Intersectional analysis, power in the public sphere is a determinant of health outcome.

- Dutch black women in urban environments have all experienced racially geared gender stereotypes. There is a spectrum of how women identify with these labels. On one end are women who embody the stereotypes and on the other are women who do not identify with them. There are two sets of risks from this on sexual health. Women who embody labels make decisions that fulfil the negative stereotype. Women who classify themselves as different from stereotypes also do not identify with risk groups, do not adjust their behavior for safer sex.

- The consequences of stereotypes on preventive/physical sexual health also come from the structural direction. The stereotypes reveal structural forces that create a greater impact of experiencing oppressed identities. The intersection of gender, race/ethnicity, and class identities increase negative sexual health outcome.
7.2 The Next Step: Suggested Use of Information and Further Research

Research from the other perspective

Although this research was performed from the target’s perspective, it would be useful and informative to do it in the public health arena to see what stereotypes health workers, policy makers, etc. have of women/people of color and perhaps how that influences their work. This would give a more complete picture for intersectional theory to identify social and institutional structures that influence sexual health outcome.

Creating proper identities to identify with

The information from this research hoped to lead to a better understanding of the role of gender and race identities in shaping health for women of color in the Netherlands. The data asserts the importance of creating health information available for the public that either destigmatizes certain groups or creates characterizations of risk groups that the people within those risk groups can identify with.

Applying intersectional analysis

The key to improving sexual health outcomes is to understand the breadth and complexity of the challenge. If the focus is solely on narrow targets (for example, to reduce negative outcomes such as teenage pregnancy or incidence of STIs) and on action by health care services alone, it will not address the range of influences that determine sexual health (Scottish). The Netherlands needs to implement systematic research into sexual health and its social implications, taking into account gender, race/ethnicity, social class, age and other factors. In turn not just race/ethnic issues,
but also class issues when creating policy on sexual health should be taken into account.

**Turning to Media: Identifying sources of stereotypes and creating policy to adjust it**

Finally, media research has great potential for anthropology. The discipline of anthropology, through ethnographies of media, is a useful tool in understanding the relationship and impact of media on its audience. The different disciplines involved in media research tend to work in isolation from one another and their findings frequently remain in a vacuum. Anthropology’s inter-disciplinary approach also offers a means to bridge knowledge from other fields to enhance the broader picture.

There are many discussions on the role of media in shaping culture. Media works similarly to medicine in that it is a model of and a model for culture. Advertisements depict not necessarily how we actually behave, but how we think men and women behave (Gornick 1979: 7). These media images are then also internalised by members of society and become ideals for certain groups to achieve (Gornick 1979). Specifically in relation to gender and sexuality, media helps construct ideals of masculinity and femininity, for example, women are generally shown in submissive positions and as sexual objects (Goffman 1979).

In relation to race and ethnicity most media analysis of depictions of women has focused on mainstream media. This excludes women of color because they are generally underrepresented in mainstream media. When women of color are represented they are often portrayed according to racially specific gender stereotypes. These stereotypes often sexualise women based on their race/ethnicity. They also
frequently dichotomise the image of women of color as either asexual "pathetic others" or hyper-sexual "exotic others", both identified in conversations with informants in this study. The presence of only these stereotypes in the media has great consequences for women of color because they are often the only or main exposure many people have to that group. For example, in the Netherlands Surinamese are 2.02% (328,000) of the total population and Antilleans are 0.79% (129,700) (CBS, January 2005). The majority of the Dutch public has not had intensive personal interaction with these groups that are misrepresented in the media; giving more weight to the importance of the representations available to the public. Understanding this demographic information and the wide consumption of technological products in urban environments, visual media serves as a major source of "interaction" with women of color for many Dutch people. In the case of the Netherlands I have come across little literature available on the relationship between media and representation of women (and men) of color in the Netherlands. It would be informative to see more research go down this road.
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Appendix A

http://home.student.uva.nl/m.paridon/

Sistah Talk

Participate

- If you'd like to contribute to this research, please take some time to complete an e-mail questionnaire. I would very much like to hear from you. It is your information that will help me understand the different factors that influence how women decide to participate in research. After this research is over, with the mother's consent, I will publish some of the data online so that we can share and discuss the experiences.

- e-mail: narda.taylor@yahoo.com
- questionnaire:
  - Which neighborhood would you like to live in?
  - Which neighborhood do you live in?
  - What is your relationship status?
  - Are you working at the moment, are you a student?
Appendix B

Questionnaire (used on the website to recruit informants)

Participate

If you'd like to contribute to this research please take some time to send me an e-mail with the following information. I know this information is in English, but you may write your answers in Dutch.

Please know that everything will be kept confidential (this means no one will know that it is your specific story). In order to do so please choose a pseudonym (a fake name) that you would like me to use in my research.

After this research is over, with the author's consent, I will post some stories online so that we can share and discuss experiences.

e-mail: maia.layne@yahoo.com

questionnaire:

Which fake name would you like to use?

Which neighborhood do you live in?

How old are you?

What is your relationship status?

Are you working at the moment, are you a student?

Where were you born, how long have you lived in the Netherlands?

What is the highest education you have received?
Appendix C

Topic Outline for In-depth Interview

What do you define sexual health as, what do you think is normal sexual health?

How do you compare your experiences compared to what you think is normal sexual health?

If you don't consider yourself in the norm, are there key factors that have influenced this? What are they?

What are the Dutch standards for being a good girlfriend, mother, lover, woman, etc? How do you find yourself fitting in (or not fitting in) to this mold?

Are there examples where you feel you are discriminated against because you are a woman? Examples because you are a person of color? How do these two identities impact your experience of discrimination?

Please describe some experiences you personally have had with gender and/or racial stereotypes?

Have these experiences influenced your behaviour and how (when it comes to dating, career, every day life, etc.)?

What are some general stereotypes that exist in Dutch society of women of color?

What do you think of the Dutch discourse of racism and/or discrimination against women? Is there a public discussion?

Many Dutch people (in the academic and political world) say there is no problem with racism here. Is this true? What are some typical forms of this type of discrimination that occur in everyday life?

Do you identify with what society says is a Black woman?

The Dutch political and academic world mainly recognizes persons of color as immigrants; they are never discussed as Dutch. Do you consider yourself Dutch? Do you feel Dutch?

If you have any rants about experiences you've had in your life or frustrations that you feel like sharing involving this topic, please feel free to add.