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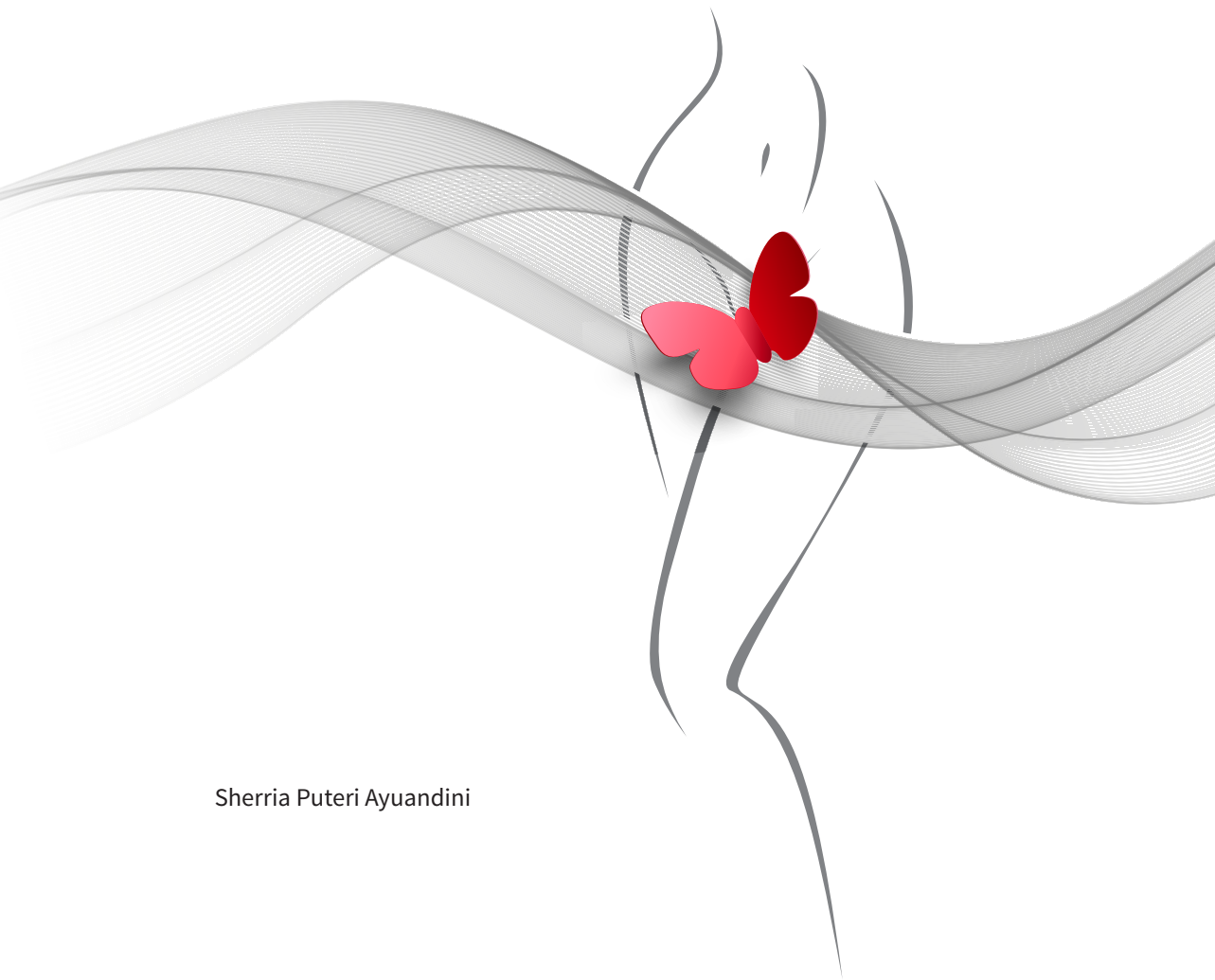
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# For One Drop of Blood

**Virginity, sexual norms and medical processes  
in hymenoplasty consultations in the Netherlands**



Sherria Puteri Ayuandini

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in hymenoplasty consultations in the Netherlands**

Sherria Puteri Ayuandini

to Iwan Tjitradjaja

He who laid eyes on an engineer and saw an anthropologist

**For One Drop of Blood:**  
Virginity, sexual norms and medical processes  
in hymenoplasty consultations in the Netherlands

## **ACADEMISCH PROEFSCHRIFT**

ter verkrijging van de graad van doctor  
aan de Universiteit van Amsterdam  
op gezag van de Rector Magnificus  
prof. dr. ir. K.I.J. Maex  
ten overstaan van een door het College voor Promoties ingestelde commissie,

in het openbaar te verdedigen in de Agnietenkapel  
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This thesis was prepared within the partnership between the University of Amsterdam and Washington University in St. Louis with the purpose of obtaining a joint doctorate degree. The thesis was prepared in the Faculty of Social and Behavioural Sciences at the University of Amsterdam and in the Department of Anthropology at Washington University in St. Louis.

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**For One Drop of Blood:**

Virginity, sexual norms and medical processes  
in hymenoplasty consultations in the Netherlands

by

Sherria Ayuandini

A dissertation presented to The Graduate School of Washington University  
in partial fulfillment of the requirements for the degree  
of Doctor of Philosophy

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## DISSERTATION ABSTRACT

Hymenoplasty is a medical procedure done to alter the shape of the hymen membrane. Dutch women of predominantly Muslim migrant ancestry resort to the surgery to maintain the appearance of premarital virginity. This dissertation research studies hymenoplasty as a social phenomenon. It asks: how do the interconnecting issues of gender, religion and migration play out during interactions between doctors and Dutch patients of migrant ancestry in the medical and institutional context of hymenoplasty in the Netherlands? Findings were collected from 2012 and 2015 through participant observations of 70 hymenoplasty consultations in medical establishments in the Netherlands. These observations were complemented with interviews with hymenoplasty providers and patients as well as with people of similar ancestry with the surgery seeking women. Written as a collection of journal articles, this dissertation addresses the issue of variability of treatment, demedicalization of the 'broken' hymen, patients' rhetoric of religion, national identity as medical recommendations, and women empowerment as topics of analysis. By closely paying attention to exchanges between hymenoplasty seeking women and medical professionals, this study posits that patients' identity markers shape the course of interactions between them and the doctors. Ultimately, differences between doctors and patients, including gender, religion and migration history, are not only brought to light during hymenoplasty consultations in medical institution, but they are also specifically addressed and treated as integral aspects of both patients' motivation for the operation as well as the cornerstones of their problems which, when dealt with, will lead to the surgery seeking women's 'salvation'.

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## CHAPTER I:

# INTRODUCTION

### **1.1 Background of Research and the Main Research Question of the Study**

In the past 15 years and particularly in the most recent decade, more and more women decided to go under the knife to 'fix' their virginity. With the rise of medical technology and opportunities for pre-marital sexual behavior, young women who believe that they no longer possess an intact hymen can now elect to undergo a clinical procedure called hymenoplasty. Hymenoplasty is a surgery that alters the shape of the hymen membrane commonly to minimize the aperture (Ahmadi 2013, Renganathan, Cartwright and Cardozo 2009, Cook and Dickens 2009). The procedure has been increasing in frequency in a decade and a half particularly in China, Canada, the United States, and Europe (Bekker et. al. 1996, van Moorst et al. 2012, Amy 2008). In the Netherlands, hymenoplasty is mostly provided by physicians of Dutch 'native' background (Ayuandini 2017a). The patients who request the surgery are usually Dutch women of Muslim migrant ancestry, particularly from Morocco, Turkey, Afghanistan and Iraq (Ayuandini 2017a, van Moorst et al. 2012, Loeber 2014). Hymenoplasty are often sought by women due to their conviction that their hymen is no longer intact, usually because of a previous sexual encounter (Ayuandini 2017a). However, they might be expected to 'prove' their virginity during the wedding night, commonly by means of blood stain on marital bedsheet (Ayuandini 2017b, van Moorst et al. 2012, Loeber 2014, Bekker et. al. 1996, Logmans et al. 1998).

At the start of this dissertation research, an exploration of hymenoplasty as a social phenomenon was still rare. Hymenoplasty is a controversial surgery in which doctors are continuously in discussion of the arguments for and against its provision (Cook and Dickens 2009, Christianson and Eriksson 2014, Cindoglu 1997, de Lora 2015). Dutch doctors particularly view the operation to be medically unnecessary (Ayuandini 2017a). Professional medical bodies all around the world such as those in Sweden, New Zealand, the US, Egypt, the UK, Canada, France, Germany and the Netherlands itself have issued recommendations for their members to avoid performing the surgery (Kandela 1996, Braun 2010, de Lora 2015, Amy 2008, Juth et al. 2013, Feitsma and Kaggie 2004). Studies conducted about the surgery have been, thus far, exclusively done through the clinical perspective. These studies mostly frame the social and cultural dimensions of the issue through the point of view of medical professionals. They either tend to focus on the ethical dilemma a physician faces when a patient is requesting the surgery or on the technicalities of the procedure itself (Bosch 2002, Bekker et al. 1996, Helgesson and Lynoe 2008, Bravender, Emans, and Laufer 1999, Logmans et al. 1998, Ou et al. 2008). Throughout these studies, the assumption that the surgery is a symbol of oppression of women and of patriarchy persists (for examples, see Bhugra 1998, Paterson-Brown 1998, Kogacioglu 2004, Parla 2001, Helgesson and Lynoe 2008).

Yet such assumption is largely made with the absence of close examination of the social expectations and motivations of the female patients. The lack of women's perspective being accommodated in hymenoplasty research to an extent is understandable. The nature of the surgery that demands high level of secrecy to protect the identity of a woman contemplating the operation makes it almost impossible for people other than the physician to be aware of her intention. It is also highly challenging to find women who have done or have considered undergoing hymenoplasty from outside of the medical establishment as very rarely a woman would admit to the experience. The core essence of the desire for hymenoplasty lies in the wish to conceal that one is no longer sexually untouched and an effort to pass as sexually 'innocent'. Admission to contemplating the operation belies this 'image', to say nothing of undergoing one. Given this situation, it is unsurprising that the voice of women is largely silent in writings on hymenoplasty. Hence, this research was started with the goal to amend this situation. Having gained access to medical establishments allowed me as an ethnographer to be present during hymenoplasty consultations between doctors and patients. The focus of the study was to bring forth the perspectives and motivations of women seeking the operation. The direction of the study was mainly based on insights gained from preliminary and pilot studies of the dissertation research and driven by what explorations were absent in the scholarship of hymenoplasty.

It is also important to bear in mind that the geographical context of the research is the Netherlands. Since the 1960s when sexual revolution happened in the country, unencumbered exploration and expression of sexuality became an integral part of Dutch society (Schnabel 1990, Ketting 1990). This ‘public acceptance’ of sexuality then becomes ‘the yardstick’ of how the new presence of Muslim migrants and their descendants is to be evaluated (Mepschen, Duyvendak, and Tonkens 2010, Israeli 2008, Butler 2008). In line with the rise of nationalist discourse in Europe recently, many politicians in the Netherlands start to define what it means to be Dutch (van Reekum and Duyvendak 2012, de Leeuw and van Wichelen 2008). The rhetoric of sexual and gender progress becomes pivotal to this effort (Uitermark, Mepschen and Duyvendak 2014). Women of migrant descent are turned into the main target of citizenship policies and their emancipation is the litmus test of the successful integration of people with migrant ancestry into Dutch society (Roggeband and Verloo 2007, Ghorashi, 2010, van den Berg and Schinkel 2009, Schinkel 2011).

Since early on it was clear to me that the study was not only about a binary divide between the ‘native’ doctors and the ‘migrant’ patients. Norms and considerations in the case at hand are multidimensional. The research became more than a mere ethnography of minority women; the phenomenon in question is not as straightforward as a Muslim patient engaging in “Western” medicine. It involves a Muslim patient, with a migrant background, growing up as a second or third generation child, often identifying oneself as being Dutch, dealing with expectations held by others from her country background, seeking help from a European doctor, who tends to object to her ethnic traditions but usually provides the aid nonetheless, intriguingly even by embracing some of the patient’s ancestral practices. Taking these complexities into careful consideration, this study sets out to answer the following question: How do the interconnecting issues of gender, religion and migration play out during interactions between doctors and Dutch patients of migrant ancestry in the medical and institutional context of hymenoplasty in the Netherlands?

## **1.2 The Method and Process of Data Collection**

The main data collection method for this study comes from participant observations of hymenoplasty consultations between doctors and patients in two different medical establishments in the Netherlands. The ethnographic access I obtained for this observation is never before gained in the case of hymenoplasty study. Typically, patients’ main concern in contemplating the operation is to successfully come across as virgin to those in their immediate social circle, commonly during the wedding night.

Therefore, there exists the highest degree of need for confidentiality upon patients' visit to the doctors as their exploration of the viability of the operation readily betrays their claim to sexual purity. Accordingly, ethnographic access that allows a party other than the physicians to be privy of the patients' history of sexual encounters is mostly unpreferable to patients and therefore unlikely. Having successfully obtained this access, I sat in and observed a total of 70 hymenoplasty consultations between patients and physicians in the Netherlands.

These observations were further complemented by my one on one meeting with patients whenever I received consent. I managed to talk privately with 1 out of 3 patients seeking treatment in the hospital. I also talked with 14 physicians and medical professionals involved in the provision of the operation. I investigated their perspectives on hymenoplasty, particularly about their own practice and engagement with surgery seeking women. Furthermore, to gain a contextual understanding of hymenoplasty as a phenomenon, I conversed with young men, young women as well as with older women of the patients' mother generation. These people share the same ancestry with hymenoplasty patients in my study. I explored their point of views of virginity specifically and sexuality in general. In total, I have conducted in depth conversations with more than 70 people. These conversations allow me to understand the desire for the operation in the specific context of the patients' social and cultural background. More detailed explanation of the methodology of the research will be further provided in chapter 2.

My focus of exploration was largely concentrating on how specific commonalities among patients play a role during hymenoplasty consultations with Dutch physicians. I also investigate how these commonalities to an extent shape the direction of the medical appointment. I was likewise particularly interested in how they are addressed and dealt with specifically by the doctors but also by the patients themselves. Similarities that I particularly paid attention to are patients' religious background, their migration history as well as their gender. To a certain degree, I was also mindful of some markers of patients' socioeconomic class, particularly their educational background. However, my individual interactions with each of them are limited. The bulk of information for the study was gained from observing their interactions with physicians. Consequently, findings pertinent to patients' socioeconomic class are scarce and in need of further and deeper explorations beyond the scope of feasibility of this study. The complementary data collection involving engagements with people of similar ancestry with the patients were mainly done to better understand the socio-cultural context of patients' drive for the operation. This includes exploring possible negotiation of sexual values surrounding female virginity between the young women and other people in her immediate social circle, investigating social forces and the

personal motivations that shape the decision of hymenoplasty and examining the extent and circulation of knowledge on sexuality and virginity among Dutch women of migrant ancestry.

As the study progressed and findings were amounting, I started to have a better understanding of the true depth of intricacies of a longitudinal ethnographic study conducted within 20 months of accumulative research period between 2012 and 2015 on hymenoplasty. Staying true to the spirit of qualitative anthropological and sociological research, the progression of the study was derived closely by findings. In the attempt to accommodate the richness of collected data, I began to frame the study to include emerging key discoveries from fieldwork. What became a significant driving force behind the outlining of the analysis and the writing of this study occurred around halfway into my data collection period. This was when I gained access to a private clinic to also conduct observations of exchanges between consulting physicians and hymenoplasty patients there. The back and forth between the doctor and surgery seeking women in this clinic are in some contrast to the hospital where I hitherto gathered data. The philosophy of the lead physician in conducting hymenoplasty consultation is also dissimilar to the lead doctor at the hospital. The differences in hymenoplasty practice between the two medical establishments, such as their consultation procedures, were significant enough to bring forward an element of the study which has thus far served as a backdrop: the research setting. The medical clinical setting of hymenoplasty consultation then took a new prominence as an important frame of analysis. The increasing focus on this aspect was also driven by changes in accessibility to patients as well as alteration in data gathering methods; both will be explained in detail in chapter 2 on methodology.

Within the time period of my main dissertation fieldwork, which was started in early 2014 and completed towards the end of 2015, writings on hymenoplasty have grown in quantity. However, due to the highly sensitive nature of the surgery, studies are still largely done by medical professionals or by soliciting views from outside of the consultation rooms (Ahmadi 2015, Cinthio 2015, Christianson and Eriksson 2014, Juth and Lynoe 2014, Christianson and Eriksson 2015, Kaivanara 2016, Loeber 2014, Wild et. al 2015, Earp 2015, Saraiya 2015, de Lora 2015, Steinmüller and Tan 2015). Some still write about service providers. These studies either focus on providers' responses to hymenoplasty requests, their views on the operation itself or ethical considerations physicians and midwives ought to be aware of in providing the service (Juth and Lynoe 2014, Earp 2015, Christianson and Eriksson 2015, de Lora 2015). Some studies have also started to look at wider societal issues particularly on gender. However, the focus of examination remains chiefly the same. At the surface, hymenoplasty presents almost a readily recognizable point of interest and accordingly, there is almost

an obvious path of study exploration. Authors have the tendency to only focus on the phenomenon of women altering their body due to a social and normative expectation of virginity put on them by others in their social circle. Recent writings on hymenoplasty almost exclusively address this point. They put an emphasis on how the desire for the operation signifies an imbalance of sexual demands on women of certain ancestry by people of their immediate social circle (Cinthio 2015, Loeber 2014, Christianson and Eriksson 2014, Steinmüller and Tan 2015). Alternatively, these studies argue how hymenoplasty can be seen as a form of resistance to such imposition of unequal requirement (Ahmadi 2015, Wild et. al 2015, Kaivanara 2016).

Hymenoplasty is desired in the context where women are largely expected to abstain from sexual intimacy before marriage while men are considerably less so and even on occasions 'rewarded' of their sexual adventures and abilities. The significance of unequal sexual expectation between men and women is also a recurring backdrop to my study. However, so prominent is this point of investigation, it has the potential to eclipse the myriad of other factors relevant in an ethnographic research of hymenoplasty. As writings from other studies have clearly demonstrate, analysis on other factors pertinent to a hymenoplasty study is largely absent (with an exception of Steinmüller and Tan 2015 who also look at socioeconomic change as a contributing factor to Chinese women's desiring the surgery). My study that focuses on hymenoplasty consultations in the Netherlands offers a never-before-explored angle to the research. It benefits from unique ethnographic access to doctors and patients exchanges during medical appointment. It is also conducted in the context where the surgery is desired almost exclusively by Dutch women of Muslim migrant background. The service, on the other hand, tends to be provided by physicians of 'native' Dutch upbringing. This uniqueness of the study brings forth migration, gender, religion and the clinical setting as important and necessary frames of analysis. All are crucial yet underexplored perspectives in the scholarships of hymenoplasty to date.

### **1.3 Chosen Form of Writing and Objectives of Each Article**

The study recognizes the exploration of virginity expectations on women as an important aspect of exploration. In the writings of my research, this sociocultural and normative sexual demand is ever present as a backdrop of the main analysis which focuses on the practice of medicine, the rhetoric of religion, women empowerment as well as national identity in the context of migration. What normally is the focus of the analysis—sexual expectations on women and/or resistance towards them—now serve as the setting. While what previously have been relegated to the background—reli-

gious conviction, the clinical framework and movement across states and borders—are now on the spotlight.

My intention in reversing this focus of interest lies in my aim to bring forward the institutional aspect of hymenoplasty as a critical frame of analysis. Following Bowen, Bertossi, Duyvendak and Krook, I am interested in observing how various identity markers gain prominence when different actors come into contact in an institutional set up (2014). Through my writing, I argue that it is of the utmost importance to start interrogating the medical context of hymenoplasty. It is in this clinical setting where, arguably, the desire to maintain an appearance of virginity first becomes problematize and therefore observable. However, hitherto, this context is almost neglected and taken for granted in the scholarship of hymenoplasty. This background is yet to be scrutinized and analyzed, particularly on how it might affect and determine the outcome of the desire. We are witnessing an irony as the patients' background is seen by scholars and practitioners alike to be paramount to their wish for the operation and therefore closely inspected in the literature. Yet there is a lack of scrutiny of the backdrop that contributes to the resolution of the wish: the medical context. The absence of this necessary examination, I argue, is a significant oversight on the side of social sciences, one which I intend to amend.

To fully address different focuses of explorations in medical institutional set up of hymenoplasty, I have opted to analyze them in the form of journal articles. Each article is a standalone complete writing which allows me to situate the focus of explorations in different cluster of scholarship. Each article focuses on a single aspect, providing the needed undivided attention to the issue without having to extensively built on the last one. The following objectives are addressed separately in different articles:

1. To discover whether the lack of recognition of hymenoplasty, both by the general public and on an institutional level, affects consultation results; Article 1 looks at how variability in hymenoplasty recommendations provided in the context of an absent of institutional acknowledgement of the procedure, lack of standardization of practice as well as asymmetrical information on the surgery for public result in a contrasting degree of surgery rate in different establishments;
2. To find out whether the commonality of religious background of hymenoplasty patients in the Netherlands play a role in their desire for the operation; Article 2 delves into the role of religion in potentially triggering hymenoplasty request through analyzing the rhetoric of patients and through investigating how religion is brought into the discussion of the procedure with physicians during consultation;

3. To examine whether Dutch doctors' point of view that hymenoplasty has no medical necessity influence their recommendations to patients; Article 3 details Dutch doctors' effort to exclude the idea of the 'broken hymen' from medical definitions by informing patients of medically 'correct' information on issues surrounding virginity and interestingly, through appropriating patients' 'ancestral' customs during the wedding night into medical recommendations;
4. To inspect whether the fact that almost every hymenoplasty patients come from migrant ancestry while the consulting physicians tend to be of Dutch 'native' background create a unique dynamic between them during consultation; Article 4 investigates how the idea of national identity, in this case Dutchness, comes into play during hymenoplasty consultations and how it is 'promoted' to the patients who are exclusively of migrant ancestry;
5. To explore whether the reality that hymenoplasty patients are exclusively women shape the way consultation is done. Article 5 studies how hymenoplasty consultations are perceived by physicians as an opportunity to empower women and looks at how such empowerment takes place.

## 1.4 The Ever-Present Backdrop to the Study

As an important consistent context to the writing up of this study, the vital explorations of virginity expectations on women are addressed across different articles. They either serve as a backdrop to the analysis or as the starting premise of the examination. The setting can be seen to be consisted of specific issues of three prongs: (1) the negotiations of sexual values between patients and other people in their quest for hymenoplasty, (2) patients' personal motivations in getting the operation and (3) the extent and circulation of knowledge on sexuality and virginity among Dutch women of migrant ancestry. The first line of inquiry permeates all five articles. This study looks at the negotiations of sexual values not only between physicians and patients but also among people of similar ancestry with the surgery seeking women. Exchanges between patients and the doctors they are consulting for hymenoplasty are in themselves forms of negotiations. Patients bring forth their understanding of different sexual norms and values, informed by their parents and other people of similar descent and/or those in their social circle. In turn, physicians offer their perspective on issues particularly pertinent to virginity and the hymen but also on sexual intimacies and



even partner choice. Across five articles, direct quotes from either patients or doctors demonstrate their perspectives of the issue which are key discoveries of the first line of inquiry of the research.

Findings that come from the exploration motivated by the second prong—investigating personal motivations of patients in getting the operation—remain the main discoveries of the overall study. They likewise informed writings for all five articles. The prominence of this probe is particularly observable in the second article. Here I look at the way patients articulate their motivation to undergo the surgery in relation to their understanding of religious and cultural forces that potentially inform such goal. It has to be said that the collection of findings that showcase the voice of women, particularly those contemplating hymenoplasty, is where this research has its most unique contribution. However, what I have learn with the progression of the research is the stories, narratives and motivations of women requesting the surgery are not only diverse and complex but also at times counter intuitive. Writings dedicated to give a medium for these experiences need to strive for the inclusions of the richness and the complexities in which an article form with limited space for elaboration is far than ideal. A book format of writing will be more suitable to give a channel for the voice and experience of women in the study of hymenoplasty. Realizing this, I have therefore prepared an outline of a book that will accommodate this writing and it is an immediate upcoming work I strive to do in the near future.

The third contextual element focusing on sexual knowledge was originally explored informed by findings from preliminary and pilot studies. Data suggested that hymenoplasty patients tend to not be aware of other ways to produce blood stained bed sheet. They were also often surprised by physicians' revelation about the medical view of the hymen and its (absent of) connection to virginity. Dutch doctors I worked with up to that point in time had similar observations. They were even convinced that this 'lack' of the 'correct' knowledge plays a significant role in shaping the drive of the patients to undergo the operation. The doctors were therefore motivated to rectify it through 'educating' patients with the 'right' knowledge during consultation. Hence, I was inspired to learn more about the different knowledge surrounding the issue of sexuality hymenoplasty patients possess. I was also curious to find out whether such knowledge influenced their decision in contemplating the surgery. I also aimed to discover whether certain ideas or information were transferred to and from other women in their immediate social circle.

However, during the main dissertation research fieldwork, it has come to my realization that more and more women who were contemplating hymenoplasty were admitting to being familiar with the 'medically correct' knowledge about virginity and the hymen. They have also come across different ways to produce blood stain on the

marital bedsheet. The premise that women contemplate hymenoplasty chiefly due to their ‘incorrect’ perceptions of the connection between the hymen, bleeding during the first penetration and virginity began to lose its original significance. When access to the third establishment—the private clinic—was gained, I started to work with a doctor there who did not perceive hymenoplasty consultations as a way to ‘educate’ patients. As a result, exchanges between physicians and patients in this establishment have a different undertone than those at the public hospital. Consequently, knowledge surrounding sexuality and virginity continues to be relevant in my study. Yet, aiming to find out the what patients knew or did not know became less important. What was more revealing was to explore how the perception of ‘what needs to be known or unknown’ as well as ‘what needs to be learned or unlearned’ about sexuality and virginity shape exchanges between doctors and patients in hymenoplasty consultations. The findings resulted from explorations of this third contextual prong is especially present in the first article. In that article, I look at a pedagogical approach team of doctors in the public hospital use as a basis of hymenoplasty consultation in their establishment. They are also relevant in both the fourth article on Dutchness and the fifth article on women empowerment.

## 1.5 Terms and Definitions

The word hymenoplasty is the chosen term used to refer to the medical procedure mostly aimed at altering the hymen membrane. Scholars have also used the word hymenorrrhaphy, which is interchangeable with hymenoplasty. My choice to use the term hymenoplasty is due to the familiarity of people involved in the research with it. Hymenoplasty is the term used both by doctors and patients alike during their exchanges. The Dutch term for the surgery, *maagdenvlieshersteloperatie*, is also used to refer to the procedure although it is used considerably less particularly by Dutch doctors. This is due to some Dutch physicians’ objections that the term provides an ‘erroneous’ image of what hymenoplasty is. The word *herstel* in Dutch translates to restoration in English. Dutch doctors find the use of this word problematic as it implies that the operation restores the hymen to its previous condition before penile penetration occurred. Due to the high variability of the hymen’s shape and form even in its ‘virginal’ state, it is highly unlikely for doctors to be able to discern what an individual patient’s hymen look like before it was potentially or allegedly altered by coitus. The word *maagdenvlies* is also considered problematic as it contains the word *vlies* which translates to membrane. Some Dutch physicians argues that the word *vlies* or membrane conjures up an image of a wall like structure, in which the hymen is not. It also

gives the impression that penetration will compromise the integrity of this structure, in which coitus does not always result in such.

Surgery seeking women are interchangeably referred to as both patients and women. The choice of the word patient does not mean to signify that the women's predicament is automatically pathologized and in need of a medical solution. Rather, it intends to highlight that the clinical setting of the study is an integral part of exploration. Apart from that, both the doctors and the women themselves do use the word patient, albeit the doctors utilize it significantly more often than the women. Care has been made in the writing to differentiate surgery seeking women than other women involved in the study.

I also consistently use the word consultation in referring to the meeting between doctors and patients. This choice is also to echo the most common term Dutch physicians use to indicate their appointment with patients. The word consultation used in this writing commonly points to the period of time when patients meet with doctors to discuss their intention to undergo hymenoplasty. However, consultation conveys a wider meaning than just an exchange or an interaction. Consultation also has an undertone of advice giving and an imparting of knowledge by an expert; in which both are very much relevant in the context of hymenoplasty. As indicated in various chapters in this dissertation, hymenoplasty consultations in the Netherlands further serve as mediums of not only pedagogy but also empowerment of patients. Due to these many layered of nuances to what consultation might imply, the word is chosen over possible alternates of such as interactions or exchanges; although the two are often utilized in a generalized sense in the writings as well.

Words that have many and layered meaning such as culture or religion are utilized the way research participants utilize them. In the second article where religion and culture are the focus of writing, I provided a working definition of them based on the colloquial use of the words in the study. The incorporation of the word 'tricks' is also based on the conversational choice of the study participants. 'Tricks' refer to different means of producing blood stain or blood like stain on the bedsheet without resorting to surgery. The word is often introduced by the doctors to patients when offering alternative courses of action to hymenoplasty. Some other words such as 'myth', 'medically correct' or 'right' are used within single quotation mark to signify the meaning of such word depends heavily on the perspective of the person using it.

## 1.6 The Chapters of the Dissertation

The main text of this dissertation is made up of five different articles in which the first four have been submitted for publication in different academic journals. A version of the first article, *How Variability in Hymenoplasty Recommendations Leads to Contrasting Rates of Surgery in the Netherlands: An ethnographic qualitative analysis*, has been accepted and published first online on September 3<sup>rd</sup>, 2016 at *Culture, Health and Sexuality* journal (Ayuandini 2017a). The third article, *Finger Pricks and Blood Vials: How doctors medicalize ‘cultural’ solutions to demedicalize the ‘broken’ hymen in the Netherlands*, was published by *Social Science and Medicine* journal in March 2017 (Ayuandini 2017b). The fourth article, *Becoming (More) Dutch as Medical Recommendation: How understandings of national identity enters the medical practice of hymenoplasty consultations*, has been accepted for publication at *Nations and Nationalism* journal and the second article, “*There’s no bleeding in the Qur’an*”: *Patients’ rhetoric of religion and culture during hymenoplasty consultations in the Netherlands*, is under the first round of review with *Medical Anthropology Quarterly*. The last manuscript on women empowerment is written in an article style but planned to be part of one of the chapters in my future intended book. As such, the length of this last article is significantly longer than what most journals commonly allow. The rest of this introduction will explain in more details the aim and content of each of the five articles written for the purpose of this dissertation. This explanation is not intended to be a summary but it is done to emphasize key concepts and arguments introduced in each. Some ideas are given further context and elaboration here as limited space within the articles prevent them to be explored in detail there. To an extent, how each article is positioned in relation to each other is also included. In general, this section is also meant to situate the articles in relevant scholarships.

### **The First Article: Variability of Hymenoplasty Recommendations**

The first article is essentially a writing about the setting of the research, outlining the practice of hymenoplasty in the two medical establishments, a hospital and a clinic, where I conducted my study. It can be seen as a comparative article in which I liken and contrast how hymenoplasty procedures are set up and followed through in each establishment. The team of doctors at the hospital put in place an approach to hymenoplasty consultations that is based on a pedagogical philosophy. Meetings with patients are seen as opportunities to impart knowledge about the procedure, the hymen, virginity and sexuality in general. This educational approach is in line with a general outlook of the hospital which happens to be one of the biggest teaching hospitals in the Netherlands. It is also part of the physicians’ attempt to deal with what they

consider to be the basis of the patients' rationale in seeking the operation: a 'medically incorrect' understanding of biological determinants of virginity. Accordingly, for these doctors, hymenoplasty appointments becomes occasions to 'correct' patients of their 'misconceptions' about the hymen and virginity. A successful consultation entails a decision by the patients to not undergo the surgery.

The team of doctors working in the clinic operate based on a different philosophical understanding in providing hymenoplasty service. Having no fundamental objection to hymenoplasty as an elective surgery, the head doctor in the clinic establishes the consultation procedures to be more practical in nature. Hymenoplasty patients often consult physicians with a practical goal to achieve particularly during her wedding night. A successful hymenoplasty consultations at the clinic often means patients being able to meet this goal either through the surgery or other means. Consequently, consultations with doctors in this establishment aim to first and foremost solicit specific goals patients want to achieve in their wedding night and to find the best way for patients to achieve such goals.

The diverse philosophy of the two establishments do not detract from the fact that both the clinic and the hospital equally aim to provide analogous information about hymenoplasty, the hymen and virginity to their patients. Similarly, both establishments comparably offer courses of action corresponding to patients' requests and goals in contemplating hymenoplasty. Yet, one champions pedagogy while the other prioritize practicality in their approach. As a result, the doctors working at the clinic that focuses more on providing practical help perform hymenoplasty almost twice as often as those working at the hospital.

The contrasting surgical rate between these two medical establishments are a crucial finding to be analyzed as it comes in the context of hymenoplasty being still widely regarded as a surgery best avoided to be performed by physicians. Doctor associations around the globe has issued recommendations for their members against the provision of hymenoplasty. In conjunction with this lack of institutional recognition, techniques and procedures of hymenoplasty depend heavily on the physicians providing the service. At the same time, due to their high need to be discreet, patients do not often "shop around" between hymenoplasty providers to find which approach better suits their needs and interests. Information of the procedures and which establishments provide hymenoplasty service is scarce and very hard to come by. With this as the backdrop, hymenoplasty patients' care become highly dependent on the doctors they by chance find and consult.

## The Second Article: Religion and Hymenoplasty

The second article deals with one commonality majority of hymenoplasty patients share: about 80% of women contemplating the operation comes from Islamic background or profess to being a Muslim on some degree or another. This article takes a look at how this commonality enters discussions in hymenoplasty consultations particularly through the rhetoric of religion by the patients. The exploration in this article was inspired by a curiosity in finding out whether patients and physicians make connection between this commonality of religious belief with the desire to undergo the surgery. This interest is particularly pertinent given hymenoplasty is considered by medical professionals to have no medical indications. In short, the article asks: is the quest for hymenoplasty influenced by certain religious conviction?

This line of inquiry is not new. Whenever a (medical) procedure is mostly requested by people of certain faith, the query becomes an intriguing if not important point to consider. This is undoubtedly the case when it comes to male and female circumcisions where the practitioners tend to come from Jewish or Muslim background for the first and from Islamic faith for the second. In the case of male circumcision, religious tenets do play a role in people's desire to undergo the procedure (Glass 1999, Rizvi 1999). Although in the US, male circumcisions are mostly done due to a widely held belief of health benefit it affords its practitioners (Introcaso et. al. 2013, Wallerstein 1983, Gollaher 1994). The case of female circumcision is a bit more complex as those who are against its provision argue for the absence of religious sanctions of the procedure. They state that the Koran, the holy book of Islam, does not contain any reference to the act (Rizvi 1999, Gruenbaum 2001, Johnsdotter 2002). However, those who undergo the procedure or desire it, either for themselves or for their family members, do see religious relevance in going through with the circumcision (Johnson 2000, Gruenbaum 2001).

In the case of hymenoplasty, patients take an active stance in distancing religion, in this case Islam, from their desire for the operation. Considering the procedure to be regrettable, patients wish for Islam to not be associated with hymenoplasty. However, patients seem to recognize the need to explain, if not justify, their presence in doctor's appointment room. As a result, patients create an artificial divide between culture and religion in order to be able to 'blame' the first for their need of the surgery while disassociating the latter from it. Congruently, physicians are readily in agreement with their patients in viewing religion to be disconnected from hymenoplasty. They also perceive religious drives to be irrelevant in a woman's quest for the surgery. Dutch doctors equally 'blame' 'culture' as the motivating factor in hymenoplasty seeking behavior, a topic I extensively analyzed in the fourth article on Dutchness and banal everyday nationalism. As Abu-Lughod has similarly observed, religion has become a

point of political correctness in which ‘blame’ is not to be assigned to it while ‘culture’ is still an acceptable scapegoat (2002).

In this article, I introduce the concept of performative virginity which is differentiated from normative virginity. This distinction is important as my findings show that virtually every young woman seeking hymenoplasty were not interested in reclaiming their ‘purity’ or ‘innocence’. They are not hoping to become a virgin again in a normative sense. What patients tend to want to achieve through hymenoplasty is to be able to demonstrate that they are virgins before marriage. This performance of chastity is what I label performative virginity, inspired by Goffman’s concept of performance (1978).

It is useful to mention here that the concept of performative virginity is different than the idea of performativity introduced by Butler (1988). ‘Passing the test’ of virginity during the wedding night can be seen as a bounded ‘performance’ in which a woman’s chastity is judged on what happen during and immediately after coitus with the new husband. A woman’s virginity in this context is not dependent on her ‘embodiment’ of chastity where repeat ‘performance’ of modesty and innocence create an image of sexually untouched individual. A woman can ‘act’ and ‘appear’ ‘pure’ throughout her acquaintances with her betrothed only to find herself divorced by him from failing to bleed during the wedding night.

This is where the concept of Goffman’s performance is particularly salient. It reminds us of his front stage and backstage notion (Goffman 1978). Bleeding during the wedding night can be considered the front stage while the labor that goes into the successful enactment of this bleeding happened backstage behind the ‘curtain’ of doctors’ closed consultation room’s door. It is also worthy to note that a woman’s act of virginity in the wedding night is nonetheless fleeting and liminal. Ironically, sexual purity of the woman can only be confirmed as it is lost; making it a seemingly one time performance, never to be repeated.

Furthermore, the findings of my study reveal that women resort to the surgery not as an act of religiosity. Patients do not expect the surgery to be a way to purge a sin or to atone for a mistake despite readily claiming that to no longer be sexually untouched before marriage is ‘wrong’. This point of view is an interesting contrast to Mahmood’s idea of bodily piety where piousness is embodied, expressed and realized through bodily acts, particularly by women (2005). Women who are seeking hymenoplasty do not seem to consider the act of ‘restoring’ their hymen membrane as a way to be a ‘better’ Muslim or to achieve any other goal of religiosity. Although it has to be acknowledged that women do frequently admit that hymenoplasty provide them with a psychological relief. Undergoing the surgery makes one able to think that all possible actions have been taken to ensure a smooth wedding night, providing one-

self with ‘peace of mind’.

Hence, the distancing of religion, in this case Islam, from hymenoplasty can be seen not only through the patients’ effort of actively claiming that there is an absence of Islamic tenet sanctioning the practice, but it can also be discerned through the ‘goals’ they aim for by getting the surgery. Their ‘virginity goal’ aims to have a successful ‘performance’ rather than to restore their ‘purity’. Their ‘psychological goal’ aims for ‘peace of mind’ rather than atonement. Both goals showcase their frame of understanding that Islam has little to no correlation with their desire for hymenoplasty.

### **The Third Article: Demedicalization of the ‘Broken’ Hymen**

The third article stemmed from the observation of Dutch doctors’ reluctance in performing hymenoplasty. Studies have often looked at the extent of physicians’ dilemma in hymenoplasty service provision, particularly exploring the minutiae of ethical considerations in weighing the pros and cons of the surgery (Cook and Dickens 2009, Christianson and Eriksson 2014, Cindoglu 1997, de Lora 2015). As much as this is a productive and important line of inquiry, I am more interested in what physicians decided to do given their personal and professional conviction about hymenoplasty. The Dutch case presents an interesting angle to explore this further. Despite viewing hymenoplasty as an unnecessary surgery, even on occasions referring to it as nonsensical, Dutch doctors are compelled to provide help for patients contemplating the operation. This urge comes from understanding that patients could potentially face unintended repercussions if found to be a non-virgin at the time of marriage. However, at the same time Dutch physicians still regret that desire for the operation exist. The optimum solution to this juxtaposition for Dutch doctors is to ensure that the patients will not come to harm in the wedding night while at the same time persuading them that the surgery is not needed.

To achieve the second part of this ideal outcome, Dutch physicians turn to what they believe is one of the more important underlying reasons why women desire the surgery. Dutch doctors consider hymenoplasty seeking women to be under a ‘mistaken’ expectation of what hymenoplasty can accomplish. This ‘mistake’ stems from an equally ‘incorrect’ understanding of the role of an ‘intact’ hymen membrane as a definite biological determination of a woman’s virginity. The request for hymenoplasty often comes from the patients having to fulfill expectation to bleed during the wedding night. This expectation arises from the understanding that the first coitus with a virgin will cause her hymen to ‘break’ and bleed. However, the link between an intact hymen and the absent of sexual intercourse is perceived to be weak by many physicians and medical professionals. A ‘broken’ hymen is then considered by doctors to be a non-medical condition with no necessity to ‘fix’. With this point of view, during



hymenoplasty consultations, Dutch physicians attempt to impart ‘medically correct’ knowledge to their patients about the hymen and virginity. This is done in order to convince the patients that there is nothing medically ‘wrong’ about a ‘broken’ hymen. I argue that doctors’ effort in this case can be understood within the frame demedicalization; a process perceived by scholars to be the opposite to medicalization but hitherto is far less explored and studied.

What is unique in the case of Dutch doctors demedicalizing the ‘broken’ hymen is their desire to still provide help despite viewing the problem of the ‘broken’ hymen to be ‘wrong’. In order to offer this assistance, Dutch physicians offer culturally informed ‘solution’ to the ‘problem’ of a ‘broken’ hymen. This way, the doctors at the same time are sending the message that the notion of a ‘broken’ hymen does not exist within the medical realm’s understanding of biological ailment. Since what is often needed to rectify the patients’ situation is the presence of blood after the first coitus with a new husband, Dutch doctors introduce alternative ways to achieve this goal. The alternative ‘solutions’ are inspired by means to produce blood on marital bedsheet more commonly practiced by women living in different areas in Morocco, Turkey, Afghanistan or Iraq. These are the countries of origin of parents and grandparents of most hymenoplasty patients in the Netherlands. These recommendations introduce a paradox to demedicalization as in order to exclude the notion of the ‘broken’ hymen from any medical correlation, Dutch physicians embrace ‘cultural’ solutions and appropriate them into medical recommendations. Consequently, the effort to demedicalize is attempted through an act of medicalization.

This article also provides a glimpse of the importance of blood as a signifier of virginity, or more accurately the loss of virginity. As what is more paramount to be achieved in the case of patients’ desiring hymenoplasty is a performative virginity, blood becomes the *pièce de résistance* of the entire performance. It is through the presence of blood after the first coitus with a new husband that a woman can be considered to have fully demonstrated her chastity before marriage. A display of blood as a way to convince ‘audience’ that a performance is ‘real’ is not unheard of. Lévi-Strauss tells the story of Quesalid, an unbeliever in shamanism who hid down in his mouth and bit his tongue or bled his gum to ‘show’ his patient and spectators that he has successfully extracted the foreign body causing illness (1963). Nevitt looks at a controversy called ‘Bloodgate’ involving a rugby player biting down on a blood capsule to mimic an injury (2010). Hunt analyzes how pro-wrestlers intentionally cut themselves to offer wrestling fans a feeling of authentic danger to fights that are otherwise heavily choreographed (2005). Each of these examples resonates with ‘blood performance’ during the wedding night although there exist many more complexities to the significance of blood in the context of women virginity. This is a topic that merits further

explorations in future publications.

### **The Fourth Article: Enacting Dutchness in Hymenoplasty Consultations**

The fourth and the fifth article I considered twin articles as both look at a similar issue but from a different angle. The two articles analyze the way doctors communicate with patients in hymenoplasty consultations, specifically on how their narrative is driven by a motivation to ‘change’ the patient they are meeting. Women who are contemplating the operation are often seen by Dutch doctors to be lacking of qualities, such as, among others, autonomy, which render them susceptible to the desire of wanting hymenoplasty. The deficiency of these characteristics are also considered by the physicians to contribute to the ‘problems’ the patients are in. In the context of their quest for the surgery, the ‘problems’ include not being able to make their own choices in a spouse or not being able to reject demands from a social circle that values bleeding on the wedding night. Consultations then becomes venues for the physicians to introduce, instill or remind the patients of traits that can amend these problems.

In the case of the fourth article, which I co-authored with Jan Willem Duyvendak, I look at this effort by the physicians using the frame of nationalism. Characteristics Dutch doctors are trying to inspire in their hymenoplasty patients concurrently are traits that are perceived by the doctors, and their patients in return, to be ‘rightly’ Dutch. Hymenoplasty and ‘being Dutch’ are seen by physicians in the Netherlands to be incompatible with one another. Hence, a patient who desires hymenoplasty is inevitably deemed to be ‘not Dutch’ or at least ‘not Dutch enough’. Simultaneously, the patient is seen to have a potential to be ‘more Dutch’ by demonstrating or at least aspiring to qualities such as self-independence, being highly educated or being professionally employed. Dutch doctors believe that the more a woman exhibits these traits, the more ‘Dutch’ she is and the less likely she would desire hymenoplasty.

The fourth article analysis is done within the framework of ‘everyday’ nationalism where the idea of national identity is evoked and promoted outside of more common settings such as public debates, policy discussions or civic integration courses. Everyday nationalism stems from Billig’s idea of banal nationalism where he argues that the expression of nationhood exists outside of incendiary occasions of national identification (1995). His argument comes from observing that the idea of nationalism seems to be considered by scholars to have vanished in the ‘Western’ countries. Explorations focus more on newly founded states to examine the idea of national belongings. Studies inspired by Billig’s idea of everyday nationalism explore daily occurrences and micro level interfaces between individuals as well as the use of commonplace material culture to showcase national ideals and belongings (Saunders 2006, Cusack 2005, Kong 1999, Huijsmans and Lan 2015, Zubrzycki 2006, Phillips 2012, Jean-Klein 2001, Palmer

1998, Hearn 2007, Azaryahu and Kook 2002, Brubaker 2006, Baumann 1996, Fox 2003).

Specifically under the umbrella of everyday nationalism, this article engages with the notion of multivocalism. Multivocalism is introduced by Kaufmann to interject the debate between the national liberalists and the multiculturalists over descriptions of national identity (2016). Multivocalism values individual's constriction of national identity and argues for their coexistence which enrich the understanding of a particular national identity as a whole. This fourth article highlights multivocalism of Dutchness in the context of hymenoplasty consultation. In so doing, the article provides a new angle to multivocalism, one that is not only of coexistence of different understanding of national identity, as proposed by Kaufmann (2016), but also one of tension and conflict. A study on everyday nationalism in the case of hymenoplasty also contributes to the scholarship of embodied nationhood, spearheaded by feminist scholars, where nationalism is inscribed on the body or enacted through bodily performance (Mayer 2013, Balogun 2012, Faria 2014, Hoang 2014).

The fourth article highlights how people of migrant descent in the Netherlands are consistently seen to always be connected to their ancestral country, despite being born and raised in the Netherlands. Hence, a Dutch person with foreign ancestry can potentially be seen to always have a degree of non-Dutchness in them. At the same time, the person can also be seen to have or demonstrate some level of Dutchness, making them simultaneously Dutch and non-Dutch. In the case of hymenoplasty, a patient who is seen by physicians to desire the operation due to their non-Dutchness, are interestingly perceived by her family to resort to the procedure particularly because she is somewhat Dutch. Dutchness becomes a state of flux in which a person with migrant ancestry can be seen by others to aspire to be more and more Dutch.

### **The Fifth Article: Women Empowerment and Hymenoplasty**

What is specifically interesting from looking at nationalism in hymenoplasty consultations also comes from the fact that the surgery can only be performed on women hence patients who are contemplating the surgery are exclusively women. In recent years, women, migrant women specifically, have often become the litmus test of 'successful integration' in European countries (Kofman, Saharso and Vacchelli 2013, Roggeband and Verloo 2007). Migrant women are seen simultaneously as the most vulnerable group of newcomers (Ghorashi 2010) while also being perceived to be the key to a complete integration of people of migrant ancestry (Roggeband and Verloo 2007). Empowering migrant women then becomes the goal that is in line with the aspiration of having a certain kind of European society (Ghorashi 2010, Roggeband and Verloo 2007).

This focus on women and the idea of empowerment are the central topic for

article number five. I look at how Dutch doctors, coming from the understanding that the patients they are seeing are in need of help, provide assistance to surgery seeking women and frame the help in the claim to empower them. The empowerment efforts Dutch doctors offer their patients are very much informed by the kind of ‘deficiency’ they consider their patients to be in. These deficiencies boil down to two main aspects: (1) patients’ perceived lack of knowledge about the hymen and virginity and (2) patients’ deemed inability to rectify her dilemmatic social situation. To overcome the first ‘deficiency’, some Dutch doctors treat their time meeting with patients as an education session. They enlighten patients with ‘medically correct’ knowledge of the hymen and virginity. As explored in the first article on variability as well as in the third article on demedicalization, some Dutch physicians are convinced that the ‘right’ knowledge of issue at hand will persuade patients to decide against the surgery. In this context, the aim of the empowerment is for patients to choose not to undergo hymenoplasty at the end. To deal with the second ‘lack’, Dutch doctors encourage the patients to ‘talk’, particularly to their betrothed and family. ‘Talking’ is seen by the physicians as a way to convince the people who might be causing the dilemma for the patients to understand the situation and lax their demand. Notably, it is the responsibility of the patients to convince their family to change their mind.

This article also looks at how the empowerment afforded by Dutch doctors to the patients aim to change more than just the immediate situation of the patients. The empowerment efforts are done in the hope to alter the customary practice of people of patients’ ancestry in expecting women to stay virgin before marriage. The empowerment is also targeted for the future as patients are perceived by the physicians to be potential mothers who would be able to amend the situation, educate and make things ‘better’ for the next generation Dutch. This dual role of women as ‘victims’ but also as the ‘solution’ of ‘problems’ are reflective in the wider debate on migration in the Netherlands. However, in the case of hymenoplasty, the roles of women of migrant ancestry are not only perceived, at least by the physicians, to end there. Women are also seen to be potential future ‘oppressor’ for the next generation Dutch women as they might in turn demand their daughter to also keep their virginity before marriage. Ultimately, by interrogating the assumptions the doctors have in providing help and by examining the kind of empowerment they offer and by looking at what roles are casted for surgery seeking women, this article looks at what kind of women subject that are reproduced through the consultation with the doctors on hymenoplasty.

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## **CHAPTER II:**

# METHODOLOGY

### **2.1 The Timeline of the Study**

Exploratory study for the dissertation was done in summer 2012 where access to the hospital, one of the two main locations of the eventual study, was gained. The main goals of this period were twofold: (1) to clarify the aim and intention of the study with the doctors whom I would be working with in due course and (2) to test the feasibility of the intended method, particularly the viability of having an ethnographer sitting in during patient consultation. During this period a separate access to conduct the study in a second hospital was also attempted. Permission was finally acquired in the fall. However, during the time of the eventual dissertation study, the head doctor took an extensive leave of absence due to a personal reason. As a result, there was only one observation of hymenoplasty consultation conducted in the establishment. Hence, from now on in this dissertation, the word ‘the hospital’ refers exclusively to the first hospital unless indicated otherwise.

In the summer of 2013, I conducted preliminary study where I refined research methods including the way informed consent was obtained from the patients. I have started to conduct several observations of consultations at the hospital including

having a follow-up interview with one patient. Administrative requirements with the hospital was also taken care of and met. The main study period for the dissertation was started in February 2014 and completed in August 2015, amounting to 18 months continuous research period. This main research interval also encompassed the conduct of in depth interviews not only with doctors involved in the provision of hymenoplasty but also with people of similar ancestry with the patients. I particularly conversed with young women of patients' age, older women of patients' mother generation and young men.

In August 2014, I acquired an access to another hymenoplasty providing establishment. This establishment is a private clinic where hymenoplasty consultations are provided by a general practitioner. In this clinic, patients' hymenoplasty appointment with doctors are often set up back to back. Due to this set-up, an immediate follow up interview with patients were not feasible to be done. Additionally, due to the clinic's effort to ensure high confidentiality environment for its patients, a follow up interview at a later time was also considered to be problematic. Consequently, none of the patients from the clinic was contacted for a one on one meeting with me.

## **2.2 The Sites of the Study and Hymenoplasty Procedures at Each Site**

Data were mainly elicited from two establishments: a hospital located in one of the major cities in the Netherlands and a private clinic located around 1 hour train ride from the capital. As has been mentioned before, access to conduct the study was also granted by another establishment. This last establishment was also a hospital, located in the same city with the first one. One hymenoplasty observation was conducted in this establishment and a one on one interview was done with the head doctor before she took a leave of absent. This second hospital observes a similar procedure with the first hospital when conducting hymenoplasty consultations.

### **The Hospital**

Hymenoplasty consultations at the first hospital (henceforth: the hospital) were provided under the department of obstetrics and gynecology. This department also encompasses the sexology department. The head of the department who is also the head doctor in hymenoplasty cases is a sexologist. Dr. Zeeman (a pseudonym) has consulted with hymenoplasty patients for the past two decades. Together with colleagues from other hospitals, Dr. Zeeman established the current protocol for hymenoplasty followed in the hospital. This protocol consists of hymenoplasty patients having to go

through 3 appointments with the doctors before a final decision about the operation is made. The first and the last appointment are conducted by Dr. Zeeman while the second appointment is with a gynecologist.

Patients are regularly referred to an appointment with Dr. Zeeman by their huisarts (a general practitioner akin to a family doctor). In the Netherlands, a huisarts is usually the first source of medical help whenever an individual has health issues or needs medical attention. Although any patient can also decide to contact the hospital on her own without a referral to arrange a meeting. Whenever a patient chooses this latter method, she will reach a receptionist who will then book the appointment for her. It is not uncommon for this kind of patient to simply ask to meet with Dr. Zeeman without particularly explaining her intention to consult on hymenoplasty. However, all receptionists have been briefed that whenever a patient does not state her intention it is most likely that such patient is looking to consult on hymenoplasty. These patients also usually tend to request to have no physical letter to be sent to their home addresses. I will then be notified of the appointment time in order for me to be able to sit in during the consultation. On average, the hospital has 1 to 2, sometimes 3, hymenoplasty consultations a month.

At the hospital, the first hymenoplasty appointment with a doctor is an intake meeting. This meeting generally lasts for about 45 minutes to an hour. In some occasions, it is as short as 30 minutes. During this appointment, the motivation and the drive behind the patients' desire for hymenoplasty are explored by Dr. Zeeman. The intake meeting is also the time when specific goals for the surgery are also identified. Not all hymenoplasty patients desire the same outcome of the surgery. Some of these patients wish to bleed as a result of the operation while others hope the procedure will lead to their vaginal opening to be 'tighter'. A number of them seek the surgery as a means of psychological closure. Apart from finding out their exact intention for the operation Dr. Zeeman also uses the intake meeting as an opportunity to impart knowledge and information. The doctor shares with surgery seeking women 'medical knowledge' about virginity, the hymen and the operation in which the patients are at times are not familiar with. Some of the information provided include the variability of the shape of an unpenetrated hymen which renders visual observation of its condition to be an inconclusive determinant of a woman's virginity. Patients are also informed that the 'tightness' of the vaginal opening comes from the contraction of the pelvic musculature rather than from an 'intact' hymen.

The second meeting the patients need to go through is an appointment with a gynecologist where a gynecological examination takes place. This examination is done particularly to observe the condition of the patient's hymen in order to know what needs to be done in cases where surgery is to be conducted. The gynecological

appointment is also the time when patients are given the chance to ‘exercise’ their pelvic muscles under the observation and aid of the gynecologist. This exercise is done in order for them to be able to voluntarily contract and relax the musculature, resulting in a tightening and loosening of the vaginal opening accordingly. This exercise is often accompanied with the patients observing firsthand the working of the muscle by looking at their own vaginal opening through a mirror. The gynecological appointment is also used, although more infrequently, to consult the patients of sexual transmitted diseases (STDs) as well as the use of contraceptive methods.

The third appointment is again with Dr. Zeeman. At this appointment, patient notifies Dr. Zeeman what she finally decides to do in regards to the surgery. 1 out of 3 patients who go to the hospital at the end chooses to not undergo the operation. Those who are going ahead with the procedure will have to make a new appointment for the surgery to be done, usually within 2 weeks of the wedding day. The operation is performed by the same gynecologist who did the gynecological examination whenever possible. The price for the operation is around €1500 and is paid out of pocket by the patients. The lead doctor at the hospital explained to me that the expenses can be covered by insurance if there are other medical indications present which necessitate surgery.

Despite the formal procedure that stipulates hymenoplasty patient must go through 3 appointments with the doctor first before deciding for or against the operation, in practice some modifications can be made. Patient can choose to inform Dr. Zeeman of their choice regarding the surgery by phone instead of meeting face to face with him again. If time is of an essence, gynecological examination and surgery can be done in the same day. More importantly, whenever a patient is very sure of her decision whether to undergo or forego the surgery after the first meeting, subsequent meetings can be waived.

### **The Clinic**

Hymenoplasty provision at the clinic is mainly provided by one head doctor, Dr. Linden (also a pseudonym). When Dr. Linden is unavailable, a substitute doctor will conduct the consultation as well as the operation. The clinic where Dr. Linden works is a small clinic that was originally dedicated for abortion purposes. It has now been for a while expanded to also provide health services relevant to sexuality and sexual issues, including consultations for contraceptive methods and/or STDs.

There are a number of doctors practicing at the clinic. Each physician usually practices for 2 to 3 days a week. Doctors can use consultation rooms available in the establishment to meet with patients. These consultation rooms are on the second floor of the building. The one Dr. Linden usually uses is adjacent to an examina-

tion room. On the first floor, the clinic has a room that serves as a receptionist and several operation rooms which can be used free of charge by doctors working there. Dr. Linden makes use one of these operation rooms whenever she performs hymenoplasty with a help from a nurse. This nurse will need to be informed ahead of time to be present during the operation. The nurse does not work at the clinic on a daily basis.

A potential patient can call the clinic to book an appointment with Dr. Linden. When it is a hymenoplasty appointment, patient is asked to come either on Thursday afternoon or Friday morning. On occasions, Dr. Linden chose to move her appointments to a different day due to either personal and professional reasons. Surgeries are usually done on Thursday mornings although Dr. Linden has been known to schedule the operation at a different day, even on the weekend, to accommodate patients who are pressed for time. There are a lot more hymenoplasty appointments at the clinic compared to the hospital, amounting to 3 to 5 a week.

Unlike at the hospital, the clinic does not formally have a procedure a patient needs to follow when contemplating hymenoplasty. Despite this, patients usually meet with Dr. Linden in several occasions, particularly when they are going through with the operation. The first appointment with Dr. Linden is comparable to that of Dr. Zeeman; it is an intake meeting where Dr. Linden explores the motivation of patients to undergo hymenoplasty. This appointment generally lasts for 20 to 30 minutes, shorter than the ones at the hospital. Dr. Linden's main aim for the intake meeting is to learn the specifics of goals that the patient wants to achieve through the surgery. In clarifying how such goal can be accomplished through her medical care, Dr. Linden also explains various information about the hymen, virginity and the surgery itself.

Dr. Linden's hymenoplasty consultation commonly encompasses a gynecological examination which is done in the room adjacent to the consultation room. This examination lasts for only about 5 minutes as the main aim for it is to observe the condition of the patient's hymen in order to know what needs to be done in the case of surgery. Dr. Linden offers two types of hymenoplasty procedure: a temporary suture aimed to assist the patient to bleed during the wedding night and a more elaborate procedure usually with a goal to reshape the hymen membrane. The condition of the patient's hymen sometimes determines which of these two operations can be performed. In contrast with the procedure at the hospital, pelvic muscles exercise for the patient is not always part of this examination. The practice of looking through a mirror at one's own vaginal opening is only done if the patient specifically asks for it.

After the gynecological examination, patient and Dr. Linden sit back in the consultation room where patient can then decide whether to go on with the surgery or not. About 60% patients decide to continue on with hymenoplasty. When this is the decision, patient books a time for the surgery with the receptionist on the first floor.

The price of surgery in this establishment is €150, a mere 10% of the expenses at the hospital. The price is set deliberately low as Dr. Linden considers performing hymenoplasty as a form of providing the necessary help for women in need.

If the type of the operation to be done is the temporary one, surgery is mostly done within the week of the patient's wedding day based on Dr. Linden's recommendation. The second kind of operation—the one that is more elaborate—can be done at any given time according to the patient's request. For patients who choose the more elaborate surgery, Dr. Linden recommends they come back for another appointment around one month after the procedure was performed. At this appointment, another gynecological examination is done to see how well the wound is healing and how good the result of the operation is. A surgery is considered successful when the hymen tissue healed well and either the hymen's opening is smaller than before or the edges are more annular and uniform. In cases where the surgery is considered unsuccessful, patients discuss with Dr. Linden what to do next. Decisions after this consultation ranges from undergoing the temporary surgery to devising alternative ways to bleed during the wedding night.

Patients can also initiate a follow up meeting with Dr. Linden whenever they feel the need. Patients who experienced discomfort after the operation have been known to do this although there has not been any case where the surgery resulted in bodily harms to the patient. Some patients who underwent the elaborate surgery had the operation performed months before their wedding date. Because of this, a number of them decided they want Dr. Linden to re-observe their hymen's condition closer to the day of the nuptial. Patients usually want to ensure that the successful result of the surgery has not been undone despite Dr. Linden's continuous reassurance that such scenario will not come to pass. The only occasion where Dr. Linden refuses a follow up gynecological examination after the surgery is when the patient underwent the temporary operation. Dr. Linden reasons that the examination involves to a degree an opening up of the vaginal canal which might cause the suture to break and the surgery to be futile.

### **Profiles of Physicians**

All the doctors I talked to in this study were of Dutch “native” upbringing except for one gynecologist who was of migrant ancestry with Muslim background. I talked evenly with senior doctors, younger doctors, those who were still in their internship period and those who were no longer in practice. Most of the physicians were female except for two, in which one was the lead doctor of the hospital where I conducted my observations. In my writings, I have chosen to generally omit the gender of the physicians. This is particularly the case in my first article in which I compare hymeno-



plasty procedure in the two main establishments from where I gathered my data. The decision to exclude the gender of the physicians was made deliberately. I have found that with the inclusion of the gender, the attention and curiosity of the readers tend to focus on how the different gender of the physicians might influence the way they consult patients. Presently, I do not have an answer to this question. My findings do not give me specific insights to extrapolate how physicians' gender might influence their hymenoplasty consultation. Inferring otherwise, even if only to hypothesize, runs the risk of me falling into gender stereotypes. Therefore, in comparing and contrasting the practice of the two establishments, I have chosen to analyze the doctors' procedures, actions and utterances instead.

One particular observation is worthy of note at this point. My first article shows that the surgery rate of the hospital with a male lead doctor is half of that in the clinic where the main physician is female. However, based on a previous study, the rate of surgery in a different hospital, where the lead doctor is also a female physician, is closely similar to the one in the hospital of this study (van Moorst et al. 2012). What is similar between the two hospitals, which in turn is different from the clinic, is the procedure employed in consulting hymenoplasty patients. I therefore maintain in the first article that it is these differences in procedure that lead to the contrasting surgery rate between the hospital and the clinic. I also further argue that the procedure stems from the consulting doctor's philosophy of hymenoplasty itself. Hence, I posit that it is the physicians' point of view of the surgery that ultimately results in the difference in hymenoplasty consultation outcome in the Netherlands.

### 2.3 Data Gathering Method

The main data collection method for this dissertation is participant observations of hymenoplasty consultations conducted in the hospital and the clinic. This participant observation is complemented with a follow up interview with patients whenever consent is obtained. I also conducted in-depth interviews with a number of doctors involved in the provision of hymenoplasty. To provide the context for the study, I likewise conducted interviews with different people of similar ancestry with the patients. In the spirit of anthropological and sociological study, every interview is also seen as an opportunity to refine questions. Immediate findings from observations of the consultations and from other interviews informed the line of inquiries. Later interviews explored further important elements of data that are considered to be the key findings of the study. Each of the data collection methods will be further detailed below:

### **Participant Observation of Hymenoplasty Consultation**

Having its root in sociology and arguably being the quintessential method of anthropological study, participant observation is a well-known and well-established data gathering technique in social sciences (Musante 2014, Jorgensen 2015). Participant observation is a powerful method of qualitative research to investigate experiences, feelings, meanings and thoughts of people resulting in rich and complex findings of study (Jorgensen 2015). In the case of exploring sensitive and controversial social phenomenon, such as research on hymenoplasty, participant observation has been known to allow better rapport with study participants thus making it possible for investigators to find insights into information that might be otherwise hidden, concealed or considered as taboo (Gruenbaum 2005, Power 2013). Having gained access to hymenoplasty consultations, I considered participant observation to be the most productive method of study to be employed.

To conduct participant observation in my study, I sat in during hymenoplasty consultations to observe exchanges between patients and physicians. Consent for me being present in the room was obtained from patient prior to her meeting with the doctor. This consent is done verbally to avoid superfluous documentation that can link patient to hymenoplasty. For the most part, I am a silent observer of the conversations between the doctor and the patient although occasionally I provided minimal aid to both. From time to time, I was brought into the conversation either by the doctors themselves, by the patients or by the persons accompanying the patients. I have also used down time during consultations—such as when the doctor needs to use the computer—to initiate a short conversation with the patient or with the person accompanying the patient.

Whenever consent was obtained, consultations were audio recorded. This was only done in the hospital as permission was not obtained in the clinic. Whenever audio recording was refused by the patient, extensive note taking took place in substitute. Recordings were then transcribed and field notes typed into the computer. Both were eventually translated from Dutch to English prior to using excerpts for writing purposes.

### **Follow-up Interviews with Patients**

Each patient whose appointment was at the hospital was requested for a follow up interview. One out of three patients agreed for a one on one meeting with me. In total, I met with 7 patients in private. It was the patient's decision when and where this follow up meeting was to occur. The majority of the patients decided for the meeting to take place at the hospital itself. This is either directly after their first appointment or at a later date—usually coinciding with their gynecological examination.

The rest desired for our meeting to be held outside of the hospital in a place that is the most convenient to them.

The aim of this follow up meeting is to explore further patients' narrative that lead them to contemplate the surgery. This includes information about their fiancé and the circumstances of their engagement and upcoming marriage, their conviction and the extent of their knowledge on virginity, the hymen and hymenoplasty, sexual expectations put upon them as well as the network of people with whom they discuss sexuality. The interview also aims to solicit patients' thoughts on their experience meeting with the doctors and their eventual decision in regard to the surgery.

Initial design of this study aims to have a series of follow up interviews with patients with one interview held after each patient's appointment with doctors. Every interview was planned to address a different set of questions according to what the patients might have experienced during their meeting with the doctor. One last interview is designed to be held about a week after the wedding to explore patient's experience during their first night. This interview is planned to find out whether the patients used certain methods to give the impression that they were still a virgin, the reaction of their husband and particularly for those who underwent the surgery, whether their expectations of the result of the surgery were fulfilled.

However, patients turn out to be more reluctant to have continuous engagements with the study than previously expected. The majority of patients were quite comfortable having me sit in during the consultation but most declined my request for a follow up interview. The majority of those who granted me a follow up interview felt one interview is plenty enough and were generally reluctant to have any additional one. This reluctance came in the context of the one interview granted by the patient not being held directly after the first appointment with the consulting doctor. Any patient had a choice to have the interview at any time that was the most convenient to her. The decision to alter the timing of the interview to suit the patients' time helped increase their willingness to be interviewed. However, it rendered the initial design of serial interviews to miss its goal to an extent. Hence, both due to patients' disinclination and the initial design turning less functional, it became more productive to only pursue one follow up interview with a consenting patient.

The very last interview that was planned to be conducted around a week after the patients' wedding date was also largely not done. It is important to highlight that this follow up is the one the medical establishment themselves consider to be the most relevant to them. Both the hospital and the clinic attempted to contact their hymenoplasty patients after the wedding. They were particularly interested to find out the efficacy of the surgery. The physicians were also curious of the success of the alternative ways to bleed during the wedding night, if any of these methods were chosen

by patients. However, it has proven very challenging even for the medical establishments themselves to contact the patients after the wedding. This is particularly true for patients who married outside of the Netherlands and decided to stay in the new country with their husbands afterwards. For the rest, it was not uncommon for their phone number or email address to become unreachable after the wedding. Doctors have hypothesized that this might be due to the patients' effort to sever any ties to the procedure. This is in order to ensure the possibility of discovery of their hymenoplasty quest to be as low as possible. In the case of this study, only one out of the patients who agreed to a one-on-one follow up meeting with me was willing to be interviewed after her wedding.

As has been mentioned previously, it was not possible to have a follow up meeting at the clinic. However, the set up of hymenoplasty procedure in said establishment involves possible recurring meeting with the head physician. As such, it was feasible for me to sit in during the second and, more rarely, the third appointment the patient had with the doctor. In total, I sat in multiple appointments of 9 patients at the clinic.

### **Interview with Providers of Hymenoplasty**

14 physicians who were involved in the provision of hymenoplasty service to one degree or another were also interviewed for the purpose of this dissertation. About half of the doctors interviewed worked in the establishments that are the sites of this study while the rest practiced in different medical establishments across the Netherlands. Interviews with these medical professionals were meant to solicit their views on the surgery itself. Studies have shown that provision of hymenoplasty is fraught with ethical dilemma. This includes whether performing the surgery means physicians are agreeing with the idea of women surgically altering their body to fulfill the expectation of others (Bekker et. al. 1996, Raveenthiran 2009, Cooks and Dickens 2009). The interview also aimed to learn physician's experience in the provision of the surgery. It likewise meant to understand better their perspectives on the issue of virginity and sexuality in general, making it possible to draw parallels and comparisons with the view of the patients.

To complement data collection in medical establishments and to gain a more thorough understanding of hymenoplasty, virginity and other issues related to sexuality in general, I also conducted in depth interview with people of similar ancestry with the patient. Hymenoplasty patients in the Netherlands are almost exclusively of Dutch migrant background with parents or grandparents born and raised outside of the Netherlands. The majority of women seeking hymenoplasty in this study have either Moroccan or Turkish, including Kurdish, descent. The rest come from Afghani, Iraqi, Pakistani or Armenian ancestry. For the purpose of this dissertation research,

I was able to have conversations with different people of Moroccan, Turkish, Afghani and Iraqi descent. I particularly conversed with young women of patients' age, older women of patients' mother generation and young men.

### **In-depth interviews with women of patients' age**

As the drive to undergo hymenoplasty is often informed by specific societal values on virginity and sexuality, it is necessary to have an understanding of sexual norms and sexual expectations a Dutch young woman of migrant ancestry might be subjected to. I conducted in-depth interviews with close to 40 young women of Moroccan, Turkish, Afghani, Iraqi and Iranian descent. These women were mostly in their early to mid -twenties and were born in the Netherlands or came into the country when they were very young. They were identified through a network I previously established during my preliminary and pilot research. I also received help from my research assistants to find young women who were willing to discuss with me about my research topic. Since contact with these young women was established through strings of recommendations, I was able to talk to women from different parts of the Netherlands as well as from various levels of education.

Interviews with young women mainly aimed to explore their understanding and views of the importance of virginity in a woman's life, their stance on different issues of sexuality, how they perceive different forces in their life—such as religion and culture—to influence that stance and how living in a Dutch society affects their views on virginity and sexuality. The topics of conversations with these young women also include their preference in partner choice, their experience in dating or other romantic relationships as well as their knowledge and views of hymenoplasty.

### **In-depth interviews with women of patients' mother generation**

Based on pilot and preliminary studies, Dutch young people of migrant background, both male and female, indicated that they were informed of expectations surrounding the issues of sexuality by their mother. It is therefore important to have conversations with this generation of women particularly on their relationship with their children and how communication surrounding the issue of sexuality was done or not done between them. Topics of conversations also included their views of virginity and their stances on different issues of sexuality. We also talked about their expectations and hopes for their children, including who and how they wanted their children to marry. Additionally, since hymenoplasty is mostly done to be able to bleed during the wedding night, the women's own experience of their wedding night and their marriage in general, including how they met their partner, was also discussed. The women were also asked about their opinions of hymenoplasty.

Conversations with these women were assisted by research assistants who acted as an interpreter whenever the women felt more comfortable communicating in their mother's language. Although quite a number of women chose to converse with me in Dutch. Research assistants also helped me making the first contact with the women. In total, I interviewed 20 women from Moroccan, Afghan, Turkish, Iranian and Iraqi descent.

### **Interviews with Dutch young men of migrant background**

To fully explore women's decisions and practices of sexuality and reproduction, it is crucial to incorporate the point of view of men as well (Sargent 2006). The ideal men to be interviewed are those who are the future spouses of the surgery candidates. However, since young women seeking hymenoplasty keep this procedure a secret from their future husband, interviewing the spouse of the surgery-seeking women could be proven ethically and pragmatically problematic. Hence, I engaged with other men with similar ancestry of the patients as a proxy for the husband's point of view. Access to these young men were gained through recommendations from my established contacts from the pilot and preliminary studies.

The interviews with men mostly looked at their ideas and expectation of virginity, both for men and women of their social circle as well as how living in a Dutch society affects their view on sexuality. These interviews also aimed to uncover the possible roles virginity plays in these men's decision in engaging in or abstaining from pre-marital sex as well as in choosing a life partner. In total, I managed to have conversations with 12 men of Moroccan, Turkish and Afghani background.

## **2.4 Addressing Invisibility – A Word on Access**

It is of the serendipitous nature that I gained my preliminary access to the first medical establishment. Having interest in the sociocultural issues surrounding the operation, the lead doctor of the obstetrics, gynecology and sexology department of a teaching hospital in one of Dutch major cities welcomed me to conduct my study there. Dr. Zeeman was even the one who suggested for me to sit in during consultations as a way to meet with surgery seeking women. Soon after, I was likewise welcomed in a second establishment, also a hospital in the same city. As has been mentioned previously, due to the head doctor's extended leave of absence, I only observed one hymenoplasty consultation here. I finally gained access to the third establishment, a private clinic in a smaller city in the Netherlands about six months into my dissertation research. I traveled regularly to this small city twice a week to observe Dr. Linden's hymenoplasty consultations.

Patients did not always consent to me sitting in during their exchanges with doctors. Equally in the hospital and in the clinic, patients have refused to have me be present in the consultation room. However, when they did allow me to sit in, it is not lost on me that their agreement might be partially due to my own identity markers as an individual. Being a young woman of non-Dutch descent who grew up with Islamic tenets and traditions makes me a direct contrast to the doctors who are, in this study, exclusively Dutch, white and not Muslims. As my attire does not immediately announce my Muslim upbringing, patients learned of it as the doctors informed them or when I mentioned it myself. Without failure, when the patient was of Islamic faith herself, there was an expression of recognition and relation when she learned that I was too a Muslim. “You know how it is,” or “In our religion...”—referring to me as part of “our”—are some of the phrases they used when addressing me. This is in some contrast to what they said to the doctors which clearly delineated them as belonging to a different group of people than the physicians. Not infrequently, the patient themselves were the ones who were curious of my religious background. “Are you a Muslim?” asked one patient to me as she stopped herself from telling me her story. She then continued after giving a nod of acknowledgment to my “yes.”

I am also aware that being a woman might have helped me being accepted to sit in during consultations. The sensitive nature of the operation and the intimate information patients are divulging during consultations lead me to believe that patients might have felt more comfortable that I, like them, am a woman too. Patients have often asked, particularly in the hospital, whether the pelvic examination they have to undergo will be conducted by a female doctor. When assured of it, patients noticeably relaxed and was further visibly relieved upon hearing that the operation, if they decided for it, would also be performed by a female physician. I too am cognizant that being a non-Dutch person might have given me a certain leeway. Although without me especially venturing in finding out why this was my experience, I am less able to pin down the rationale for it. As a whole, I realize that my identity markers are potentially what have given me the opportunity to gain this never before achieved ethnographic access to observe exchanges between physicians and patients surrounding a secretive and sensitive surgery.

During consultations, I consciously made an effort to be as quiet and as invisible as I could. I had two reasons for this decision. Firstly, realizing the sensitive nature of information the patients might be sharing with the doctors, I consider it as a sign of respect for me not to pry or to be over curious about what the surgery seeking women are revealing. Strategic wise, understanding that patient at any point can decide to eject me out of the room, which fortunately never happened, I took it as wiser to not draw too much attention to myself. I am after all an additional person that can poten-

tially be seen by the patients to be the source of possible 'leakage' of information of the status of their sexual purity. Having no real added value to their quest of getting the operation, it is not inconceivable that patients could see me as an extra unneeded individual that is best to not be present. Because of this, I consider being quiet and mostly invisible, to be the best policy. More than that, I take it as beneficial for me to be a quite observant which allows the patients to get used to me being around without potentially feeling intimidated, worried or threatened. This I have hoped to make them feel more welcoming to the idea of talking to me one on one later on.

Secondly, I wish for the exchanges to mostly occur between doctors and patients. I do however fully realize that by simply being there, I have probably altered the nature of interaction between patients and doctors. Nonetheless, aspiring to observe the dynamics of this interaction, I consider it more fruitful for the analysis if the conversations between physicians and patients are largely without interference from a third party, let alone a researcher. I wanted to observe what questions are asked and what statements are brought up without me having to prompt them either by putting forward the query myself or by volunteering a comment. Regardless of this, I was nonetheless not uncommonly brought into the picture, more often by the doctors but also by the patients or by the persons who accompany them. The sleeve of my sweater was often a way to illustrate the flexibility of the hymen by the doctor at the hospital. I have been dispatched to fetch envelopes, papers and other stationaries at the clinic. I was tasked with helping patients schedule their next appointment. Once, I held a patient's hand as she was nervous and needed assurance when a nurse took out her blood with a sterilized syringe. The blood was to be put in a vial which she would spill during her wedding night. Patients and people accompanying them have chatted with me in the consultation room, particularly when the doctor was out taking care of administrative matter or getting some medical equipment. They asked me of where I came from, shared with me their worries and even often were curious of my project. "Is it only Muslims who do this?" one sister of a patient asked me. "Did you meet people who's not from the Netherlands?" inquired a different patient. These conversations were brief as the doctor was only away not more than 5 minutes at a time. But during that short moment, I was more than a mere quiet invisible observer.

In my writing, at the very least in these articles included here as chapters, I am also mostly invisible. Part of this is because it reflects the consultations where I strive to be silent and inconspicuous. It is also my intention to bring attention mainly to the exchanges between physicians and patients themselves. Mostly writing myself out of the narrative emphasizes my role as the discreet observer despite inevitably being a participant even if in the smallest sense. I have however taken care that I indicate where my involvement is apparent. This is including when I was the one who prompt-



ed a certain answer or putting forward a particular question that was otherwise unasked. During consultations, unless the patient was the one who initiated it, my questioning usually only happened towards the end of the meeting. The consulting doctor often would turn to me and invited me to address the patients just in case there was still things I would like to specifically know. Otherwise, probably comparable to how often I use of the pronoun “I” in my writings, my interjections were infrequent.

## 2.5 Data Analysis

In the spirit of qualitative study and constant comparative method, preliminary analysis was done immediately and cyclically. Findings were fed back to the data collection effort in order to hone in discoveries and to develop the exploration to be closely in line with emerging themes from field research (Glaser 1965, Boeije 2002). Later stages of the study used grounded theory approach to identify important concepts and key findings as the bases of the overall analyses and the main arguments (Strauss and Corbin 1994). A computer-assisted qualitative data analysis software (CAQDAS) Atlas.ti was used whenever necessary to support a thorough examination of data. Codebooks were developed both in vivo and with abstractions to aid the process of synthesis (Kelle 2004). Preliminary codes used at Atlas.ti were developed based on emerging and immediate findings from the field, rather than determined a priori, and these codes were developed into a code book using technique comparable with those outlined in Bernard and Gravlee (2014) and Miles and Huberman (1994).

## 2.6 Limitation of the Study

It is to be acknowledged that the study can still be seen as relatively small scale as it involves mostly two medical establishments and two lead consulting doctors. This number is due to the high sensitivity and secrecy of the topic in which ethnographical observation is rendered almost impossible. However, conducting similar study in different medical establishments or different countries will allow a richer understanding and should be aspired to as a future endeavor.

The sensitivity of the study and the need for confidentiality demands the study to be the most accommodative to patients' need for secrecy. This renders a more extensive engagement with them, e.g. recurring meetings or following them to their place of residence or work, impossible and potentially unethical. I have also consciously made the decision to never find or recruit any potential or former hymenoplasty patients

from my non-surgery seeking participants. To avoid accidental discovery as well as to ensure no suspicion is ever casted on any person agreeing to have an interview with me, I have kept observations at the medical establishments and interviews with people of migrant ancestry in two separate social and spatial domains. Having learned through pilot and preliminary study that the slightest speculation of a woman's virginity might cause her unnecessary adversary, I consider the above outlined measures to be highly necessary. However, I would encourage any study that was able to find ways to have more thorough views of potential or former hymenoplasty patients to be pursued as this will allow insights that this study is unable to provide.

The relatively low number of engagement with men in this study provides another potential point of exploration for future research. The view of men is undoubtedly crucial in the issue of expectations and maintenance of virginity of unmarried women in hymenoplasty cases. As this study focuses more on the clinical setting and the experience of women, men's point of views were solicited as a supplement. Men's perspectives help illuminate context and to provide a more thorough understanding of the issue of virginity and sexuality in general among Dutch people of migrant ancestry. Understanding more thoroughly men's view point allow a richer comprehension not only on hymenoplasty and the quest of women for the surgery but also on various societal norm on virginity particularly and sexuality in general.

## 2.7 Protecting Privacy and Ensuring Confidentiality

I have obtained research clearance from Washington University Institutional Review Board as well as from the ethical boards of the two hospitals to conduct this study. This includes from the second hospital where I ended up only doing one hymenoplasty consultation observation. All institutions have thoroughly made sure that my methodologies guarantee the privacy and confidentiality of my informants.

Realizing the sensitivity of the topic and the need of the patients for discretion, I have put in place several measures to maintain the highest ethical standards during and after the research. I only interacted with patients after their explicit consent has been given. I have experienced occasions where patients were unwilling to have me in the consultation room and they were informed that their treatment would not be affected by this choice. I did not interact with patients under such circumstances. Patients could opt out from the research at any point without any effect on their treatment and they were informed of this.

My engagement with people of similar ancestry with the patients was in separate spatial and social domains from my interactions with the patients. To ensure this

separation even further, I intentionally avoid finding surgery seeking women or those who have done hymenoplasty through my engagement with people outside of the medical establishments. Moreover, people of migrant ancestries in the Netherlands are not situated in one geographical location nor are they clustered in one neighborhood. I engaged with people from different cities in the Netherlands as well as from various residential areas in these cities. Furthermore, my contacts with the Moroccan and Turkish people, in particular, in the Netherlands were first established through my preliminary research. This research focused on marriage, divorce, and sexuality in general and not particularly on virginity only. This line of inquiry was continued during main dissertation data collections allowing interviewees to be more at ease during the interview. Rapport between the interviewee and me was also better developed came the time the topic of conversation turned to virginity. These widening of the focus of exploration as well as the broad geographical coverage of informants ensured the dilution of sample and further avoid unintentional overlapping between the patients and their social circle.

Any distribution of confidential materials will only be done with a removal of direct and indirect identifying information. No name of cities will be identified in relation to locations including that of the two main establishments of the study. Any names used for the purpose of publication are pseudonyms including the names of the doctors involved. Particularly to protect the identity of the patients the following were observed: (1) Age of any patient was only given in a range rather in specifics, (2) No indication of specific dates of any single doctor's appointment or surgery was provided, (3) No indication of specific dates of any wedding celebration was provided, (4) Visual descriptions of any patient were intentionally vague and (5) If a patient comes of migrant ancestry other than that of Turkish or Moroccan, no specific country's name was used to signify her background. To further ensure the confidentiality of the informants, an identification number was assigned to each of the participants. A file that contains the correspondence of this code to the informants' names is kept in an encrypted password-controlled file.

Due to the sensitivity of the subject, informed consent process was a crucial aspect of the research. Being fully aware of the priority to meet patients' need of confidentiality, the consent process was made deliberately in layered fashion. Permissions were sought separately for observations of consultations, audio recording and one-on-one follow up conversations between the ethnographer and the patient. Since all patients were able to drop out of the study at any point, some have chosen to participate only in one certain occasion but not in others. For example, patients were willing for their conversations with the doctors to be observed but not to have a one-on-one interview with me. Consent for the observation was obtained prior to the patients'

first meeting with the doctors and it was conducted in person at the medical establishment. This consent was done verbally to avoid any unnecessary documentation of patients' name linked to the surgery. A separate consent was then obtained to audio record the consultations and whenever patients refused, extensive note taking took place. Audio recording only took place at the hospital. The consent process for audio recording did involve the patient signing a document agreeing to the recording as the hospital required such documentation. However, the patients were not asked to affix their real name or any name for that matter to the signature which the hospital allowed. Informed consent for a follow up meeting with me was again done verbally.

For doctors, young women and young men interviewed, a document of informed consent was used in which a signature was required to signify agreement to participate in the research. Signed informed consent was waived for older women. My early research period has proven that older women of migrant ancestry in the Netherlands were very wary of signing any documents. This was mostly due to their often far than pleasant experience when migrating to the country. Verbal informed consent was then obtained as the alternate.

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## **CHAPTER III:**

# VARIABILITY OF HYMENOPLASTY RECOMMENDATIONS

### **3.1 Article Title**

How Variability in Hymenoplasty Recommendations Leads to Contrasting Rates of Surgery in the Netherlands: An ethnographic qualitative analysis

### **3.2 Abstract**

Hymenoplasty is surgery to alter the shape of the hymen membrane in the vaginal canal, commonly performed to minimise the aperture. This medical operation is often requested by women who expect that their virginity will be under scrutiny, particularly during their first sexual encounter on their wedding night. Despite increasing demand for the surgery all over the globe, there is no one standard of practice in performing hymenoplasty. In the Netherlands, the manner in which medical consultations concerning the procedure take place depends heavily on the consulting physician. This paper looks at two different approaches to hymenoplasty consultation in the Netherlands: a pedagogical philosophy adopted in a public hospital and a practical approach employed by a private clinic. Each approach culminates in a contrasting result: patients in one medical establishment are twice as likely to undergo hymenoplasty than those visiting the other.

### 3.3 Introduction

Hymenoplasty, also known as hymenorraphy, is surgery to alter the shape of the hymen membrane in the vaginal canal, commonly performed to minimise the aperture (Ahmadi 2013, Renganathan, Cartwright and Cardozo 2009, Cook and Dickens 2009). In the past decade, the demand for hymenoplasty has been increasing in countries such as China, Canada, the USA and in various European countries (van Moorst et al. 2012, Amy 2008, Steinmüller and Tan 2015). In the Netherlands, the operation is often requested by Dutch women of migrant background, particularly from Morocco, Turkey, Afghanistan and Iraq. This medical procedure is frequently sought by women who consider themselves to be no longer sexually untouched, yet are facing the expectation of virginity on their wedding night (Logmans et al. 1998, van Moorst et al. 2012, Wild et al. 2015).

Despite increasing demand for the surgery all over the globe, there is no one standard way of performing hymenoplasty (Wild et al. 2015, Raveenthiran 2009, Goodman 2011). Physicians who perform this surgery rarely learned to do so in medical school and were more likely to have developed their own technique and/or acquired it from a senior practicing doctor on the job. Doctors around the world are still actively sharing the way they personally perform the surgery in medical journals (see for example Saraiya 2015, Triana and Robledo 2015, Ou et al. 2008, Prakash 2009 and Wei et al. 2015).

This lack of standards for performing hymenoplasty is partly due to the fact that the operation is a fairly new addition to the practice of medicine (Goodman 2011). In the Netherlands, this situation is compounded by the stance of medical associations, medical ethics boards and hospital departments which often discourage surgeons from performing hymenoplasty (see, for example, the Dutch obstetric and gynaecological association's statement (Feitsma and Kagie 2004)). Dutch institutional reluctance to acknowledge the surgery reflects similar position statements issued in recent years on comparable medical procedures collectively referred to as Female Genital Cosmetic Surgery (FGCS) by professional bodies in other countries, including in Egypt, the USA, Canada, Sweden, New Zealand, France, the UK and Germany (Kandela 1996, Braun 2010, de Lora 2015, Amy 2008, Juth et al. 2013).

Among doctors and medical professionals, hymenoplasty is still widely seen as a controversial topic. Physicians and midwives, as well as social scientists, are divided on the ethical nature of conducting the surgery as well as whether or not the operation is necessary to be performed (Cook and Dickens 2009, Christianson and Eriksson 2014, Cindoglu 1997, de Lora 2015). Those in support of the provision of hymenoplasty equate it with cosmetic and ritualistic surgery, favour women's autonomy in choosing

the operation, consider it a way to help patients who are often facing a precarious social dilemma, and/or view it as a form of women's empowerment (Logmans et al. 1998, Ahmadi 2015, Ross 1998, Juth and Lynöe 2015, Kaivanara 2016).

Those who are more cautious about doctors engaging in the practice cite the possible surgical exploitation of patients, reason that performing the surgery is perpetuating sexual inequality between men and women and argue that physicians may be considered to be colluding in deceit (Raphael 1998, Raveenthiran 2009, Roberts 2006). For physicians, their main objections mostly stem from the absence of medical reasons for the surgery, particularly because the link between a seemingly 'intact' hymen and the absence of sexual intercourse is considered to be weak (Adams, Botash and Kellogg 2004, Edgardh and Ormstad 2002), as well as due to the procedure's questionable efficacy (Juth et al. 2013, Raveenthiran 2009).

In the context of this controversy, hymenoplasty, perhaps somewhat ironically, is not a very difficult procedure to conduct. One gynaecologist maintained in a personal exchange that so long as one knows how to perform surgery, one should be able to figure out how to do hymenoplasty. A different doctor, who has performed hymenoplasty on a weekly basis for the last five years, claims similarly, 'As long as you know how to stitch a wound, you can do the operation.' Lack of formal acceptance of the operation and heterogeneity in the surgical method, as well as the relative simplicity of the technique, render the practice of hymenoplasty highly dependent on the doctor who is doing the surgery.

In the Netherlands, consultation concerning hymenoplasty is similarly dependent on the consulting doctor. Before the operation, the patient who desires the surgery needs first to meet with the doctor to talk about her intentions. The manner in which this consultation ensues depends heavily on the consulting physician. As hymenoplasty is a highly contested surgery, doctors' deliberations about performing or not performing this operation do not only include the biological aspects but also the social effects it may cause (Juth and Lynöe 2015, Ahmadi 2013). As a result, each hymenoplasty consultation is somewhat coloured by the stance of the consulting doctor concerning the operation.

Despite recognition of the variability of physicians' responses to requests for hymenoplasty (Essen et al. 2010, Juth and Lynoe 2015), there is an absence of a closer look at the effect of these diverse approaches on the outcomes of the consultations. Drawing on participant observations of 70 meetings between doctors and patients in the clinical setting, this paper looks at two different approaches to hymenoplasty consultations in the Netherlands: the first, provided by a team of doctors in a public hospital, the second, offered in a private clinic. The ethnographic access to hymenoplasty consultation this study employs is unprecedented as the surgery is a highly



sensitive medical procedure where secrecy and confidentiality are of the utmost concern both for the patients and the physicians, as discovery may result in unintended repercussions, including ostracisation, divorce and even death (Eich 2010, Amy 2008). Academic and scientific articles about the surgery that include a focus on the clinical setting are almost exclusively written by medical professionals involved in the provision of the service. This is to be expected as patients often desire only their physicians to know of their intention and no one else apart from them.

### 3.4 Methodology

#### **A hospital and a clinic: the sites of the study**

The study was conducted in two establishments that deal with hymenoplasty patients regularly throughout the year. The first is a teaching hospital, located in the southern area of a major city, the other is a private clinic situated about one hour from the capital by train. The hospital receives about 30-50 patients a year while the clinic receives double that number. Permission to carry out the study was also obtained from a third establishment, a different hospital in the same city as the first hospital. This second hospital employs closely comparable procedural stages of hymenoplasty consultation to those of the first hospital. However, the number of patients coming to this second hospital was significantly lower (no more than five a year) during this study's main data collection period. Due both to the low number of patients as well as the similarity of procedures with the first hospital, this paper will only look at the consultations conducted in the first hospital (henceforth: 'the hospital') and in the clinic, apart from one vignette taken from the third establishment. The choice of the vignette from the third establishment is considered necessary to illustrate the situation under discussion.

#### **Data collection**

The findings presented in this paper were collected through fieldwork conducted by the author over the period from 2012-2015 in the Netherlands. The main data derives from in-person observations of 70 hymenoplasty consultations. Since the 1970s, the observation of doctor-patient interaction has been viewed as a productive research method in the social study of medicine (see for example Korsch and Negrete 1972, Pilnick and Dingwall 2011 and Arora 2003), but it is hitherto unprecedented in the case of hymenoplasty due to the sensitive nature of the surgery.

In this study, patients were identified as they arranged their first hymenoplasty appointment, which was commonly done either personally by telephone or through a

referral letter from their huisarts - general practitioners akin to family doctors. During an in-person visit to each establishment and prior to their first meeting with a specialist, women were informed about the study and verbal consent was obtained for the meeting to be observed. Due to the need for high level of confidentiality, a waiver of written informed consent was approved from the ethical review board of Washington University in St. Louis to ensure the patient's real name was not associated with the surgery in any documentation. Observations took place during the gynaecological examination and the surgery once only, and specific agreement had been given by the patient involved. In the first of these observations, I was seated with no direct view of the patient's genitalia but with partial observation of the movements of doctors.

Refusing to participate in the study (11 patients) did not influence the care provided and this was made clear to each patient. Further consent was then obtained for doctor-patient exchanges to be audio recorded (11 instances). In cases where audio recording was not used, extensive note taking took place instead (59 instances). The consultation excerpts and ethnographical vignettes presented in this paper are translated versions of the transcribed audio recordings, or carefully reconstructed exchanges documented in the field notes. The research protocols received clearance from the Institutional Review Board of Washington University in St. Louis as well as from both medical ethics boards of the two studied hospitals.

### **Data analysis**

In the spirit of qualitative study and constant comparative method, a preliminary analysis was performed immediately and cyclically whereby findings were fed back to the data collection effort in order to hone in discoveries and to develop the exploration so as to be closely in line with emerging themes from field research (Glaser 1965, Boeije 2002). Later stages of the study used a grounded theory approach to identify important concepts and key findings as the basis of the overall analysis and its main arguments (Strauss and Corbin 1994). The computer-assisted qualitative data analysis software Atlas.ti was used to support the detailed examination of data (Kelle 2004), whereby codebooks were developed both in vivo and based on commonalities to aid the process of synthesis and the writing of this article specifically.

## **3.5 Findings**

### **The procedural set-up of the consultation**

In the hospital as well as in the clinic, consultations are most of the time headed by one doctor. Both head doctors' philosophies of care were reflected in the hystero-

plasty consultation as performed in the medical establishment they were working in. Dr. Zeeman (a pseudonym) was the head of the hospital's sexology department. In the past decade, Dr. Zeeman, in collaboration with colleagues in two other hospitals, has established a step by step protocol for how hymenoplasty consultations should be conducted. This protocol involves the woman seeking the operation going through three different appointments. The first one is an intake meeting where Dr. Zeeman explores the reason for the request and the background of the patient, which lasts for around 45 minutes. The second visit is a meeting with the gynaecologist. Finally, the patient meets with Dr. Zeeman again for the third visit to inform the doctor of her decision to proceed or not with the surgery.

In contrast, at the clinic the patient often decides after the first visit whether or not she wants to continue with the surgery. Dr. Linden (a pseudonym), the head doctor of the clinic, meets with the patient for about 20 to 30 minutes to ascertain her reason for wanting the operation. This visit often includes Dr. Linden performing a gynaecological examination to determine whether surgery is possible to be done given the condition of the patient's hymen. The office in which Dr. Linden conducts the consultation is adjacent to an examination room, accessible by a connecting door. The physical examination rarely lasts more than five minutes. Afterwards, Dr. Linden and the patient return to the consultation room and the patient can then determine what the best course of action is going forward.

### **A cultural motivation for the operation**

Both Dr. Zeeman and Dr. Linden see the root cause of the patient's 'problem' as one and the same thing. In October 2014, during an informal gathering of practicing sexologists in the Netherlands, held every six months or so to share knowledge and practice, Dr. Linden gave a presentation on her experience with hymenoplasty patients. A significant part of the presentation covered the description of the reasoning behind the patients' desire to have a hymenoplasty. Dr. Linden started the presentation by saying that the presentation touched on the cultural anthropological aspects of the problem. Dr. Linden then continued by detailing the different cultural expectations patients may be subject to that result in them desiring to have the surgery, including having to keep their chastity before marriage.

In a similar line of thought, Dr. Zeeman often remarks to me during our conversations that there are a lot of 'myths' about the hymen and virginity that many patients and people in general still believe in. To Dr. Zeeman, patients are not only lacking in knowledge of the hymen and virginity, they are also often in possession of erroneous beliefs about the subject. Dr. Zeeman attributes this perpetuation of incorrect understanding to the kind of stories people of the patients' background circulate among

themselves: ‘From their own background they are getting all kinds of other information and they don’t believe the “Western” information,’ Dr. Zeeman explained to me in one of our exchanges.

### **Philosophy of the consulting doctors**

As Dr. Zeeman considers that the root cause of hymenoplasty seeking behaviour lies in patients’ misapprehension of issues related to the hymen and virginity, Dr. Zeeman views every consultation as a chance to correct the patient’s cultural misconceptions. The mistaken understandings Dr. Zeeman addresses include, among other things, widely-held beliefs that the condition of the hymen is a conclusive determinant of virginity, that a woman who is still a virgin always bleeds after first sexual penetration and that a hymenoplasty guarantees the presence of blood on the wedding night.

Coming from the position that the surgery is not a medical necessity, even calling it ‘nonsense’ on several occasions, Dr. Zeeman maintains that for the team of doctors in the hospital, success entails having the patient opt out of the procedure. However, Dr. Zeeman always affirms at the beginning of the consultation that if after the meeting the patient still desires the surgery, she will be operated on. What is important is that by the end of the consultation, the patient is in possession of what the doctor considers the ‘medically correct facts’ about the hymen and hymenoplasty. Dr. Zeeman sees a decision made by the patient after they are aware of the ‘correct’ facts and knowledge of virginity and the hymen to be more fully informed than the patient’s initial desires that are mainly driven, according to Dr. Zeeman, by incorrect beliefs.

Dr. Linden at the clinic does not share the same view as Dr. Zeeman about the surgery. While recognising there is no medical need for the surgery, Dr. Linden does not have any specific objection to performing it. In fact, Dr. Linden sees the operation simply as another ‘trick’ to ensuring there is blood on the marital bed sheet; nothing fundamentally different to using a finger prick or a vial of blood. Dr. Linden also reasons that even if the patient gains more information about virginity after the consultation, she may still face difficulties because her future husband may not have the same knowledge. For Dr. Linden, the operation is a practical and immediate solution to the patients’ dilemma concerning virginity.

### **The purpose of question and answer**

The following is a typical exchange observed during Dr. Zeeman’s consultations.

Dr. Zeeman: *“How do people prove that you’re a virgin?”*

Patient: *“I don’t know. That’s why I’m here.”*

Dr. Zeeman: *“Do you have to show the [blood stained] sheet?”*

Patient: *“Maybe.”*

Dr. Zeeman: *“Did you bleed the first time?”*

Patient: *“Yes. A little.”*

Dr. Zeeman: *“How many women do you think do not bleed the first time?”*

Patient: *“A few?”*

Dr. Zeeman: *“A lot more than a few. Only less than half of women actually bleed.”*

Patient: *“Really?”*

Dr. Zeeman: *“How do they solve the problem if they don’t bleed?”*

Patient: *“I don’t know.”*

Dr. Zeeman then explains some of the ways other than surgery that women can ensure a blood-stained sheet.

Throughout this question and answer type of interaction, whenever the patient answers ‘wrongly’, Dr. Zeeman provides her with the ‘right’ reply; this is how Dr. Zeeman ‘corrects’ the mistaken knowledge the patient has about the hymen and virginity. This back and forth between the doctor and the patient resembles that of a teacher and student. As the hospital Dr. Zeeman is working at is a teaching hospital, it is perhaps unsurprising that the consultation also has these pedagogical undertones to it.

Dr. Linden’s consultation is in stark contrast to Dr. Zeeman’s. Dr. Linden frequently remarks that the consultation provided in the clinic is more practical in nature compared to the one in the hospital. This often means that Dr. Linden will meet with the patient to discern what the patient wants to achieve through the operation and tailor the treatment based on that. Dr. Linden’s aim is less about educating the patients and more about finding the best solution for them. In the Netherlands, women who are contemplating hymenoplasty do not all have the same goal in mind. Some hope to bleed at the wedding night, others wish for their husbands to feel that the vaginal opening is ‘tight’. Some need to convince their in-laws of their virginity, while others only need to assure the husband. A few resort to hymenoplasty to find closure on a sexual violation that lies in their past.

Dr. Linden offers different solutions to the patient based on the end goal a particular patient expects to achieve. These solutions do not always mean surgery. For those who need only to convince the husband, Dr. Linden suggests they use a capsule that is infused with a red dye. This pill is inserted into the vagina about half an hour before sex and a red liquid in a colour similar to blood will seep out after. For those who need to convince the in-laws, Dr. Linden will explain that the patient can use a finger prick to produce drops of blood on the sheet or they can resort to taking their own blood and putting it into a vial which can then be spilled during the wedding night.

The following is a typical interaction in Dr. Linden's clinic:

Dr. Linden: *"Okay, so what do you want now? Do you want a statement of virginity? Do you want to bleed? Do you want to feel tight?"*

Patient: *"All three, I think. More tight than blood."*

Dr. Linden then explains to the patient that being tight is caused by the pelvic floor muscles being contracted.

Dr. Linden: *"Are you going to bed with him the first time round in Morocco after marrying in the mosque?"*

Patient: *"Yes."*

Dr. Linden: *"Well, if you want blood, then it's a bit complicated."*

Dr. Linden continues by explaining the two types of operations that can be performed. The first one involves an elaborate technique where the hymen tissue is shaped in a particular manner. The other one, which Dr. Linden calls a temporary operation, is one where surgery is performed in the week of the wedding day in order for the suture to still be fresh. The suture is then pulled apart during vaginal penetration which results in blood.

Patient: *"I probably go there [Morocco] one month before [the wedding]. I don't have to show the sheet."*

Dr. Linden: *"Then I have a good solution for you."*

Dr. Linden then describes the red dye capsule that could be inserted into the vagina.

As is evident here, Dr. Linden takes the cue from the patient. Dr. Linden's interaction with the patient resembles more of a conversation taking place over the phone line between a customer and a technical support provider than between a teacher and student in a classroom.

### **Questions about bleeding after the first penetration**

The most illustrative of the contrast between these two approaches was observable when looking at one question both doctors ask their patients, namely: 'Did you bleed the first time you had sex?'

Dr. Zeeman: *"Do you know how many women bleed on first penetration?"*

Patient: *"I don't know."*

Dr. Zeeman: *"50-60% all around the world. Did you bleed?"*

Patient: *"I didn't bleed."*

Dr. Zeeman: [Facing the patient's sister] *"Did you bleed?"*

Patient's sister: *"I'm still a virgin. I'm not married yet, remember?"*

Dr. Zeeman asks the question as a way to affirm the point that not all women bleed. The information Dr. Zeeman is sharing would have a stronger impact and is

potentially more easily accepted if the statement can be related to the patient's own experience, in this case, not bleeding during first penetration. Hence, this question is asked as another means of educating the patient. Dr. Linden, on the other hand, has a different reason for asking the question:

Dr. Linden: *Did you bleed the first time around?*

Patient: *A little bit... Actually, I saw nothing.*

Dr. Linden: *If the first time there was no blood, it's hard to say that from the surgery you will actually bleed. You may have a flexible hymen.*

Dr. Linden then continued by explaining how using the red dye capsule might also be a good option for the patient.

For Dr. Linden, there is a practical reason for asking that same question. When a patient does not bleed the first time she experiences penetration, Dr. Linden's view is that the chances are that the patient's hymen is flexible in nature. Hence a reshaping of the hymen, the way the more elaborate version of the operation is done, may not increase her chance of bleeding during the first night. This will be communicated to the patient if she leans towards having this type of operation performed. Additionally, by asking this question Dr. Linden has a better idea of what type of solution that might be best to offer to the patient.

### **The aim of the gynecological examination**

Patients' second visit to the hospital which involves an examination by a gynaecologist has both pragmatic and educational purposes. Practically, it is necessary for the physician to have a look at the condition of the patient's hymen to know what can be done if the surgery is to be performed. Pedagogically, the examination is another way to impart more knowledge about the hymen and virginity to the patient. Dr. Zeeman thinks it is important for women to have a first-hand look at their own hymens as this exercise may further demystify patients concerning 'incorrect' beliefs surrounding virginity.

The following exchange illustrates what typically happens during an examination with the gynaecologist. This particular conversation took place at the second hospital which has the same protocol as the hospital where Dr. Zeeman works. There are three people in this conversation, the patient, the gynaecologist, and the head doctor whose role is comparable to Dr. Zeeman's:

Gynaecologist: *"Okay, we will do the examination now. We will see what it looks like down there."*

Head Doctor: *"And you have to see it yourself."*

Patient: [Laugh] *"Noooo, I don't want to see it. I don't want to see anything!"*

[Gynecologist performs examination on the patient]

Patient: *“Can you tell whether I’ll bleed or not?”*

Gynecologist: *“No.”*

Patient: *“I don’t want to see anything.”*

Gynecologist: *“Have you seen it yourself?”*

Patient: *“No.”*

Head Doctor: [Picking up a mirror] *“You have to look into the mirror. If not, you’d see nothing. See how it is closed? That’s your external. And that’s your internal. See how there’s no big hole? See how small it is? There, that folded thing. Do you see that? So small. It is not entirely closed, of course. Now, let’s try to contract your muscle.”*

What doctors hope a patient will see when she inspects her vaginal opening by looking through a mirror are several things. First, they hope to show that the hymen is not completely closed, as some patients imagine the hymen to resemble a wall-like structure. Second, the intention is to reveal that the opening of the hymen is more often than not smaller than the patient may have imagined. However, the most important part of this exercise of looking at your own hymen is accomplished through the dual action of contracting the pelvic muscle and seeing the effect of this at first-hand. Dr. Zeeman indicated to me that women often feel empowered when they witness this. This brings them the confidence that they themselves can make sure that the expectation of virginity put upon them on the wedding night can be met by regulating their own body by contracting the pelvic muscle to tighten the vaginal opening. This confidence may be enough to make the women decide to not to have the surgery; an end result that would be considered a successful outcome by Dr. Zeeman.

When performing the gynaecological examination, Dr. Linden never asks the patient to look into the mirror unless the patient herself asks to do so. The pelvic muscle exercise is also not performed, except when the patient indicates the need. Dr. Linden’s examination is aimed more at finding out what can or needs to be done if an operation is to take place. For example, on one occasion with a patient Dr. Linden explained after the examination that the patient would be better to opt for the temporary and not for the more elaborate surgery due to the absence of clefts on her hymen. On another occasion, a gynaecological examination was not even carried out as a result of Dr. Linden’s assessment of the situation, which the patient agreed to. Since her fiancé was aware that the patient was no longer a virgin and the couple only needed to convince the groom’s family of this by producing a blood-stained bed sheet, there was no need for the surgery and, therefore, there was no need at all for the examination.



### 3.6 Discussion

#### Similar but fundamentally different

The hymenoplasty consultations provided by Dr. Zeeman and Dr. Linden share some similarities. Both doctors impart comparable information to their patients, particularly on what they consider to be medically correct knowledge of the hymen and virginity. Imparting information on the hymen and virginity is also advocated by many scholars (Christianson and Eriksson 2013, Wild et al. 2015, Essen et al. 2010). The two doctors also introduce alternative course of actions to surgery for the patients to consider and resort to if preferred. Both too equally stress that their only desire is to provide the best help, which Dr. Zeeman reasons that it also means explaining to the patients that the operation might not always be the most useful solution. Ultimately, the two doctors emphasise that it is the patient's decision how to proceed.

However, Dr. Linden and Dr. Zeeman acknowledge that their philosophical views of hymenoplasty vastly differ. Dr. Zeeman considers the consultation a success if the patient opts out of surgery, while Dr. Linden sees the operation as just another device to fulfill expectations and has no fundamental objections to performing the procedure. These contrasting philosophies translate into the distinct ways in which consultations are done by each doctor.

For instance, Dr. Zeeman does offer alternatives to surgery - solutions that are similar to Dr. Linden's - to the patients. Yet Dr. Zeeman's explanation of doing so is not prompted by an elaboration of the specific goals each might achieve. Dr. Zeeman's aim by laying out all different alternatives the patients can resort to, is to illustrate that there are other solutions that are as, if not more, viable as surgery. This knowledge may then persuade the patient away from having the operation, a result Dr. Zeeman considers a success. Dr. Zeeman's consultation is pedagogical. The mandatory visits Dr. Zeeman's patients have to go through are arguably comparable to learning modules. It is only after going through them all that a patient is in possession of enough knowledge to make a fully informed decision as to whether or not to go through with the surgery.

On the other hand, Dr. Linden also provides the patients with 'education', for example through imparting information about virginity and the hymen. However, this information is conveyed as a part of the practical solutions Dr. Linden is offering based on the patient's individual situation. As a vignette previously illustrated, Dr. Linden may explain about the role of the pelvic muscle floor because the patient desires 'to be tight'. Similarly, Dr. Linden also explains the different shapes of the hymen and how it is not possible to determine whether or not someone is a virgin just by looking at the hymen in conjunction. Dr. Linden's treatment of patients is in a sense more tailor-made than that of Dr. Zeeman.

In short, both Dr. Zeeman and Dr. Linden provide comparable sets of information to the patients. The approach to the delivery of this information is what differentiates the two. Dr. Zeeman takes a more educational route, presenting the patient with all of the information first before the patient can then make a final decision about what to do. Dr. Linden takes a more pragmatic direction, offering alternative treatments while gradually learning what it is that the patient ultimately wants to achieve. It is important to highlight here that it is not that one doctor's approach is strictly educational while the other is purely practical but, as this paper has demonstrated, there are pedagogical aspects to Dr. Linden's consultation, just as there are pragmatic aspects to Dr. Zeeman approach. However, the philosophy of the consulting doctor, including what they consider is the root cause of the patients' problems and how best to help, determines which of the two becomes prioritised. The differing approaches then translate into a significant difference in outcome in terms of the number of patients who decide to have the surgery. Of all the patients consulting with Dr. Zeeman only around 33% decide to proceed with hymenoplasty while among those who meet with Dr. Linden, almost 60% patients decide to proceed.

### **Addressing the financial gain**

At face value it may not be surprising that the private clinic performs more surgery compared to its public sector counterpart. After all, more operations mean more money and it is only to be expected that private establishments identify profit as one of their priorities. However, it needs to be mentioned that the price of hymenoplasty differs significantly between the two establishments, arguably uncharacteristically, with the private clinic offering a much lower price. The surgery costs around 1500 euros in the public hospital while in the private clinic it is but 150 euros - a mere 10% of the public hospital's cost. This particular private clinic is an exception to the norm as other private providers of hymenoplasty in the Netherlands and in Belgium, for instance, charge a considerably higher price for the procedure ranging from 1500 to 2200 euros.

It has to be acknowledged that despite the low price, performing more surgery does mean more income for the private establishment. However, it has also to be said that Dr. Linden has a significant say in the low price and can set the price of medical services provided in the clinic. Dr. Linden explains that the low price is made possible due to the low rent charges of the consultation room and the fact that all of the facilities and equipment needed for the surgery are available in the clinic, including an operating room that is free of charge to use: 'All I need is for the anaesthetic and some other small stuff and a bit for my time,' Dr. Linden explains. Dr. Linden considers provision of hymenoplasty a form of help to patients. The decision to keep the cost low stems from the same ideal.

### Study Limitations and Future Work

This is a small-scale study involving two medical establishments and two lead consultants. This small number is due to the sensitivity and secrecy of the issue being examined and limited opportunities for ethnographic observation. Conducting similar studies in different medical establishments or different countries will allow a richer understanding and should be aspired to as a future endeavour.

Furthermore, when looking at hymenoplasty as a medical procedure, scholars should recognise that the provision of this service is a productive window through which to look at how social issues such as gender (Christianson and Eriksson 2015, Eich 2010, Wild et al 2015, Awwad 2011, Hegazy and Al-Rukban 2012) and contrasting cultural norms (Webb 1998, Loeber 2015), as well as the concept of ‘othering’ (Christianson and Eriksson 2013, Krumer-Nevo and Sidi 2012), may come into play during medical consultations. These are all topics that are undoubtedly relevant to the study and merit more in-depth exploration in future work.

### 3.7 Conclusion

This study contributes to the growing body of research on doctor-patient interaction (see for example Korsch and Negrete 1972, Esquibel and Borkan 2014, Menchik and Jin 2014, Emanuel and Emanuel 1992, Rubinelli 2013, Hurwicz 1995, Kayser-Jones 1995) especially the growing scholarship on communication between physicians and patients of migrant backgrounds (Dawson, Gifford and Amezcuita 2000, Lechner and Solovova 2014). When it comes to the specific issue of hymenoplasty, this paper extends previous literature highlighting variabilities in the provision of the service (Essen et al. 2010, Juth and Lynoe 2015) and provides insights on how different approaches to consultation lead to contrasting outcomes. Hymenoplasty consultations, revolving around a medical intervention that is controversial and devoid of standardisation, provide opportunities for physicians to steer the direction of the medical process.

More importantly, this contrasting outcome comes within three crucial contexts: (1) the absence of regulation and standardisation of practice, (2) institutional and professional bodies’ tendency to recommend physicians against the provision of the surgery and (3) lack of publicly available knowledge about hymenoplasty, the hymen and virginity. This setting creates almost zero possibilities for patients to compare and contrast different available treatments for them to base their care decisions<sup>1</sup>. It might be therefore high time for medical professionals and scholars alike to aspire to amend

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<sup>1</sup> None of the patients participating in this research indicates that they have visited both medical establishments under study. Views from patients that have done so would undoubtedly be invaluable.

this situation in the hope to provide a more consistent treatment of patient and a better care in general.

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## **CHAPTER IV:**

# RELIGION AND HYMENOPLASTY

### **4.1 Article Title**

“There’s no bleeding in the Qur’an”: Patients’ rhetoric of religion and culture during hymenoplasty consultations in the Netherlands

### **4.2 Abstract**

This paper contributes to the scholarship of medicine and religion, particularly Islam. Among the plethora of studies on the subject, scholars have explored the relevance of belief systems in cases where certain (medical) procedures are requested by patients who mainly come from the same religious denomination. This paper offers a unique insight by looking at hymenoplasty consultations where religion is brought into medical conversations not as a justification to seek the surgery, but rather in the attempt to dissociate religion from the procedure. Coming from the understanding that both they and physicians find the desire for hymenoplasty regrettable, patients actively excuse religion, in this case Islam, from being connected to motivations for the operation. In an effort to distance Islam even further from hymenoplasty, patients create an artificial divide between religion and culture, in which the former is to be defended while the latter is to blame for their need for the surgery.

### 4.3 Introduction

This paper contributes to the scholarship of medicine, healing and religion, focusing in particular on Islam, by looking at how religion is incorporated into and excluded from the narratives of patients contemplating a surgery called hymenoplasty. Hymenoplasty is a medical procedure done to alter the condition of the hymen membrane located in the vaginal canal, typically to minimize the aperture (Karaşahin et.al. 2009, Renganathan, Cartwright and Cardozo 2009, Cook and Dickens 2009). For decades if not a century, studies have looked at how and in what ways religion and medicine interconnect, including, to name a few, how religious beliefs affect health care decisions and treatment choices (Wheeler 2015, West 2014), how religious tenets are used to justify certain health care decisions (Sargent 2006) and the effect of patients' religiosity on the course of treatments they pursue (Alferi et. al. 1999, Parsons et. al. 2006). Research is also abundant on the accommodation of religious beliefs and religious practices as a part of care (Dalemaan and VandeCreek 2000, Mohr and Huguelet 2004) as well as in examining the incorporation of religiosity as an integral aspect of health and wellbeing (Bensley 1991, Waite, Hawks and Gast 1999).

Specifically, when it comes to Islam and medicine, scholars have looked at how Islamic reasoning and principles interact with different medical practices (Tober and Budiani 2015). Biomedical and biotechnological advances open up new ways of looking at and dealing with the body (Foucault 1973) and Islamic jurisprudence responds to these medical innovations. Studies have looked at how Islamic reasoning and ethics are evoked due to the advancements in reproductive technologies—such as gamete donation or in vitro fertilization (Clarke 2013, Inhorn 2006), contraception and contraceptive technology (Sargent 2006), organ donation (Hamdy 2012, Rady and Verheijde 2014), end of life (Sachedina 2005) and stem-cell research (Fadel 2012, Chamsi-Pasha and Albar 2015), to mention a few. Among the plethora of explorations into the intersection between Islam and medicine, there is arguably one realm where studies of religion and bodily practices have often revolved around possible correlational relationships: ritualistic surgery.

The term 'ritualistic surgery' was first coined by Bolande (1969) to refer to procedures that necessitate no clinical intervention but are done to fulfill individual needs, for instance the need of parents in cases such as childhood tonsilectomy or neonatal circumcision. Since then, many scholars have produced prolific studies that explore two particular practices that can be seen to fall under this definition: female and male circumcision (Wallerstein 1983, Grisaru, Lezer and Belmaker 1997). These two practices can be argued to be closely interlinked with religion, as the majority of people who adopt, perform and undergo the procedures are commonly of the same belief—

Judaism for male circumcision, Islam for both male and female circumcision (Sipsma et. al. 2012, Gruenbaum 2001, Glass 1999, Rizvi 1999).

The practice of male circumcision has always been associated with religious tenets, particularly in Islam and Judaism (Wallerstein 1983, Glass 1999). For many of the male followers of Judaism specifically, undergoing circumcision is due to religious covenants and not for health reasons (Glass 1999). In Islam, male circumcision is both a health and a religious issue, particularly as the prophet Muhammad recognizes the practice as a part of the rule of Tahara (cleanliness) (Rizvi 1999). It has to be mentioned that non-religious male circumcision is also done, most notably in the U.S., where health-motivated circumcision is practiced routinely (Introcaso et, al. 2013, Wallerstein 1983, Gollaher 1994).

Female circumcision (or what is also known as female genital cutting (FGC)) has been extensively studied in the context of its linkages to Islamic tenets. Scholars have noted how religious figures and authorities have often dismissed the correlation; stating the practice, particularly the pharaonic type, is more of a social construct rather than one that is sanctioned by Islam (Rizvi 1999, Gruenbaum 1991). This claim is made in part due to the lack of justification of the practice in the Islamic holy text, the Qur'an, even though a less severe form of the cutting, called sunnah circumcision, was acknowledged by the prophet Muhammad (Gruenbaum 2001, Johnsdotter 2002). Despite this, people who practice the ritual often make connections between their belief and the circumcision, particularly as both are considered to be interconnected parts of their identity and also because they consider Islam to permeate every facet of life (Johnson 2000, Gruenbaum 2001).

As has been argued by Logmans et. al. (1998), hymenoplasty can be seen as a ritualistic surgery, particularly because it is perceived medically unnecessary by scholars and medical professionals alike (Raveenthiran 2009, Cook and Dickens 2009, van Moorst et. al. 2012). In recent years, hymenoplasty is increasing in demand in places such as the U.S., Canada, various European countries, the Middle East and China (van Moorst et. al. 2012, Amy 2008, Steinmüller and Tan 2015). Hymenoplasty is often requested by women who consider themselves to be no longer a virgin and typically hope to show otherwise to their husbands, family and/or in-laws by the presence of blood after the first marital intimacy (Logmans et. al. 1998, Wild et. al. 2015, Ayuandini 2017a). In the Netherlands, women who request the surgery tend to come from a Dutch migrant background with ancestral links to countries such as Morocco, Turkey, Afghanistan and Iraq (Ayuandini 2017b). Data from this study shows that 80% of these women self-identify as Muslims.

This paper explores a unique case of hymenoplasty consultations, where religion is brought into medical conversations not as a justification to seek the procedure,

but rather in the attempt to dissociate religion from the treatment. Coming from the understanding, shared by them and the physicians alike, that the desire for the surgery is regrettable, patients actively excuse religion, in this case Islam, from being connected to the motivation for the operation. In the effort to distance Islam even further from hymenoplasty, patients create an artificial divide between religion and culture in which the former is to be defended while the latter is to blame for their need for hymenoplasty.

### **Islamic Jurisprudence on Hymenoplasty**

In exploring hymenoplasty patients' rhetoric of Islam, this article does not intend to provide a comprehensive overview of Islamic jurisprudence on hymenoplasty. However, it is useful to mention a few references to contextualize this paper's findings. For a more extensive elaboration on the topic, see Eich (2010), Rispler-Chaim (2007) or Wynn (2016), in which all will be referred to in this section. I will divide the brief summary based on three major sources of Islamic jurisprudence: (1) the Qur'an—the holy book of Islam with verses containing the words of God, (2) the hadith—the documented spoken words of the prophet Muhammad, and (3) the fatawa—the plural of fatwa, a religious ruling issued by religious scholars and authorities who possess comprehensive understanding of Islamic jurisprudence. For each, I will look at how they address hymenoplasty, bleeding after the first penile to vaginal penetration—arguably the most common outcome expected to be achieved through the surgery—as well as the notion of virgin and virginity.

There is no specific reference to hymenoplasty or to bleeding in the Qur'an. In contrast, the Qur'an is very precise in its sanction of virginity—or more specifically 'chastity', particularly before marriage as sexual relationships are confined to the marital realm. This reference is made both in Q 4:25 and Q 5:5 where intercourses outside of the marital bond are pronounced to be unlawful (Rahman 1998). Apart from addressing virginity, there is also some mention of the word virgin in the Qur'an. The word appears in Q 56:23 and then again in Q 66:5 (Rispler-Chaim 2007). In both, virgins are promised as companions to male believers; in paradise for Q 56:23 and when remarrying after a divorce in Q 66:5.

Comparably, the word virgin is referred to in a number of hadiths, ranging from how specifically a virgin can give her consent to a proposal of marriage to the advantages of marrying a virgin. Sahih Bukhari (volume 7, book 62, number 16, 17, 172 and 174) recorded the Prophet encouraging Jabir bin Abdullah to choose a virgin over a non-virgin to marry (Rispler-Chaim 2007). Both Sahih Muslim (book 008, number 3445) and Sahih Bukhari (volume 7, book 62, number 140 and 141) write of a hadith where a husband was advised to spend seven nights with a newly wedded virgin wife while

only three with a newly wedded non-virgin wife (Rispler-Chaim 2007). However, there seems to be an absence of hadiths that specifically indicate any means resembling a procedure of restoring the hymen. There is also an absence of reference to bleeding after the first sexual penetration or if blood could be used as the sign of virginity.

Therefore, when it comes to hymenoplasty, fatawa are where religious rulings are more tailored to attend to specific matters. A fatwa is often sought when the Qur'an and the hadiths are considered to be unclear on a certain subject and therefore, fatawa tend to be more specific in focus. Concerning hymenoplasty, Islamic leading scholars have been polarized in their judgement. Sheikh Muhammad Sayyid Tantawi, a grand mufti (interpreter of Islamic jurisprudence) of Egypt from 1986 to 1996, was known to be sympathetic to hymenoplasty, particularly for rape victims, as the surgery can be seen as a protection (sahr) for her (Rispler-Chaim 2007). In contrast, in 2002 a Saudi mufti, Sheikh Muhammad Saleh Al-Munajjid, published online his ruling against hymenoplasty, declaring it as a route to deceit as it can open the possibility for women to commit zina (unlawful sexual relationship outside of marriage) (Wynn 2016).

Five years later, in 2007, an Egyptian Grand Mufti, Ali Guma, issued a favorable fatwa on hymenoplasty during one of his television appearances (Eich 2010). His ruling was made in response to a statement by Suad Salih, a former dean of Al-Azhar University, declaring that the operation should be allowed specifically in cases of rape or those involving repentant women. Guma agreed with Salih and extended his ruling to allow a wife to lie about her pre-marital sexual experience to her husband in order to save their marriage. Conversely, to provide yet another contrasting opinion of the surgery, a prominent Jordanian Muslim scholar, Hamdi Murad, in an interview in 2009, issued a fatwa that rejected hymenoplasty on the basis of deceit and stated that marital life that started with the surgery could be deemed corrupt (Mahadeen 2013).

Therefore, in short, hymenoplasty is not explicitly addressed in the Qur'an nor the hadiths while the fatawa issued by Islamic scholars and authorities have been varying in their sanction of the operation.

#### 4.4 Methodology

Findings presented in this paper were collected through fieldwork conducted from 2012 to 2015 in the Netherlands. Data were elicited by means of participant observations of 70 hymenoplasty consultations, mainly in two medical establishments with one observation done in a third. The first establishment under study is a public hospital in one of the major cities in the Netherlands while the second is a private clinic situated about an hour train ride from the capital. Ethnographic access to

hymenoplasty, not only on this scale but even at all, is unprecedented due to the sensitive nature of the surgery where confidentiality and secrecy are the utmost concern of doctors, patients and anthropologists.

Being fully aware of this priority, the consent process was made deliberately in layered fashion where permissions were sought separately for observations, audio recording and one-on-one follow up conversations between the ethnographer and the patient. All patients were able to drop out of the study at any point and many chose to participate only in one stage but not others, e.g. they were willing for their conversations with the doctors to be observed but not to have a one-on-one interview with the ethnographer. Consent for the observation was obtained prior to the patients' first meeting with the doctors and it was conducted in-person at the medical establishments. It was made clear to the patients that refusal of participation in the study would not affect treatment. A separate consent was then obtained to audio record the consultations and whenever patients refused, extensive note taking took place. Excerpts and vignettes presented in this paper are transcriptions of the recordings and carefully reconstructed accounts from field notes, both translated from Dutch to English.

Observations of exchanges between doctors and patients were supplemented by one-on-one follow up conversations with the patients whenever a separate consent was obtained. Due to the set-up of the consultations, this follow-up was only able to be done in the public hospital where 1 out of 3 patients were interviewed. In addition, more than a dozen hymenoplasty providers, including general practitioners, sexologists and gynecologist were also interviewed separately. Around half of these physicians worked at the two studied establishments.

Analysis was done cyclically and on-going, in parallel with the conduct of the ethnography where immediate findings and discoveries were used to inform further explorations and exchanges with participants of the study. Later stages of research were mindful of the emergence of key findings and specificities, which then served as an initial foundation for final analysis. The qualitative data analysis (QDA) software Atlas.ti was used when necessary to support a more thorough examination of the findings. Findings, quotes and themes encountered during data gathering, instead of codes that were determined a priori, were then used as the basis for developing a codebook which ultimately informed data synthesis and this article's arguments.

## 4.5 Findings

### No Mention of Bleeding in the Qur'an

Any hymenoplasty consultation observed for this study always began with the doctor soliciting patients' reasons and motivations for seeking the operation. Throughout their experience, doctors in the Netherlands learned that each patient aspired to achieve specific goals when contemplating the surgery and these goals varied from one woman to the next. Most patients desired to bleed, usually during the wedding night with a newly wedded husband. Others wished for their vaginal opening to be tighter—inspired by their understanding that a sexually untouched woman experienced unease of access during her first coitus. Still some patients sought the operation as a means of closure from a troublesome traumatic past, typically from sexual violations. What the patients aimed to accomplish through the surgery was unavoidably linked to their past. Hence, Dutch doctors considered it important to listen to the narrative of their patients' motivations and the background of their requests.

When explaining to the physicians their reasoning for the operation, patients at times brought forth religion as a part of their explanations. In this case, most of the time the patients talked about Islam, as the majority of the patients in this study were Muslims. The following was a narrative involving Najat, a Dutch Moroccan woman. Her story was representative of how Islam entered the conversation in a hymenoplasty consultation.

Najat: *“My mom told me I have to bleed. My sister in law bled a little. My cousin didn't bleed but that's fine because her husband can feel [that she was a virgin]. This is all because of culture. There's nothing [about bleeding] in the Qur'an. Only that you need to be modest (bescheiden).”*

From Najat's account above, it was quite clear that her ultimate aim was to bleed after the first sexual penetration with her new husband. Based on patients' admissions in this study, bleeding was indeed the most common goal of undergoing hymenoplasty. In this context, Najat then brought her religion into her conversation with the doctor by referring to the Qur'an specifically. She stated how the holy book did not mention bleeding during the wedding night.

The physicians also knew well that there was no mention in the Qur'an about bleeding or about requirements for women to bleed after first sexual penetration. This information was even often offered by doctors to patients upon learning that the patient is a Muslim—either by the attire she was wearing or through her volunteered admission. The following conversation involving Oumaima, also a young Dutch Moroccan, was a typical way the doctor introduced the information.

Doctor: *“There’s nowhere in the Qur’an that says women should bleed.”*

Oumaima: *“Yes, correct.”*

Doctor: *“Double standard.”*

Oumaima: *“Exactly.”*

Dutch physicians who were involved in the provision of hymenoplasty were well aware that in the majority of cases, patients who met with them to consider the operation came from an Islamic background. All doctors I talked to confirmed that around 4 out of 5 patients they consulted for the surgery self-identified as followers of Islam in one way or another. Therefore, it was not surprising that the doctors explored a possible connection between the desire for the operation and the patient’s religious belief.

However, most doctors maintained that they did not consider patients’ religion as the main rationale for the surgery. Very sure they were of this view that they often did not actively seek to find out what their patient’s religious belief was when it was not immediately apparent—usually through the patient’s attire—or when the patient did not volunteer this information. This is particularly noteworthy since, as has been mentioned previously, Dutch doctors considered learning the background of the patient to be an integral aspect of their consultation. For this study alone, out of 70 consultations observed, roughly 10% of the time when the attire of the patients did not immediately reveal their religious identity and/or when the patients did not provide a volunteered admission of their faith, I was the one who posed the question to the patient. This was in some contrast with doctors’ solicitation of patients’ ancestral lineage as there was only one occasion when the doctor did not clarify the patient’s ethnic descent. Dutch doctors seemed to be quite comfortable in leaving religion, in this case usually Islam, out of their initial conversation with the patient.

Dutch physicians in this study clarified that based on their understandings there was an absence of reference to bleeding in the Qur’an. This understanding further confirmed their view that religion might not be a relevant motivation for seeking hymenoplasty. This was partly the reason why they then communicated their understanding of the Qur’an to the patient upon learning the patient was a Muslim.

If we go back to the vignette showing the doctor volunteering knowledge of the absence of bleeding in the Koran, we see that the patient readily agreed with the physician’s statement. The patient’s response in this case was typical. Patients were always in agreement with the doctors when information about the absence of a reference to bleeding in the Qur’an was presented to them. But what is important to note here is that the way the doctor made this statement, instead of only providing information or a way of confirmation, can also be seen to insinuate an irony: if there is no religious requirement to bleed, then why aim to do so? This unspoken paradox was not lost on the patients. Consequently, patients often offered an ‘alternative’ explanation as to



why they desired to bleed during the wedding night even if there was no agreed upon religious tenet about it. The following was a conversation between Zohra, a Dutch Muslim woman of Moroccan background, and the doctor.

*Zohra: “Yes, my fiancé, I have talked to him about this subject. Yeah, he thinks it is not nice if a girl has made a mistake in her life. Well, I think it’s nonsense because in our belief for men it [sex before marriage] is also not a good thing. But virginity of men cannot be checked/examined (gecontroleerd). He wanted that he is the first for the woman. That’s crooked (krom) but our culture is like that. (with urgency) Belief is not. Belief is fine/perfect (prima). What I mean is that you are similarly assessed.”*

*Doctor: “In the Qur’an, there is no mention of it [bleeding].”*

*Zohra: “Yes, exactly, but in our culture it’s shitty (laugh) if I can say so.”*

As can be seen in Zohra’s response, which represents many other similar replies from patients, ‘culture’ was the alternative ‘explanation’ patients often offered to doctors for their presence in a hymenoplasty consultation room.

### **Blame it on Culture**

What that word ‘culture’ actually referred to varied from one patient to the next. On occasions, it signified habits of life, customs and rituals, social norms and expectations of a group of people sharing a common ancestry. However, it could also narrowly indicate what different notions, of sexuality in particular, the closest people to the patient—her family, her fiancé and in laws—were used to. It might be useful at this point to also visit what the word ‘religion’ referred to according to the patients. ‘Religion’ seemed to also encompass a different array of meanings, including that of divinity and sacred tenets. Although arguably, patients mostly used the word—as well as its particularities such as Islam, Christianity, etc.—as a ‘catch-all’ phrase to refer to a particular system of belief. From now on, the word ‘religion’ and ‘culture’ will be written within a single quotation mark, signifying that the article is referring to the words patients, and other people in the study, employed. However, I argue that what specifically each of the words fundamentally means is less important than how they seem to be utilized by the patients in hymenoplasty consultations: in juxtaposition to one another.

Zohra’s exchange with the doctor clearly illustrated this. When explaining what was required of her during the first sexual penetration she quickly clarified that the expectation was culturally informed and had a nonreligious basis. Her explanation also highlighted what she understood to be Islam’s position on the matter: both men and women are required to be virgins before marriage. This understanding of Islamic tenets was often brought up by patients when the topic of religion entered the con-

versation. “In Islam, both girl and boy should not have sex before the marriage,” explained Deeba similarly to me when I talked to her after her visit to the doctor.

The statement signified further irony in the patients’ desire for hymenoplasty. Patients explained that Islam, as they claimed to be stated in the Qur’an, does require both men and women to keep their chastity before marriage but it is ‘culture’ and cultural demands that lead to only women being expected to ‘prove’ their virginity during the wedding night. This in turn resulted in women not unlike them turning to hymenoplasty to fulfill the expectation.

This differentiation is crucial. Patients regularly expressed their discontent that there exists an expectation of women to bleed during the wedding night. Consequently, as it is important to clarify here, despite seeking the operation, patients regretted their situation of having to contemplate undergoing hymenoplasty. In fact, almost all considered it unfortunate that they had to resort to such action. Amina, a Dutch Moroccan woman, repeatedly told me that she really did not want to get the surgery but she felt she had to. “I have no desire for the operation, but it is needed.”

Many patients saw the demand to ‘prove’ their virginity to be unfair and unbalanced as, similarly to how Zohra expressed it, they considered there was no available way for men to be ‘checked’ of their virginity. As a result—and granted because of other possible social factors not extensively explored in this paper—within the patients’ social circle, it is more acceptable for men to be non-virgins before marriage and they experience little to no social consequences of that situation<sup>2</sup>. Many of the patients were of the conviction that almost all men they knew were no longer virgins before marriage. The following conversation is a good example of this. It was the continuation of the exchange between Najat and the doctor presented before.

Doctor:            *“Do you think these men [who want to marry a virgin] are virgins?”*

Najat:             *“No (laugh) 100% sure that they’re not. Only very few are virgins.”*

Doctor:            *“But why do they want to marry a virgin then?”*

Najat:             *“Yes, that’s culture for you.”*

It is evident from Najat’s remarks that unflinching, when talking about the requirement of virginity, patients alluded to how ‘religion’ and ‘culture’ seem to demand different sets of expectations on women and men. ‘Religion’ equally requires both to keep their chastity before marriage while ‘culture’ only necessitates women to do so. At the very least, ‘culture’ demands women to demonstrate that they are virgins by the time of marriage.

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<sup>2</sup> Scholars have recognized that the provision of hymenoplasty is a productive window to look at the issue gender and gender equality (Christianson and Eriksson 2015, Eich 2010, Wild et. al. 2015, Awwad 2011, Hegazy and Al-Rukban 2012). This is a topic that is undoubtedly relevant to the study and merits a more thorough and in-depth examination which lends it at the present to be beyond the scope of this paper and opens a path for future explorations and analysis.

### **Performing Virginity**

The specificity of expectations highlights what patients ultimately regretted out of their quest for getting the operation: they lamented the requirement to bleed during the wedding night for women. I argue that bleeding is different than just being a virgin. Bleeding is about ‘showcasing’ that virginity. Hymenoplasty patients seemed to understand that they were expected to put on a ‘show’. Amina, providing me with her own way of contrasting ‘religion’ and ‘culture’, stated, “In Moroccan culture you have to show you’re a virgin but not in Islam. In culture you have to show blood but not in Islam.” Amina’s remark reminds us of Goffman’s idea of performance where an individual creates a certain impression of him/herself through the enactment of actions (1978). In this case, virginity is performed through the act of bleeding after the first penetration. This bleeding—what I would call ‘performative virginity’—was what was seen as problematic and regrettable by many patients.

Dutch physicians equally considered the expectation to bleed put upon their patients to be undesirable. This was mainly because they considered bleeding because of the first penetration to be unsupported by scientific findings. Blood loss after the first coitus has been argued and shown by scholars and medical professionals to not always occur (Raveenthiran 2009, Hegazy and Al-Rukban 2012, Christianson and Eriksson 2013). Some doctors also perceived the demand to be largely condemnable therefore it was best if the requirement was no longer imposed on women. This sheds light onto why doctors seemed to be at ease with bringing up the absence of the requirement to bleed in the Qur’an as this clearly distanced ‘religion’ from a problematic custom. Relatedly, Dutch physicians never actively inquired whether or not Islam sanctions pre-marital explorations of sexuality. This again emphasizes the differences between the performance of virginity, which is a practice and deemed regrettable equally by hymenoplasty patients and physicians, and the requirement of being a virgin, which can be seen as an ideal.

### **Valuing Virginity, Seeing the Loss as a Mistake**

However, patients often insinuated that they did not regret that ‘religion’—in this case, Islam specifically—requires virginity before marriage for both women and men. In fact, some aspired to this principle, believing staying a virgin before marriage was an important religious value to uphold. Jasmina, a Dutch Moroccan patient, explained to me, “[...] I have my religion so that’s why I want to be a virgin before marriage.”

Patients therefore recognized that a demand put upon them to stay virgin before marriage does have roots in religious conviction. Time and again, some patients did attribute their fiancé’s desire to marry a virgin to stem from an aspiration to fulfill the religious ideal of virginity before marriage. This remains relevant even if the fiancé

himself was no longer virgin but particularly true in cases where the future husband has maintained his chastity. This was the situation for Rachida, a Moroccan Dutch woman who was marrying her virgin boyfriend. Rachida's boyfriend highly desired to marry a virgin.

Doctor: *"Why is it important to him that you're a virgin?"*

Rachida: *"More because of religiosity. But also because of his expectation."*

Rachida's story was echoed by other patients who were marrying a fiancé who has kept his virginity before marriage; stating that their future husbands considered chastity to be important due to their religious conviction.

As many patients considered religious demands for virginity before marriage to be good, or at the very least acceptable, keeping one's chastity was seen as a virtue and failure to do so was perceived as not ideal, even portrayed in a negative light. Consequently, many patients evaluated the sexual intimacy that led them to lose their virginity to be a regrettable mistake. One example of this concerned a Latifa, a Dutch woman of Middle Eastern ancestry who came in for a consultation accompanied by her boyfriend, Faisal. The couple wanted to marry yet neither of their families agreed with their union. Faisal stated that he wanted Latifa to be able to marry well and in this case that meant her being able to bleed during the wedding night. When asked by the doctor whether they had had sex with one another, Faisal answered, "Yeah, the first time was a mistake. But that was only one time." Hearing that, the doctor ventured further, "Whose fault was it? Yours or hers?" To which he responded, "Both". This kind of admission was not uncommon. Oumaima, for instance, said, "In the Qur'an, Islam says no to sexual relationship before marriage. I am Islamic, I understand most but not all. I understand that it was a mistake. But I didn't do it with anyone else. And I was 18 at that time. When you're in love you say nothing."

### **Psychological Need for Hymenoplasty: Not to Purge One's Sin**

However, framing the loss of one's virginity before marriage as 'a mistake', or even sinful as some patients also sometimes insinuated, does not necessarily mean that the act to seek the operation was seen by patients as an effort to rectify the error. Patients in this study almost exclusively had come to terms with the understanding that their virginity was already 'lost'. In the words of Amina: "I can't go back to being a virgin again." When patients met with the doctor to consult on the operation, their aim was not to reclaim purity—they were not in a quest to restore their virginity in a normative sense. As has been mentioned earlier, patients' goals in getting the operation were much more practical: they aimed to bleed or to be felt as 'tight'. Patients sought hymenoplasty in the hope to sufficiently appear to be virgin during the wedding night; they aimed to successfully 'perform' virginity physically.

Nevertheless, some patients have also alluded to a psychological goal to undergoing the surgery. Particularly for those who lost their virginity as a result of a non-consensual act, they told the doctor hymenoplasty provided them with the closure they needed to move on. Farrah, a Dutch Middle Eastern woman, was violated in her country of birth when she was in her teens before she moved to the Netherlands. Farrah was in her 30's when she met with the doctors. She was not able to even contemplate getting married in the past because she was traumatized by what happened to her, even though she wanted to find a husband. After more than ten years dealing with her trauma, she felt she was finally ready and she saw hymenoplasty as her gateway to a better life. "Back then I was very afraid. Now (almost shouting) I'm afraid. But back then, I wasn't... I wasn't normal. I could not see. But now, I will try. Maybe, everything will be fine. I want to go forward. Everything in the past will be forgotten," explained Farrah to me in her halting Dutch, stressing the importance of the operation as the beginning of her effort to realize the life she always wanted.

For others whose experience of virginity loss was not as traumatizing as Farrah's, hymenoplasty sometimes still also served as a psychological help, particularly in providing them with mental assurance. Many patients expressed that they were willing to go under the knife to feel that they had at least tried everything they could think of to make sure that their wedding night would happen without a glitch. Deeba stressed to me that that was exactly her reason for getting the operation.

Author: *"But the doctor said even if they did the surgery, there might not be blood."*

Deeba: *"Yeah, I know. I've been thinking about that. A lot. But I don't want to say later, I wish I had done it. I wish I had done it. Maybe it would have helped. I wanted to do everything that can help me. I don't want to say later, I wish."*

Hymenoplasty patients in this study ultimately desired to avoid possible unintended outcomes that might happen from being considered a non-virgin by the time of marriage. These consequences range from immediate divorce to experiencing physical violence (Ayuandini 2017a). Laila, a South Asian Dutch woman, even repeatedly said, calmly as though stating a fact, that her family would not hesitate to end her life given the worst case scenario.

In light of these possible social and physical repercussions, patients considered hymenoplasty as another step that needed to be taken to feel a little bit surer that they would not have to experience unwanted consequences. Ultimately what patients were looking to gain through the surgery was what they called the feeling of rustig or calmness, akin to having peace of mind. Dutch doctors readily recognized this specific need of their patients. As Dutch physicians tended to be of the mind that there existed

no biological need for the hymen—hence ‘restoring’ it presented no medical necessity—they acknowledged that the surgery might serve to fulfill something more psychological than physical for some patients. “It is the surgery of the mind,” remarked one of the doctors to me. Hence, there existed a psychological aspect to hymenoplasty where patients underwent the surgery to achieve ‘peace of mind’. However, that ‘peace of mind’ was not achieved because hymenoplasty made one ‘pure’ again or helped one purged a sin or corrected a mistake. Rather, the surgery allowed psychological relief by providing patients with mental assurance that they had done all they could to achieve a successful wedding night or, in the case of patients with sexual trauma, by offering them a way to gain closure.

Either aiming for a physical goal or a psychological one or both, hymenoplasty patients in this study framed their desire for the procedure and for the result of the surgery as culturally informed. Normative understanding of these goals, which could arguably be linked closer to religious tenets and religious beliefs were excluded by the patients from their rhetoric. As evident from the previous sections, religious connection to the desire for hymenoplasty was even vehemently denied by the patients; a sentiment that was, to an extent, also echoed by the physicians consulting them.

#### 4.6 Discussion—Defending Religion

It has to be acknowledged that patients’ understanding of what could be constituted to fall under the realm of ‘religion’ and what could be seen to be strictly culturally informed was not always clear. It was not unheard of that patients considered the reason why they were sitting in the consultation room was also somewhat motivated by religious convictions. This was mostly because being a virgin—which was seen as undoubtedly required by ‘religion’—and producing blood during the wedding night—were considered to be almost inseparable for many patients. One constituted the other although ‘showing’ that one bled was more readily understood as separate from simply being a virgin.

Some patients also recognized that ‘culture’ and ‘religion’ equally permeated ways of life and often the two became so intertwined that it was not possible to separate them easily. Social expectations put on them, such as bleeding during the wedding night, sometimes were also attributed by patients to both ‘religion’ and ‘culture’. Hence, it was not surprising that patients themselves considered being a Muslim an important predictor for getting the operation. An older sister of a patient once asked me a question whether I have met patients from various background contemplating the operation. Upon hearing my explanation that I have also met patients of Chris-

tian upbringing, she exclaimed in surprise, “What? I thought this is only for Muslims!” To that remark, her sister, the patient, quickly responded, “No, there’s no mention in the Qur’an about bleeding. It’s about culture.”

Ellen Gruenbaum in her book *The Female Circumcision Controversy* remarks that the strongest argument against female circumcision in Islam is the fact that there is no reference to the procedure in the Qur’an (2001)<sup>3</sup>. Similarly, as can be seen time and time again from different hymenoplasty patients’ remarks, the fact that the Qur’an does not denote any requirement of bleeding during the wedding night is an important reason for patients, and doctors alike, to distance Islam from hymenoplasty.

But why were patients so inclined to make sure that Islam was not linked to their contemplation of hymenoplasty? Previous sections have shown that the act of getting the operation was seen to be regrettable by the patients. Patients lamented the existence of a requirement for them to bleed during the wedding night. They considered this expectation ‘weird’ or ‘crooked’ or even ‘wrong’. Hence, their action of getting the operation as a result of this ‘obligation’ was also self-assessed as unfortunate. This unfavorable light put on hymenoplasty did not deter those who felt they really needed the operation to be done. It did, however, compel them to clarify and make sure that their belief, which in this case most likely Islam, was not thrust under the same light.

What is important to point out here is that patients’ compulsion to ‘defend religion’ can also be seen from their understanding, as evident in the remark made by an older sister of a patient presented above, that Islam is a good predictor for a woman getting hymenoplasty. They also assumed that others might then ‘blame’ Islam for the desire to undergo the operation. This explains their apparent need to provide a different explanation when the doctors, for instance, pointed out that the Qur’an does not sanction bleeding. Not only could this statement by the doctor be interpreted as highlighting an irony, it could also be seen as trying to assign blame. As a result, patients then offered a different ‘culprit’ upon which the blame can be cast: ‘culture’.

## 4.7 Conclusion

In exploring the existence of juxtaposition between ‘religion’ and ‘culture’ in the rhetoric of hymenoplasty patients in the Netherlands, this paper does not seek to define what each of the terms really refers to nor how the two fundamentally differ. In lived experience, the two are very much intertwined and co-influencing and an attempt to separate them would not be productive. Even the founding fathers and

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<sup>3</sup> Although there are some known hadiths where the prophet Muhammad advises for female circumcision in a less severe form (Gruenbaum 2001).

mothers of anthropology, sociology and other social sciences have indeed often acknowledged how religion and culture are very much interwoven (see for example Tylor 1871, Malinowski 1948, Durkheim 1912, Geertz 1973, Douglas 1966). However, hymenoplasty patients in this study did aim for this division to be observed, motivated equally by being self-compelled to provide explanation of their situated irony—wanting an operation they regretted they had to undergo—and by their desire to distance ‘religion’ from any cause that might shed it under a negative light. The patients’ effort might result in an artificial divide but their narratives did actively aim to separate ‘religion’ from ‘culture’ by venerating the former and denigrating the latter.

The aspired division between ‘religion’ and ‘culture’ remarked by patients inadvertently was linked to another important separation. We observed how patients aspired for chastity before marriage and judged themselves for making ‘a mistake’ of experiencing pre-marital sexual encounters. But they also condemned the existence of expectations of showcasing sexual purity through the presence of blood on the marital bed sheet. Here, we see another divide being communicated, one that is of normative and performative virginity. The former, signifying fulfilling the requirement of chastity before marriage, was desired by patients but, based on their own admission, has become unattainable. The latter, involving bleeding during the wedding night, was the patients hope to successfully accomplish by undergoing the operation.

Arguments can also be made that there exists a third separation in the case of psychological goals patients aim to achieve. Psychologically, patients desired ‘peace of mind’ (rustig) through undergoing the operation. This state of a rustig mind was seen to be achieved by feeling assured that one has taken all steps that could be taken to guarantee a successful wedding night. For those with sexual trauma, ‘peace of mind’ could be gained from hymenoplasty as it provided closure to a devastating past. Despite framing being a non-virgin before marriage as a mistake that violated religious expectations, patients in this study did not aspire to achieve ‘peace of mind’ because the surgery allowed them to feel that they have purged a sin. Again, we see here a possible religious link to the surgery being excluded through patients’ rhetoric of desired psychological goals.

Hymenoplasty patients’ quest for an operation they deemed to be necessary but regrettable created an urge to justify their surgical choice while making sure things they valued were not linked to the decision. As a result, an arguably artificial divide was created by the patients between ‘religion’ and ‘culture’; this divide in turn led to the emergence of separations between normative virginity and performative virginity and between the motives of purging sins and finding closure.



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**CHAPTER V:**

DEMEDICALIZATION  
OF THE ‘BROKEN’ HYMEN

**5.1 Article Title**

Finger Pricks and Blood Vials: How doctors medicalize ‘cultural’ solutions to demedicalize the ‘broken’ hymen in the Netherlands

**5.2 Abstract**

This paper provides new perspectives on the scholarship on medicalization and demedicalization, building on an ethnography of hymenoplasty consultations in the Netherlands. By looking at how doctors can play an active role in demedicalization, this paper presents novel insights into Dutch physicians’ attempt to demedicalize the ‘broken’ hymen. In their consultations, Dutch doctors persuade hymenoplasty patients to abandon the assumed medical definition of the ‘broken’ hymen and offer nonmedical solutions to patients’ problems. Drawing from unique ethnographical access from 2012 to 2015 to 70 hymenoplasty consultations in the Netherlands, this paper’s original contribution comes from closely examining how demedicalization can be achieved through the process of medicalization. It investigates how Dutch physicians go even further in their efforts to demedicalize by medicalizing ‘cultural’ solutions as an alternative course of action to surgery.

### 5.3 Introduction

This paper contributes to the scholarship of medicalization-demmedicalization by looking at how demmedicalization is attempted by Dutch doctors through, ironically, the process of medicalization. In the effort to demmedicalize a condition that this paper refers to as the ‘broken’ hymen, Dutch physicians negate the assumed medical definition of the condition and prescribe nonmedical treatments for patients’ problems. Literature on demmedicalization and physicians’ roles has largely focused on how doctors limit participation in addressing problems they consider needing actions outside of medical attention (Kurz 1987, Sulzer 2015, Haines 1989). The case of hymenoplasty consultations in the Netherlands provides a contrast to this norm, insofar as doctors decide to be actively involved in demmedicalization.

This paper is not intended to be evaluative nor normative. Critical analysis of the conduct of doctors are meant to advance scholarship on medicalization/demmedicalization and on hymenoplasty. The most important contribution of this paper comes from examining Dutch doctors’ idiosyncratic practice of appropriating ‘cultural’ solutions when they make medical recommendations. They even go further by devising their own culturally informed medical treatments. The case allows insights into two important lines of inquiry: (1) What distinguishes practices physicians are comfortable medicalizing from those they prefer to keep outside of the medical realm? (2) How do the geographical context and the localized normative understandings of certain practices play a role in physicians’ attempt to medicalize/demmedicalize?

#### Medicalization and Demmedicalization

The term medicalization was first framed by Irving Zola (1972) to further the theorizations of medical authority’s expansion into problems existing outside of strict medical realms. More recently, Peter Conrad formulated one of the more widely accepted definitions of medicalization as a process that encompasses “defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it. [Medicalization] is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession” (1992: 211). Scholars traced the beginnings of medicalization to the late 1800s, where behaviors and attitudes that were previously conceived as sinful gradually became reinterpreted as criminal and later medical (Fox 1977).

The steady rise of medicalization since then has become attributed to various larger systems such as “medical imperialism”, social control and scientific revolution

(Illich 1976, Zola 1972, Golden 1999, Freidson 1988). Psychiatry was one of the first realms where medicalization was observed and criticized (Szasz 1963). Ever since then, medicalization has become an illustrious focus of exploration in sociology and anthropology where scholars study and examine topics such as, to name a few, childbirth (Davis-Floyd 2009, Jordan 1997), alcoholism (Schneider 1978), gambling addiction (Rosecrance 1985), sleeping disorder (Williams 2002), shyness (Scott 2006) and ADHD (Malacrida 2004). Clarke (2010) argues that the latest reincarnation of medicalization is biomedicalization, resulting from the pervasiveness of science and technology in everyday (post)modern life.

Some scholars have also explored the limit and resistance to medicalization. Strong (1979) argues for the existence of factors constraining the power of medicine and medicalization. Studies have also examined resistance to medicalization in the form of non-compliance, for example, in the case of homelessness (Lyon-Callo 2000). It is also found in the promotion of an alternative discourse to medicine, for example in the case of childbirth (Davis and Walker 2013).

Both resistance to and limitations of medicalization can lead to demedicalization. One of the more commonly used definitions of the term comes from Conrad (1992), who outlined it as “a problem [that] is no longer defined in medical terms and medical treatments are no longer deemed to be appropriate solutions” (224). Although some scholars question this definition as it asserts that demedicalization can only be achieved when both conditions are fulfilled (Davis 2006) and that demedicalization is seen as an absolute rather than a continuum (Halfmann 2012). Similarly, Sulzer (2015) argues that demedicalization and medicalization should be seen as a contested process because *de jure* and *de facto* situations might not be aligned with one another. More generally, Golden (1999) cautions that demedicalization should not be perceived as merely the opposite of medicalization but rather to be understood as a complete historical process of its own.

Even though there is not yet a definitive characterization of demedicalization, it can be seen as starting with a social movement rising from outside of medical practice to challenge the medical formulation of a certain condition, identity or activity. This has been particularly the case with homosexuality and breast feeding (Conrad and Angell 2004, Torres 2014). Demedicalization is also observed to take place when questions arise over medical efficacy, such as in the case of circumcision (Carpenter 2010). It likewise occurs when engagement in a certain ‘harmful’ behavior is increasingly seen as a result of choice, such as in the case of self-injury (Adler and Adler 2007). The erosion of medical authority to administer treatment and the availability of technology to enable self-care, such as sex therapies (Tiefer 2012) and artificial insemination (Wikler and Wikler 1991), are also seen as factors that facilitate demedicalization.

### The Role of Physicians in Demedicalization

Both in the efforts to resist medicalization and in the attempt to demedicalize, social scientists have observed the role of physicians. Albeit rarely, doctors have been found to make attempts to question and even resist medicalization of a certain practice, notion or condition. Thomas-MacLean and Stoppard find that Canadian doctors acknowledge the limitations of the medicalization of depression and choose to frame the understanding of the condition outside of medical discourse. Kurz (1987) looks at the reluctance of physicians to accept the idea of a battered person 'syndrome' to be 'diagnosed'. These physicians consider battering to stem from social factors which are held to be outside of the realm of medicine. Hence battering is not a legitimate medical concern although the resulting injuries are. However, shortly after Kurz's publication, the American Medical Association (AMA) did issue guidelines on diagnosis and treatment of victims of abuse (Flitcraft 1992). In the case of Borderline Personality Disorder (BPD), Sulzer (2015) claims that clinicians have been known to deny care for patients whom they sometimes suspect 'fabricating' their symptoms. These patients are considered not truly sick and therefore untreatable medically. These two cases are seen by the authors to simultaneously demonstrate doctors' resistance to medicalization and the practice of partial demedicalization.

One of the more unique cases of physicians' refusal to medicalize was observed by Haines (1989) in the case of lethal injection as a means of capital punishment. Since the introduction of state laws in 1977 to terminate criminals' lives by lethal injection, doctors have actively resisted legislative attempts to frame the process as medical. Physicians' rejection was due to their concerns that the initiator of the idea, who were exclusively of non-medical backgrounds, had politicized agendas. The refusal of participation also stemmed from their consideration that the act violated the Hippocratic oath of *primum non nocere*—first, do no harm.

As it is evident from the collection of scholarship presented in this section, the term 'demedicalization' in relation to the role of physicians in the process is synonymous with non-participation. Doctors would rather not contribute their expertise in cases which they deem to either be unworthy, to violate medical ethics or not to have a medical basis. The contribution of this paper to this discussion lies in the uniqueness of the case of hymenoplasty consultations. In the Netherlands, doctors involved in the provision of hymenoplasty offer their service to the patients despite recognizing the absence of a medical indication of the surgery. This paper argues that providing medical advice is an integral part of the doctors' attempt to demedicalize hymenoplasty. More precisely, it is crucial in their effort to demedicalize the motivating reason for undergoing the surgery: the 'broken' hymen. The doctors then go even further in the attempt to demedicalize the 'broken' hymen by offering alternative courses of



action to their patients. These alternatives are informed by practices that originate from outside the medical realm. However, since they are offered as a part of a medical consultation using medical resources, this paper posits that doctors are actively medicalizing non-medical solutions in order to demedicalize the 'broken' hymen.

#### **5.4 The 'Broken' Hymen: A Medical Perspective in the Case of Hymenoplasty in the Netherlands**

Hymenoplasty is a medical procedure done to alter the shape of a membrane in the vaginal canal commonly known as the hymen. In its intact condition, the hymen is still widely believed to be the hallmark of a virgin (Christianson and Eriksson 2011, Steinmueller and Tan 2015). Women who are contemplating hymenoplasty often do so because they believe that their virginity will come under scrutiny, typically during the wedding night. In many societies, the presence of blood on the marital bed sheet after the first penetration by a newly wedded husband is considered to be a visual sign that the bride owned an 'intact' hymen and therefore was previously sexually untouched (Logmans et. al. 1998, Buskens 1999, Skandrani et. al. 2010, Cinthio 2015, Ghanim 2015). Women who are considering hymenoplasty often ultimately desire to bleed in order to successfully 'perform' virginity during her wedding night (Ayuandini 2017).

However, scholars and medical professionals have shown that blood loss does not always occur after the first coitus (Raveenthiran 2009, Hegazy and Al-Rukban 2012, Christianson and Eriksson 2013). Doctors and physicians also consider the link between an 'intact' hymen and an absence of sexual penetration to be weak (Ayuandini 2017, Adam, Botash and Kellogg 2004, Edgardh and Ormstad 2002, Bravender et. al. 1999). Furthermore, it is difficult to discern what an intact hymen should look like. The hymen of a virgin woman is not of one standard shape: the amount of tissue, the regularity of the edge and the width of the aperture differ from one woman to the next (Hegazy and Al-Rukban 2012, Pokorny 1987). Consequently, physicians have stated that visual examination of the hymen is not a definitive means to discern whether or not sexual penetration has occurred.

In-depth interviews as well as conversational exchanges with physicians in the Netherlands, including with gynecologists, sexologists and general practitioners, reveal that a 'broken' hymen is not seen by Dutch doctors as a condition that merits medical intervention (Ayuandini 2017). Physicians are still in disagreement about the functions of the hymen, hence none have claimed that a particular state of the hymen renders a woman to be biologically impaired (Hegazy and Al-Rukban 2012,

Hobday, Haury and Dayton 1997). The exception is in the case of an imperforate hymen, which can cause pain due to the blockage of menstrual blood (Dane et. al. 2007, Rathod et. al. 2014). In the words of one Dutch doctor interviewed about hymenoplasty, “You would not die if you [were] not operated [on].” Dutch physicians also consider a ‘broken’ hymen—a hymen that is altered in condition after sexual penetration—to be quite ‘natural.’ According to the doctors, some alterations of the shape of the hymen after the first coitus is to be expected and can be seen as ‘normal.’

In Dutch, hymenoplasty procedure is also known by its local name: *maagden-vlieshersteloperatie*, which translates to “hymen restorative surgery”. The word *maagden-vlies* itself can either be translated as maidenhead or as virgin (*maagd*) membrane (*vlies*). Due to the high improbability of knowing what each individual woman’s hymen looked like before it was ‘broken’, Dutch doctors are reluctant to see the operation as a ‘restorative’ procedure. One doctor often remarks to the patient that the operation is more of a constructive surgery rather than a reconstructive one. Two techniques of the surgery are known by Dutch physicians (Feitsma and Kagie 2004). The first involves a temporary suture of tissues. Coitus will ‘break’ the suture resulting in (minor) bleeding. The second is done by gathering different parts of the hymen tissues to form a more uniformly shaped hymen opening. Neither technique guarantees bleeding during the wedding night, adding to physicians’ reluctance in performing the operation (Ayuandini 2017, van Moorst et. al. 2012).

Since doctors perceive that there is an absence of any medical information to support the claim of a ‘broken’ hymen, there is a concomitant lack of medical necessity to ‘repair’ it. The ‘problem’ of a ‘broken’ hymen is considered to be situated outside of the medical realm. The need to ‘fix’ this membrane is also usually informed by non-medical beliefs and encouraged by non-medical practices, particularly wedding rituals. Therefore, Dutch physicians deem the ‘broken’ hymen a misconception and say that it has no place in the medical understanding of bodily integrity.

## 5.5 Methodology and the Context of the Study

The findings presented in this paper are based on access to unique ethnographic observations of 70 hymenoplasty consultations in the Netherlands. Data was collected between 2012-2015 from 2 main medical establishments: a public hospital in a major Dutch city and a private clinic situated about an hour train ride from the capital. Observations of doctor-patient interactions are well known qualitative research methods since the 1970s (see for example Korsch and Negrete 1972 and Pilnick and Dingwall 2011), but untried in hymenoplasty case. Hymenoplasty consultations involve

high sensitivity and require the utmost level of secrecy to protect the identity of the patients. This situation makes ethnographic access to observe exchanges between doctors and patients difficult. Studies on hymenoplasty have been hitherto largely done by medical professionals involved in the provision of the service or by soliciting views from outside of the consultation rooms (Ahmadi 2014, Cinthio 2015, Essen et. al. 2010, Juth and Lynoe 2015, Kaivanara 2016, Loeber 2015, van Moorst et. al. 2012, Wild et. al 2015). The ethnographic access obtained by this study is therefore unparalleled.

Patients were identified as they made their appointments to meet with doctors to discuss hymenoplasty. Appointments were arranged either personally by phone or through a referral from their huisarts (a general practitioner akin to a family physician). All observations of exchanges between doctors and patients were done with a full consent from both. Consent from patients to observe their conversations with doctors was obtained in person prior to the first meeting with the physicians. Separate consent was then sought for the consultation to be audio recorded. In cases where patients refused recording, extensive notes were taken. Excerpts presented in this article came both from transcribed recordings as well as from field notes, both translated from Dutch to English. All procedures were reviewed and approved in advance by Washington University and hospital institutional review and ethical boards.

To complement the observations, this study also included in-depth interviews with 14 physicians who were in one way or another involved in the provision of hymenoplasty. About half of these doctors practiced in the two main medical establishments participating in this study. The rest worked in other medical establishments throughout the Netherlands. Doctors' views are integral parts of the argument presented in this paper. To refer to the doctors in the study, I interchangeably use the word "doctors", "physicians" or specifically "Dutch doctors" or "Dutch physicians".

Analysis is done following the tradition of qualitative study and constant comparative method where immediate findings refine the progression of research (Glaser 1965, Boeije 2002). Grounded theory is used in later stages to hone in on arguments (Strauss and Corbin 1994) and computer-assisted qualitative data analysis software (CAQDAS) Atlas.ti was used to support the process.

## 5.6 Findings

### Demystifying an 'Intact' Hymen

Doctors dedicate a significant portion of their consultation time informing patients about 'medically correct' knowledge of the hymen and virginity. The most common 'misconception' they aim to dispel is the causal link between an 'intact'

hymen and the absence of sexual intercourse. Patients contemplating hymenoplasty consider their hymen to be no longer 'intact' and are anxious about whether they will bleed on their wedding night. Some patients imagine the hymen to be similar to a wall-like structure which will 'break' and bleed when penetrated. Some others visualize the membrane as resembling a ring with a smooth and annular edge which will be disturbed in the event of coitus. Almost all participants believed that the integrity of the hymen could be observed visually.

During consultations, doctors address the patients' preconception of the hymen and its link to virginity. This is often done by highlighting how visual observation of the hymen is not a conclusive method to determine a woman's chastity. Doctors explain how the hymen is normally and naturally of different shapes and no particular shape is an indication of the absence of sexual penetration or otherwise. As a way of illustration, one doctor often points to the sleeve of the patient's sweater, drawing attention to how the flexibility of the opening resembles that of the hymen. As a hymen can stretch and bend, it is possible for sexual penetration to cause no disruption to its integrity.

Another doctor chooses to ask her patients to envision a flower. A flower has natural notches and clefts, similar to a hymen. Crevices and indentations can be present on a hymen even without a prior history of sexual penetration. Patients often consider any observable fissure on the membrane as a sign of a 'broken' hymen. The flower metaphor is then useful to underscore that even an 'intact' hymen may have breaks and openings.

Doctors also use other types of visual aids to disconnect the link between the shape of the hymen and a woman's virginity. One doctor shows patients a brochure with drawings of hymens with very little tissue or with sizeable opening. The doctor uses these pictures to address another idea patients often have about the hymen: that the membrane has a small opening. This idea explains why hymenoplasty-seeking women in the Netherlands generally believe that penetration is more difficult with a virgin.

A different doctor chooses to use computer slideshows to display hymens with small openings and annular edges; the kind of hymen that most patients consider to be those of virgin women. However, these images are photos of the hymens of women who have had sexual penetrations. One is even notably of a woman who has had a baby. The visual aids used present a contrast. The brochure shown by the first doctor is meant to illustrate that a virgin woman can have an intact hymen with a large opening. The slideshow utilized by the second doctor demonstrates the complementary situation: a woman who has had sexual intimacy can possess (or at least have the appearance to possess) a hymen with a small opening.

### **The Role of the Pelvic Muscles and the Absence of Bleeding**

Doctors also inform the patients that the small opening of a hymen can be achieved through contracting the pelvic floor muscles. This is partly also to address the patients' understanding that a virgin woman is believed to be 'tight'. It is not uncommon for patients to think that the 'tightness' of a virgin is due to the fact that her hymen opening is small and results in less degree of ease of entry during the first coitus. Patients also frequently mention how they know men to be able to feel whether or not a woman is still a virgin by virtue of her 'tightness'. Doctors address this pre-conception by informing the patients that it is likely that the 'tightness' men claim to be able to feel as well as the difficult penetration with a virgin comes from the tensing of the pelvic muscles. A sexually inexperienced woman is more likely to feel anxious during her first coitus, hence her pelvic muscles tense up resulting in difficult penetration. Dutch Doctors also speculate that the tensing up of the muscles and the anxiety are what most likely cause the bleeding after first coitus. Friction between the penis and the unlubricated vaginal wall may create a small laceration which results in bleeding. However, doctors never rule out the possibility that the hymen can be scratched or cut as a consequence of first sexual penetration. The resulting wound may also produce blood.

To further convince patients that the 'tightness' of the vaginal canal comes from tensing up the pelvic floor musculature, Dutch doctors encourage their patients to try contracting and relaxing these muscles. Patients are also urged to observe how the 'closeness' or 'openness' of their vagina is affected with each motion. It is not uncommon that the physicians even guide their patients through this exercise, especially if it is done during the gynecological examination to discern the state of the patient's hymen. Some doctors go even further by encouraging their patients to gaze in a mirror at their own vaginal opening when doing the exercise. Dutch physicians are convinced that if patients can see how contracting the pelvic muscles results in the narrowing of the vaginal opening, they will be more likely to abandon the idea that difficult penetration with a virgin is due to an 'intact' hymen.

In the consultation, Dutch doctors also address the notion of bleeding during first intercourse. Even though not all patients are under the impression that first penetration with a virgin woman will result in blood loss, some still hold that idea to be true. When consulting with the latter type of patients, Dutch doctors bring forth statistical 'evidence' to support their claims and state that about 50% women do not bleed the first time they have sex.

### Cultural References and Cultural Solutions

The variability of the shape of an ‘intact’ hymen, the role of the pelvic musculature in creating ‘tightness’ of the vaginal canal, as well as the absence of blood in half of the cases of first sexual penetration, are seen as valid grounds by Dutch physicians to decouple the notion of the ‘broken’ hymen from its assumed medical definition. This indicates an attempt of demedicalization. However, Dutch doctors also widely recognize the patients’ need to bleed during the wedding night as a potential cultural requirement. Physicians are aware of wedding practices where linens are checked for a sign of blood, which is still believed to signify the bride’s well-kept sexual purity. Although it is becoming less common, they also recognize that some women of particular ancestry are still expected to go through this wedding ‘ritual’ in one form or another (Pham 2012, Eşsizoglu et. al. 2011, van Moorst et. al. 2012).

Dutch doctors acknowledge that the immediate need of the patients to produce a blood-stained bed sheet is practical in nature. They also aspire to provide help to patients who might be in a significant social dilemma if found to be no longer sexually untouched. Therefore, Dutch physicians introduce their patients to alternative ways of producing blood during the wedding night as a part of their hymenoplasty consultation. These alternatives range from pricking one’s own finger to inserting either a capsule infused with red dye or a small sponge soaked in blood into the vaginal canal. The capsule will dissolve after about half an hour and the bloodlike red dye will stay inside the vaginal canal up to approximately three hours. The act of penetration will allow the red dye to seep out to stain the linen. The sponge would not dissolve but coitus would coax the blood out and produce the desired result. For patients who are unsure about cutting their own finger or are uncomfortable about inserting a foreign object into the vagina, there is ‘the vial’. In this practice, a phlebotomy vial of blood is taken from the patients themselves and an anticoagulant substance is added to make sure the specimen stays fluid. The vial is then kept in a freezer until the wedding day. Then it is to be taken out, thawed and at the needed moment, the blood can be spilled out onto the sheet.

What is interesting about these alternatives is the fact that most of them are inspired by practices done by women in the ancestral country of the patients. Hymenoplasty-seeking women in the Netherlands tend to come from migrant backgrounds, having at least one parent or grandparent born and raised outside of the country. The majority of women seeking hymenoplasty in this study have either Moroccan or Turkish, including Kurdish, descent. The rest come from Afghani, Iraqi, Pakistani or Armenian ancestry. Dutch doctors informed patients how in the countries of their ancestry, women shared with other women what to do in the event that a newly married woman ‘failed’ to bleed after the first penetration.

- Doctor: *"You can even just prick your finger, with a pin."*  
 Patient: *"and..."*  
 Doctor: *"... and you put it inside your wedding dress. And during the wedding night as he is... well..."*  
 Patient: (laugh)  
 Doctor: *"... when he's completely gone, you prick your finger and smear it on the cloth."*

Apart from using a pin to prick their finger or a small blade to create a little nick, some brides rather choose to carry a sack or a pouch of goat blood with them. The content of this sack is then spilled onto the linen to produce a blood stain after coitus.

By introducing the patients to these alternatives, the doctors serve two purposes: 1) They pragmatically provide the help the patients are seeking and 2) arguably more importantly, they offer 'cultural' solutions to a 'cultural' problem. The second part situates the need to 'perform' virginity and its solution outside of the medical realm. This corresponds to Conrad's second condition to demedicalization which is solving a problem without medical treatments (1992).

The fact that these alternatives are seen by the doctors to be 'cultural' solutions rather than medical solutions is made apparent in the following vignette. The doctor in this vignette is advising a Dutch Turkish woman in her early 20s.

- Doctor: *"[...] you need to devise (verzinnen) other ways to bleed."*  
 Patient: *"Such as?"*  
 Doctor: *"Well, this is culturally specific. Depends on where you're from. Where are you from?"*  
 Patient: *"Ankara."*  
 Doctor: *"Well, in Ankara, people come from many places."*  
 Patient: *"Yes."*  
 Doctor: *"The most chosen solution for people from Turkey is the finger prick."*

Here we can see how the doctor takes into account the ancestry of the Dutch patient he is advising. For him, it is important to know exactly where the patient's family originally came from. He will then offer the alternative solutions that, to the best of his knowledge, are tailored to the methods of creating blood stain on the bed sheet that are more commonly practiced in the area.

The doctor later also mentioned other alternatives to the patient, including practices not found in the area in question. But he gave priority to those that were, as in his own statement in the vignette above: "Well, this is culturally specific. Depends on where you're from," which highlights how alternatives are seen as more culturally informed than medical.

In the consultation, Dutch doctors inform their patients of what they consider to be ‘medically correct’ information about the hymen and virginity. They also offer alternative solutions that are ‘culturally’ informed. Through these measures, hymenoplasty providers in the Netherlands situate the need for the operation that stems from the necessity to ‘perform’ virginity during the wedding night outside of the medical realm. However, we cannot neglect the fact that hymenoplasty consultations happen in a clinical setting. The advice given and the solutions offered are not only situated in a medical environment, but they are also made available using medical resources.

### **Medicalizing to Demedicalize**

In this context, demedicalization is ultimately achieved through the act of medicalization. Take for instance the alternative solutions to producing blood offered to the patients. These ‘culturally’ informed solutions are not applied in their ‘original’ form. After all, doctors do not hand their patients a sack of goat blood to be used on the wedding night. They do, however, recommend that the patients have their blood taken out and put into a vial to be spilled when needed. The blood vial is the medically modified version of the sack of goat blood which is only made possible by the utilization of medical resources. For a woman to have her blood in a vial, she needs to have her blood taken by a certified nurse using a sterilized syringe on an exposed skin surface that is cleansed by an alcoholic swab. The blood is then put into a vial where an anticoagulant substance is added to ensure its fluidity. The ‘cultural’ solutions the doctors offer are at the same time medical alternatives.

Medical alternatives to ‘cultural’ solutions do not stop at the blood vial. Doctors also provide a medically tailored solution to cutting one’s skin to produce blood. Instead of being handed a pin to pierce one’s finger, the patient is given what the doctors call a finger prick. This is a special short needle, sheathed in a casing where a pressure on one end will trigger the needle to jut out. This type of finger prick is commonly used to obtain blood needed for different forms of blood tests. In the case of hymenoplasty, the needle is used to ‘recreate’ the effect of pricking one’s finger with a pin. With this, Dutch doctors devise another medically modified solution to the ‘culturally’ informed alternative of producing blood during the wedding night.

Another recommended way to produce blood is by having the first penetration coincide with the menstruation period. The risk involved in this method is to know with high confidence the timing of menstruation. However, with medical assistance, the certainty of the timing can be increased. Doctors recommend their patients to take birth control pills to regulate their bleeding. They then advise their patients to stop taking the pills shortly before the wedding so they can be sure blood will be produced during penetration. Again here, producing blood during the wedding night that is con-



sidered by Dutch doctors to be a culturally informed need is accommodated and met through medical means.

### **Culturally Informed, Medically Manufactured**

The most intriguing solution offered by doctors to their patients is arguably the suppository. A suppository is a dissolvable medical capsule containing a red dye to be inserted into the vaginal canal. In the Netherlands, the suppository was first introduced by a gynecologist practicing in Utrecht in mid 2000s. Through her practice, she recognized the need of some of her patients to produce a blood-like stain on their marital bed sheets. She regularly recommended the suppository to her hymenoplasty patients. The suppository was produced in a pharmacy and was only available through a medical prescription. It satisfied some of the women's needs although the inventor lamented that the color of the dye was somewhat more purplish than red. Later, the suppository was also offered by other doctors in the Netherlands as an alternative solution to hymenoplasty.

This suppository is undoubtedly a medical solution to what the doctors consider to be a 'cultural' problem. The formula for the suppository was invented by a medical doctor and the production was done in a medical establishment—a pharmacy—by a medical professional—a certified pharmacist. More importantly, access to it could only be gained through medical means: a medical prescription written out after a consultation in a clinical setting.

In recent years, the suppository is no longer produced and has been replaced by a gelatin capsule containing red food coloring. Inspired to find a solution to the suppository's color inaccuracy, a doctor in a private clinic successfully found a combination of substances to create the reddish color that resembles fresh blood. The capsule can be obtained for as little as 2.50 euros. This doctor is less strict about the need for a medical prescription or medical consultation to obtain the capsule. She allows the capsule to be bought by others and then given to a woman who would benefit from it. However, the availability of these capsules is still mediated through a medical setting. They are not openly available to the general public and the doctor is the only person who can create and dispense them.

The suppository and all the alternatives highlighted above are devised and made available through an extensive use of medical resources, including medical tools, establishments and expertise. The access to them is also somewhat, if not fully, restricted. This is not to mention that the entire process happens through a medical system where a woman seeking to 'perform' virginity during the wedding night is advised through stages of medical consultations. The stages might include an intake meeting, a physical examination and more often than not a counseling session. Not to forget

that the woman in question is assigned the role of a patient where she can then be medically advised on how to address her 'cultural' problem.

## 5.7 Discussion and Concluding Thoughts

A 'broken' hymen is thought by patients seeking hymenoplasty to be a membrane with a 'damaged' appearance. It has clefts and notches and there is not much tissue remaining as a result of sexual penetration. A 'broken' hymen is also considered to be the reason why women do not bleed after sexual intimacy which indicates that she was no longer a virgin. This is likewise the patients' explanation why the vaginal canal is no longer 'tight'. These ideas are considered by Dutch doctors to have no medical basis as their own medical experience and observations as well as their knowledge of scientific research and studies demonstrate otherwise. The notion of the 'broken' hymen for Dutch doctors has no medical definition.

Doctors' active role in the demedicalization of the 'broken' hymen starts with their attempt to instill in their patients a 'medically correct' understanding of the condition of the hymen. Medically researched facts and visual aids are used to encourage patients to decouple the link between a woman's chastity and the condition of her hymen. Gynecological examination and patients' opportunity to take a first-hand look at their own vaginal canal serve as another tool to demedicalize the 'broken' hymen. All of these attempts to demedicalize are notably done in a medical establishment by medical experts through medical processes. Seen in this light, it is clear that demedicalization of the 'broken' hymen is actually achieved through a medicalization framework.

Scholars have argued that medicalization and demedicalization should not be seen as separate processes that happen distinctly from one another (Burke 2011, Lowenberg and Davis 1994). The two are argued to exist simultaneously and in gradation rather than in absolute terms (Halfmann 2012). In her exploration of the demedicalization of breastfeeding, Torres (2014) establishes this coexistence, because lactation consultants simultaneously medicalize and demedicalize breastfeeding. There are some parallels to be drawn between Torres' observation on demedicalization of breastfeeding and the case of hymenoplasty consultations presented in this paper. One particularly relevant to this case is how the process of medicalization can precede demedicalization; the former is a means to achieve the latter. The case of hymenoplasty consultations in the Netherlands represents an important contribution to the scholarship of demedicalization. It shows that medicalization and demedicalization processes not only can coexist, but also may be causally linked to one another.

However, in the case of hymenoplasty consultations in the Netherlands, physicians take this a step further by actively medicalizing alternative courses of action being offered to patients. As these alternative 'solutions' are culturally informed, Dutch doctors' attempts to demedicalize the 'broken' hymen include the provision of nonmedical treatments to address the patients' problems. These alternative treatments are then 'medically appropriated' to be offered as medical recommendations. Demedicalization of one notion that is considered to exist outside of the medical realm—the 'broken' hymen—is achieved through medicalizing practices that equally originate from outside of the medical world—finger pricking, among others. Here, doctors are exercising their prerogative on what can and cannot be part of the medical realm.

Furthermore, the case of hymenoplasty consultation in the Netherlands is unique in that medicalization of the 'broken' hymen almost exclusively originates from outside of the medical realm. Patients are the ones who initiate medical engagement as a result of concern about potential social or physical repercussions from being found to be a non-virgin. Doctors' attempts to simultaneously provide help for patients and keep the issue outside of the medical domain cannot be divorced from their understanding of ethics. Beneficence is the ideal Dutch physicians involved in the provision of hymenoplasty often claim they are striving for (Beauchamp and Childress 2012). This explains why they are comfortable in medicalizing alternative 'solutions' but are wary of providing hymenoplasty. The alternatives are seen to be in line with the spirit of beneficence while the provision of hymenoplasty is fraught with ethical quandaries. Scholars question whether performing the surgery means physicians are agreeing with the idea of women surgically altering their body to fulfill the expectation of others (Bekker et. al. 1996, Raveenthiran 2009, Cooks and Dickens 2009). What can be seen as doctors choosing between medicalization and demedicalization can be argued to be in line with the aspired ethics of their profession. It is also important to underscore at this point that if the patient still insists on getting hymenoplasty by the end of the consultation, doctors will agree to perform the surgery. Dutch doctors respect patients' ultimate decisions regarding the procedure.

In the exploration of physicians' rejection of the medicalization of lethal injection, Haines criticizes the tendency of social studies scholarship to frame medical professionals as constantly desiring to extend their authority outside of medical practice (1989). But as in the case of legal injection, the physicians studied here are not necessarily keen on having their expertise linked to practices that can be seen to violate their ideals. This is particularly true when the basis of medicalization is also considered to be medically false and scientifically unproven, such as in the case of hymenoplasty and the 'broken' hymen. In fact, many medical professional bodies

across the globe have encouraged their members not to perform hymenoplasty, including those in Egypt, United States, Canada, New Zealand, Sweden, and England (Kandela 1996, Braun 2010, de Lora 2015, Juth et. al. 2013). In the Netherlands, the Dutch Association for Obstetric and Gynaecology (Nederlandse Vereniging voor Obstetrie en Gynaecologie-NVOG) recommends physicians not to perform hymenoplasty unless there are no other alternatives available after consulting with patients (Feitsma and Kagie 2004). Therefore, there is a nuance to Dutch physicians' involvement in the provision of hymenoplasty; one that is reflective of the NVOG's statement. The doctors are willing to consult patients contemplating the operation but they are not eager to actually perform the surgery.

As a concluding thought, the case of hymenoplasty consultations in the Netherlands brings forward the contextual and localized nature of the process of demedicalization. The efforts of Dutch physicians to demedicalize the 'broken' hymen operates within the context of the Netherlands. Ever since the sexual revolution in the 1960s, sexuality has been considered to be an integral part of Dutch society (Schnabel 1990, Ketting 1990). Where pre-marital sex is largely seen as acceptable, a 'broken' hymen, particularly before marriage, does not have a problematic contextual framing. But elsewhere, virginity before marriage is desirable if not obligatory. Patients have indicated that this ideal is still widely aspired to in countries of their ancestry. They have further stated that in such countries, physicians are more willing to offer their expertise and play an adjudicator role when a woman's chastity is in question; they do so by examining her hymen. This is not to dismiss the potential importance of a financial incentive in any individual physician's decision to conduct hymenoplasty (Wynn 2016). However, it merits further exploration of how doctors in other countries might adhere to a different set of considerations than those of Dutch physicians regarding the 'broken' hymen. It is even feasible that physicians in other countries do frame this condition as medical. Exploring this possibility can provide new insights into how medicalization/demedicalization processes are influenced by and derived from contextual, local, and normative factors that reside outside of the medical realm.

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## **CHAPTER VI:**

# ENACTING DUTCHNESS IN HYMENOPLASTY CONSULTATION

## **6.1 Article Title**

Becoming (More) Dutch as Medical Recommendations: How understandings of national identity enter the medical practice of hymenoplasty consultations

## **6.2 Abstract**

This article looks at how Dutch as a national identity enters the practical setting of a medical consultation. Extending the growing scholarships of everyday nationalism and engaging with the notion of multivocalism, this article shows how Dutchness is understood in the form of desirable personal characteristics. These characteristics are promoted by physicians to patients of migrant ancestry looking for a surgery called hymenoplasty. This article presents unique scholarly observations of a case where a particular understanding of national identity is recommended as part of medical advice. Furthermore, by closely examining exchanges between doctors and patients, this article argues that Dutchness is a state of flux where a person of migrant ancestry can simultaneously be seen by others as Dutch and non-Dutch.

### 6.3 Introduction

In recent decades in Europe and in the US, nationalist discourse is steadily on the rise (Bonikowski, 2016; van Reekum, 2012; Gingrich and Banks, 2006), prompting necessary examinations of how nationalism enters public life and national conversations anew. This paper takes the case of the Netherlands and looks at how Dutchness is understood, enacted and promoted, chiefly by physicians, in a practical setting of medical consultation. Nationalism scholarship as of late has been increasingly championing explorations of national identity as it is defined by ‘ordinary’ people rather than the ‘elites’; a theoretical leaning that is mostly referred to as everyday nationalism (Billig, 1995; Skey, 2011; Fox and Miller-Idriss, 2008). By looking at the micro-social interactions between doctors and patients, this paper extends the scholarship on banal nationhood by exploring the ambiguity of national identity in everyday lives. This focus corresponds to Kaufmann’s latest call to look at nationalism through the lens of multivocalism (2016). He offers the concept as an intervention in the debate between the national liberals and the multiculturalists over descriptions of national identity. Kaufmann argues for a more central role of individuals in the context of “crowdsourced nationalism” where various understandings of national identity can differ from one individual to the next (2017, p. 21).

In the Netherlands, where the country has witnessed a resurgence of the populist anti-immigration agenda, many politicians and public figures today have started to define what it means to be Dutch (van Reekum and Duyvendak, 2012; de Leeuw and van Wichelen, 2008). This agenda is reflected within national media debates (Prins, 2002; Eyerman, 2008) and in more tangible forms such as during civic integration courses (Suvarierol and Kirk, 2015), naturalization ceremonies (Verkaaik, 2010) and parenting classes (van den Berg and Duyvendak, 2012). Scholars claim that citizenship in the Netherlands is increasingly understood by state elites in primarily cultural terms (Verkaaik, 2010; van Reekum and Duyvendak, 2012; Shadid, 2006; van den Berg and Schinkel, 2009; Duyvendak, Geschiere, Tonkens 2016). Being Dutch is seen as a state of contrast, specifically towards those that are considered to be the cultural Other, in particular, Muslim people of migrant ancestry (de Leeuw and van Wichelen, 2008; van Reekum and Duyvendak, 2012).

What Dutchness means and what cultural norms it signifies are constantly debated. Allegedly in line with ‘Dutch liberalism’, the value of autonomy and the emphasis on individual rights are traits often claimed in national conversations and public discourse as typically Dutch (de Leeuw and van Wichelen, 2008; Duyvendak, 2011; van den Berg and Duyvendak, 2012). Acceptance of homosexuality, recognition of gender equality as well as secularism are other traits that are also valued as Dutch (Mepschen,

Duyvendak and Tonkens, 2010; de Leeuw and van Wichelen, 2008; Verkaaik, 2010). These characteristics are lumped together under the umbrella of ‘modernity’, as all political parties, including right-wing populists, define ‘modern’, progressive values – particularly in the fields of religion, gender and sexuality – as core Dutch characteristics (Mepschen, Duyvendak and Tonkens, 2010, Roggeband and Verloo, 2007). Accordingly, a person of migrant background can achieve modern-ness through ‘full’ integration by adopting the aforementioned progressive qualities (Mepschen, Duyvendak and Tonkens, 2010).

In analyzing these new ‘culturalist’ tendencies in Western Europe, one cannot overlook the pivotal role played by the rhetoric of sexual and gender progress (Uitermark, Mepschen and Duyvendak, 2014). This entails, as a consequence, policies that address the presence of people with migrant ancestry in the Netherlands - specifically in the first decade of the second millennia - mostly targeting women of migrant descent (Roggeband and Verloo, 2007, Ghorashi, 2010). One hears in public debates the assumption that integration is not complete if women of migrant descent do not enjoy the full freedom of their Dutch counterparts. Families and spouses are seen by policy makers as obstacles to autonomy (van den Berg and Schinkel, 2009; Schinkel, 2011) and the condition of migrant women is considered to be the mark of the success or the failure of people of migrant background’s integration into Dutch society.

This paper offers a complementary outlook to a more ‘top-down’ understanding of Dutchness. Through analyzing exchanges between physicians and patients in hymenoplasty consultations, we look at how individuals understand and employ the concept of Dutchness as national identity. Observations of hymenoplasty consultations in the Netherlands also provide a unique opportunity to simultaneously explore how national identity enters the realm of medicine and how values of gender and sexuality are conflated and operate within Dutchness. Hymenoplasty is a medical procedure that alters the shape of the hymen membrane, commonly done to minimize the aperture (Karasahin et. al., 2009; Renganathan, Cartwright and Cardozo, 2009; Cook and Dickens, 2009). This surgery is often requested by women who believe that they are no longer physically a virgin and will face examination of their chastity immediately following their wedding night (Ayuandini 2017a, Logmans et. al., 1998; van Moorst et. al., 2012; Wild et. al., 2015). In the Netherlands, the operation is almost exclusively sought by Dutch women of migrant ancestry with at least one parent or grandparent born in countries such as Morocco, Turkey, Afghanistan, Iraq or Pakistan (Ayuandini, 2017b).

It is important to note that physicians involved in the provision of hymenoplasty in the Netherlands nearly all come from ‘native’ Dutch backgrounds. Doctors interviewed for the purpose of this study are no exception. All the doctors being consult-

ed, except for one, have stated that their preference is to not perform hymenoplasty. Their view is a reflection of medical ethics boards, hospital departments, as well as doctors associations that often urge Dutch physicians not to perform hymenoplasty (see Dutch obstetric and gynecological association's statement in Feitsma and Kagie, 2004). They regret the fact that the desire for the operation exists. Some of these physicians nevertheless still decide to provide the surgery or at the very least, meet with women contemplating hymenoplasty. Dutch doctors have been known to meet with hymenoplasty-seeking women in order to offer them alternative solutions to surgery (Ayuandini, 2017b). In the Netherlands, the meetings are also frequently aimed to dissuade patients from getting the operation (Ayuandini, 2017a). The way this is done is in line with the doctors' understandings of the causes behind the desire for hymenoplasty as well as what they deem to be the core reasons why some women are able to reject the surgery while others cannot.

In this paper, we first and foremost look at how Dutch physicians define and employ the idea of Dutchness. We chiefly examine their rhetoric, specifically how Dutchness is understood as a set of preferred characteristics. In so doing, we provide a new angle to multivocalism, one that is not only about coexistence of different understandings of national identity, as proposed by Kaufmann (2002), but also one of tension and conflict. We highlight how Dutch doctors' understandings of Dutchness face are challenged by the patients, by other people in the patients' life and even through their own discordant behaviors on different occasions in their medical practice. It is crucial to underscore here that what it means to be Dutch is not solely present in the point of view of the Dutch doctors in the confined context of hymenoplasty consultations. Excerpts and vignettes presented in this paper will show that patients often have similar ideas. It is not uncommon for the patients to agree with the positions of the doctors even frequently preempting the physicians' remark by volunteering comparable understandings of Dutch ideals. However, this does not detract from the fact that it is the doctors who are taking active measures to promote Dutchness, notably by encouraging their patients to adopt and exercise certain qualities as an integral aspect of their expert advice to address the patients' 'medical' situation. Staying true to our data that reflects this situation, it is our deliberate choice to primarily analyze the understanding of Dutchness through the doctors' rhetoric rather than the patients'.

This article does not seek to define what it means to be Dutch. However, it does argue that in the setting of hymenoplasty consultations in the Netherlands, the idea of Dutchness and being Dutch experiences a process of translation into distinct traits that are considered desirable by the physicians providing the service. What we aim to illustrate in this paper is twofold: (1) How national identity, in this case Dutchness, is prescribed by doctors as a solution to the patients' problem and (2) How Dutchness

becomes a state of flux where a person of migrant ancestry can simultaneously be seen by others as Dutch and non-Dutch.

## 6.4 Methodology

All findings presented in this paper were collected during 20 months of research conducted between 2012 and 2015. The main means of data collection was the close observation of 70 exchanges between doctors and patients during hymenoplasty consultations. All patients involved in the study were of migrant ancestry while out of 14 doctors who participated, 1 was of non-Dutch descent. All doctors were women except for 2, however, our findings do not show meaningful correlations between doctors' gender and their approach of practice. The consultations were mostly done in two establishments: a public hospital in one of the major cities in the Netherlands and a private clinic located about an hour from the Dutch capital by train.

The ethnographic access as the basis of this study is unprecedented due to hymenoplasty being a highly sensitive medical procedure where secrecy and confidentiality of the patients' identity is of the utmost priority. Discovery of the patients' intention to undergo the surgery by people in their social circle has frequently been cited by the patients as having unintended and unwanted consequences. Patients fear social drawbacks if it is found out that they are no longer a virgin. Accordingly, to ensure patients' anonymity, any identifiable personal information is omitted from this article.

Patients' consent to have their conversations with doctors observed was obtained in person prior to their first meeting with physicians. For observations done in the public hospital, further consent was sought from patients to audio record the consultation. In cases where consent was not obtained for audio recording, as well as for every observation in the private clinic, extensive field notes were taken. Audio recordings were later transcribed and both the transcriptions as well as field notes were translated from Dutch to English for the purpose of this paper. Observations of the consultations were supplemented with direct exchanges with doctors before and after the consultations.

In line with a constant comparative methodology and following the tradition of in-depth qualitative study, initial analysis was done in an immediate and cyclical manner in order for early insights to be fed back into field research (Glaser, 1965; Boeije, 2002). In this way, the development of the research was ensured to be consistent with emerging themes and data collection was constantly refined and attuned. The grounded theory approach was utilized in later stages of the study to distinguish important findings and key concepts to be used as the foundation of main arguments

and overall analyses (Strauss and Corbin, 1994). A computer-assisted qualitative data analysis software (CAQDAS) Atlas.ti was used to support an in-depth analysis of data. This served to structure the argument and aid the writing of this article (Kelle, 2004).

## 6.5 Findings

### Patients of Migrant Background

Doctors in the Netherlands generally see a very close connection between the desire for the hymenoplasty surgery and the ethnic cultural background of the inquiring patient<sup>4</sup>. The linkages between the two is an expected line of thought, as women who are seeking hymenoplasty in the Netherlands, although being full Dutch citizens, almost exclusively come from migrant backgrounds (Ayuandini, 2017a). Data from this study demonstrates that 100% of hymenoplasty patients have non-Dutch ancestry, in which 4 out of 5 have parents with roots in Muslim majority countries. These patients are typically Dutch born citizens with at least one parent or grandparent who migrated to the Netherlands from Morocco, Turkey, Afghanistan, Iraq or Pakistan. Immigration took place either in the 1970s, for those with ancestry from Morocco and Turkey, or in the early 2000s, for those from Afghanistan, Iraq and Pakistan. A few of the women seeking the surgery moved to the Netherlands when they were younger. Conversations with more than a dozen doctors involved in the provision of hymenoplasty in the Netherlands show that it is extremely rare for a Dutch woman with no migrant ancestry to contemplate getting the surgery. With more than 100 years of experience in total, only two of the doctors could recall a patient of ‘native’ Dutch background consulting them for hymenoplasty.

### Hymenoplasty and Patients’ Ancestry

With this as the context, it is unsurprising that Dutch doctors frame the desire for hymenoplasty as related to the patients’ migrant ancestry. Some doctors attribute the request to what they consider to be a scientifically unfounded connection, often believed by people of the patients’ background, between the condition of the hymen and the absence/presence of sexual intimacy. The hymen is a membrane in the vaginal canal in which its ‘intact’ condition is still considered in many countries to be the sign of a virgin (Logmans et. al. 1998; van Moorst et. al., 2012; Wild et. al., 2015; Eich,

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<sup>4</sup> 80% of patients in this study self-identified as Muslims, with the rest being orthodox Christian or different Iraqi religious denomination. However, participating patients and doctors consistently argue for the exclusion of religious beliefs from possible connections to hymenoplasty and would rather converse about “traditions” instead. Our findings correspond with Abu-Lughods (2002) where people find it difficult to talk about religion and rather speak of ‘culture’ instead.

2010; Buskens, 1999). However, doctors consider the link between a seemingly ‘intact’ hymen and the absence of sexual intercourse to be weak (Gay-y-Blasco, 1997; Boddy, 1989; Edgardh and Ormstad, 2002). Dutch doctors regularly referred to the conviction that an ‘intact’ hymen is a hallmark of a virgin woman as the ‘myth’ of virginity. Belief in the ‘myth’ continues to be a strong driver for patients seeking hymenoplasty. Doctors regret the enduring dissemination of the ‘myth’ among people of patients’ ancestry. One physician explained to me, “From their own background they are getting all kinds of other information and they don’t believe the ‘Western’ information.”

Some other doctors consider the patients’ desire for hymenoplasty to stem from their connection with men of migrant backgrounds. These men, particularly those the patients are dating or about to marry, not infrequently allude, insinuate, or even directly require them to be virgins before marriage. In fact, in one of the very rare cases where hymenoplasty was requested by a Dutch woman of no migrant ancestry, the operation was sought for because she was marrying a Dutch man of migrant parentage who expected her to still be a virgin on their wedding night. This arguably idiosyncratic case, somewhat fortuitously, further confirms the norm: migrant ancestry is a consistent common denominator for the desire to undergo hymenoplasty.

It is worth noting here that being connected to men of migrant background, whether through blood or through marriage, is an important reason a patient would seek hymenoplasty in the eyes of Dutch doctors. Men of migrant ancestry are often seen as unfair in their expectations regarding patients’ sexual history. They tend to be portrayed as practicing a regrettable double standard (*dubbele moraal*) where they freely explore pre-marital sexual intimacy while expecting their bride to be sexually untouched before marriage.

Studies have shown that Dutch women of migrant ancestry, particularly those of Moroccan and Turkish descent, tend to marry or date men who share a similar ethnic background (van Tubergen and Maas, 2007; Hooghiemstra, 2003; Kalmijn and van Tubergen, 2006). Findings from this study correspond to this earlier scholarship and the tendency for patients’ partner to be of similar ancestry is also observed by Dutch physicians. This observation reaffirms Dutch doctors’ view that there is a strong correlation between the patients of migrant descent who desire hymenoplasty and the ‘myth’ of virginity perpetuated by the people of her similar background. Doctors also see a correlation between being of migrant descent and the tendency for patients to marry men of migrant ancestry who would expect them to be virgins on their wedding night.



### Incompatibility Between Being Dutch and Hymenoplasty

Hence, the physicians assume the inversion to be equally valid: if the patient was not of migrant ancestry, in other words, if she was (truly) Dutch, she would not have the need for hymenoplasty. During consultations, it is therefore not uncommon for doctors to establish that in the Netherlands, as well as among the Dutch and Dutch society, hymenoplasty does not belong. In one notable occasion, when a patient inquired why the operation was not readily available in the country<sup>5</sup>, the doctor's answer encapsulated this succinctly.

Patient's friend: *"Why aren't there any other places providing this [hymenoplasty]?"*

Doctor: *"Well, people tend to see it as nonsense."*

Patient's friend: *"Nonsense? But this is a real problem!"*

Doctor: *"Yes, but in Dutch culture it is not important, that's why people see it as not important."*

Not uncommonly doctors emphasize this point to the patient by indicating that even the desire for the surgery could not have come into existence in the Netherlands.

Patient: *"But I feel guilty about it [not being a virgin]. But I can't take back what has happened."*

Doctor: *"Well, yes, in the Netherlands that past is not actually a problem, right?"*

Patient: *"No, that's true."*

The patient in this short vignette was a Dutch woman of Moroccan background who was born and raised in the Netherlands. However, as evident from the excerpt, the doctor seemed to have overlooked the fact that the patient was a Dutch citizen and her virginity dilemma was in fact an integral, if unfortunate, part of her life in the Netherlands. Her dilemma marked her as being 'outside' of 'Dutch culture'. This finding is in line with other scholars' observations that Dutch people of migrant ancestry are still seen as outsiders despite being born in the Netherlands, being a full Dutch citizen and only speaking Dutch (Essed and Trienekens, 2008).

The dissimilarities between being Dutch and being of migrant descent are sometimes highlighted by physicians through pointing out the differences between groups of people. Doctors make comments on how a Dutch person who does not have migrant ancestry will consider a woman who is no longer a virgin before marriage to be appealing as a partner.

Patient's friend: *"Yeah, no. I lost my virginity to my love when I was young and he*

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<sup>5</sup> Our explorations do not show any indication of 'black market' existence of hymenoplasty providers in the Netherlands. Patients however did sometimes allude to hymenoplasty being offered in their ancestral countries.

*left me after (laugh). And then I got married to a Dutch guy. And I have..."*

Doctor: *"And he knew about it..."*

Patient's friend: *"Yeah, I told him, "This is who I am. I am no longer a virgin. [...] He said, "Oh okay." Yeah, and then there's no problem anymore."*

Doctor: *"But that was because he's a Dutch guy."*

Patient's friend: *"I think so, yeah... (to the patient) Maybe you need to be with a Dutch [guy]... (laughing without finishing her sentence)."*

This comment is complementary to Dutch doctors' view on men of migrant background, as was illustrated earlier. Here, the Dutch guy is seen to be easily accepting of the patient's past while a man of migrant ancestry is considered to be the exact opposite: he disapproves of the patient's sexual history hence he is the source of the problem in her life.

The comparison is also made between Dutch women of migrant background and those who have no migrant ancestry. A notable example of this can be found in one of the doctors' speech to patients about the possibility of bleeding after the first sexual penetration. This doctor has conducted research among young Dutch women in the Netherlands on whether or not they bleed after their first sexual encounter. The result of this study is often mentioned to hymenoplasty patients as a way to highlight that expecting a virgin woman to always bleed the first time she has sex does not correspond to medical facts. The doctor regularly remarks that based on the research, 25% of women coming from migrant backgrounds did not bleed after experiencing their first coitus. Among Dutch women with no migrant ancestry, the percentage is doubled: 50% of women did not experience bleeding after their first sexual penetration. The doctor further explains that the reason for this difference is because the women of migrant descent tend to feel very afraid when they have sex for the first time. "They don't know what will happen. So, it's easier to bleed," states the doctor, "[A Dutch girl] is ready to have sex. She is lubricated enough. But for girls from other cultures, they are sometimes scared, they even feel like they're a prostitute. So, when you're afraid and tense like that, blood can also come."

It is evident through the illustrations provided in this section that there are obvious unquestioned assumptions being put forward by the doctors. Dutch people and Dutch society, which embody the life in the Netherlands, are portrayed to be entirely open to the explorations of sexuality and, in this case, pre-marital sexual encounters. This is the reason why men of migrant background are seen to be unaccepting of women's sexual history before marriage. This is also the logic behind why Dutch women of migrant background are perceived to be sexually inexperienced and even anx-

ious before their first sexual encounter.

### Always Connected to ‘Foreign’ Roots

The image of a patient who remains connected (*blijft verbonden*) to her non-Dutch heritage is frequently apparent from the exchanges recorded during consultations where physicians often frame her as ever-linked to other people with a similar foreign background. When addressing the patient, the consulting doctor regularly brings up the patient’s ancestry and not infrequently even tailors the medical advice given accordingly. The following vignette illustrates this. Here, the doctor was about to explain to the patient alternative ways of producing blood during the wedding night.

- Doctor:           “[...] *you need to devise (verzinnen) other ways to bleed.*”
- Patient:           “*Such as?*”
- Doctor:           “*Well, this is culturally specific. Depends on where you’re from. Where are you from?*”
- Patient:           “*Ankara.*”
- Doctor:           “*Well, in Ankara, people come from many places.*”
- Patient:           “*Yes.*”
- Doctor:           “*The most chosen solution for people from Turkey is the finger prick.*”

There is no fundamental reason why a certain alternative is better for a patient of a particular background. Either a finger prick, a vial of blood or a capsule containing red dye can be used to produce blood or a blood like stain. They can be used as effectively by a woman of Turkish background as by a woman of Moroccan background. Yet the patient’s ancestry seems to be an important part of the advice giving.

Because the connection between the patient and her cultural heritage is naturalized by the doctors, some Dutch physicians are at times amused that the patients they are consulting have never heard of alternatives to producing blood during the wedding night; advice which is supposedly shared by women of her ancestry. Blood after the first penetration is still widely believed to be a sure mark of a virgin, as coitus is understood to ‘break’ the hymen of a chaste woman (Logmans et. al., 1998; Buskens, 1999; Skandrani et. al., 2010; Cinthio, 2015; Ghanim, 2015). Dutch doctors label these alternatives to produce blood as ‘tricks’.

- Doctor:           “*What I find funny about all of this is that in Morocco women know about these tricks. They tell each other.*”
- Patient:           “*Well, I don’t know anything about it. Why don’t they make a documentary so people like me can watch and find things out?*”

As evident from the above conversation, Dutch doctors assume that the patient is always connected to her cultural heritage and this is not left unchallenged by the

patient. Not infrequently, it is the patient themselves who would directly remind the doctor that she is very much a Dutch woman, being born and raised in the Netherlands.

Doctor: "What do women in Afghanistan do if they don't bleed?"

Patient: *"I live here. I grew up here. I don't know about the story about what happened."*

However, the more profound challenge to the physicians' assumption that the patient is always somewhat foreign comes in instances when doctors themselves express their surprise upon observing and assessing that the patient in front of them can very well be seen as Dutch. When Oumaima, a Moroccan woman in her early twenties, mentioned she first came to the Netherlands in her late teens, the doctor exclaimed in astonishment, "How can you speak Dutch so well?" When Besjana, a woman of Eastern European descent with a Caucasian look first came for a hymenoplasty consultation, the doctor remarked, "People will think you're Dutch." Both Oumaima and Besjana are Dutch citizens. These comments made by the doctors highlight their categorizations of patients who they understand to be the Other. For many doctors in the Netherlands, there is stereotyping of women who might have a greater tendency to contemplate hymenoplasty. The line of thinking is thus (just to name a few): this woman tends not to have a Caucasian appearance; she is most likely a Muslim; and she probably does not speak Dutch that well. The more she exhibits these characteristics, the more likely she will be to desire hymenoplasty.

It is not surprising that this categorization is informed by the more common demographic characteristics of the patients to which the doctors are accustomed to through their extensive experience in the provision of hymenoplasty in the Netherlands. However, it is notable that the doctors start to expect the kind of characteristics their patients possess even before meeting them in person. This explains the physicians' amazement when the stereotypes differ in practice.

More importantly, doctors do not only have certain expectations that their patients are not entirely Dutch, but they also sometimes assess how Dutch the patients are.

Doctor: *"Did you have more relationships after your first boyfriend?"*

Patient: *"After that I had two more relationships. The last one was for five years."*

Doctor: *"So you were a typical Dutch girl then?"*

Patient: (Laugh) *"Yes, I was."*

It is not uncommon for doctors to make remarks about the Dutchness of the patient they are consulting. "She is very Dutch in that sense," or "She is Dutch that way," were just some of the comments made. In one notable occasion, after a patient of

Moroccan descent exited the room, the doctor turned and exclaimed, “She’s half Dutch already!”

The last doctor’s comment is particularly noteworthy. With this remark, the physician signals that any patient coming for hymenoplasty consultation has the potential to be more Dutch, probably even to be ‘fully’ Dutch. In fact, they are already on their way to becoming Dutch. This is an important point to highlight as this line of thoughts plays a significant role in the physicians’ objectives when meeting with a woman contemplating hymenoplasty. We will come back to this point a bit later.

### **Assumed Characteristics of Dutchness**

As has been mentioned at the start of this article, physicians involved in the provision of hymenoplasty in the Netherlands often aim to dissuade their patients from undergoing the operation. As evident in some of the vignettes presented here, one way to persuade the patient to not continue with hymenoplasty is to present alternative ways of producing blood during the wedding night, called “tricks” by physicians. Doctors hope that by knowing there are other less intrusive methods, patients will ultimately decide against getting the operation. Another of the means the doctors frequently resort to is to make sure that the patients they are consulting acquire, exhibit and perform certain characteristics that would make them less likely to undergo the operation. Dutch doctors are of the mind that there are particular traits which are incompatible with the desire for the operation. The doctors are convinced that the more a woman exhibits these characteristics, the more likely she rejects the idea of undergoing hymenoplasty.

At the same time, this paper has also demonstrated that doctors in the Netherlands consider the desire for surgery to be incompatible with being Dutch. Excerpts from doctors’ exchanges with their patients show that this is because the physicians consider Dutchness to be inconsistent with the expectation of virginity on the wedding night. Dutchness is also perceived to be incongruous with the absence of sexual exploration before marriage. Hence, in the mind of the doctors, the more Dutch a woman is, the less likely she will be under the pressure of ‘proving’ her virginity on the wedding night and the less likely she will be to contemplate getting hymenoplasty. In short, Dutch doctors are convinced that if a woman possesses the ‘right’ characteristics or if she is Dutch (enough), she will not undergo the operation. Not surprisingly, the two ultimately conflate: exhibiting certain traits that are perceived to be incompatible with the desire of hymenoplasty is also identified as a hallmark of being Dutch.

There are several ‘desirable’ traits Dutch doctors time and time again allude to in their conversations with patients. These characteristics also relate to the physicians’ idea of the core reason that leads to the patient contemplating the surgery. Since

many consider the desire for hymenoplasty to stem from the lack of understanding about the ‘medically correct’ information of the hymen and virginity, doctors perceive education to be an important factor. Hence, being an educated knowledgeable woman is one of the characteristics Dutch physicians see as preferable in their patients. An educated woman is considered to be less likely to desire hymenoplasty.

Another characteristic that many doctors deem important is what they called ‘being strong’. It is particularly applicable in cases where the patients were victims of sexual abuse. Data from this study shows that close to one out of three women who are considering hymenoplasty in the Netherlands lost their virginity as a result of sexual violation. For these women, ‘being strong’ is regularly equated with addressing their sexual trauma (which was either because of abuse, rape, or deceit). For some, this means seeking psychological help. For others, it means reporting their violators to the police. Still some choose to talk to their family or relatives about the situation. While for others, being strong might be as simple as severing ties with the man who committed the violation. For patients who were not sexually violated, talking to others about their situation and walking away from men who caused them trouble are also seen as signs of ‘being strong’. All of these steps indicate that the woman is taking more control in their life and is no longer a helpless individual whose course of life and actions are determined by other people.

Closely related to this, some of the doctors see the root cause of the desire for hymenoplasty to be the men in the social circle of the surgery-seeking women. This includes, primarily, her betrothed or (ex) boyfriend. Hence, doctors consider women who are able to stand up to these men or those who are able to break their relationships with them to be the kind of women who will decide not to undergo hymenoplasty. These are women who have the ability to be independent and self-sufficient.

It is furthermore considered to be essential that the patient is autonomous. For the doctors, the idea of autonomy is closely related to being able to go to school and/or being able to hold employment. Dutch doctors are often concerned that after marriage, their patients will stop their education—if they are marrying while in school—and they worry that patients will no longer seek a paying job. The unease the physicians have about this issue does not necessarily come from the possibility that the patients would choose to stay home rather than work. It comes more from the concern that the new husbands will prohibit the patients from seeking employment. This is observable in the following vignette.

Doctor:           *“You’re such a smart woman. I find it weird that you want this operation.”*

Patient:           *“Well (smiles) I’m still busy with my study. I’m not working yet.”*

Doctor:           *“Your fiancé is also okay with you studying and wanting to work?”*

- Patient: *“Yes, he works too. [...] So he understands. My father also said that it’s important for him that his daughter finishes her study.”*
- Doctor: *“Also after you have children? You can still work?”*
- Patient: *“Well, I don’t want to have children just yet. But yeah, on the one hand I thought it’s best for children to be raised by their own parents, on the other hand, when you work there’s also child care. So...”*
- Doctor: *“I have seen a lot of modern women after marriage simply stay at home.”*
- Patient: *“Yes, but you change after you are married. You have more responsibility.”*
- Doctor: *“Yes, but what I meant was autonomy [autonomie].”*
- Patient: *“Yes. Yes... I think. It’s still possible.”*

This excerpt shows us anew that the physicians consider the men in the patient’s life, in this case the husband in particular, to be the reason that she could not make a decision for herself. The patient is questioned about her ability to be an autonomous individual. It is however worthy to note here that the physicians conflate the ability to exercise autonomy with having or continuing employment, a tendency that has also been observed by scholars elsewhere (Roggeband and Verloo, 2007). Being a working woman is now considered to be a preferred quality which is incompatible with desiring hymenoplasty.

### **Advising, Worrying, Praising**

All of the desirable traits mentioned above are evident from the doctors’ talk with the patients during hymenoplasty consultations. The most common methods physicians use to convey the characteristics to the patients are through their advice. One doctor suggests to a patient, “You can focus on yourself first. Find a job so you can be independent. And then you can find a partner who is like that too. Then two independent people can be together.” The doctor’s advice here clearly highlights one trait: independence. But the advice also emphasizes, again, the importance of having paid employment. Both, as has been mentioned before, are traits Dutch doctors consider to be incompatible with desiring hymenoplasty.

Advice is not the only way to inform the patients of the desirable qualities. Expressions of worry are also used to convey a similar message. This is evident in the last excerpt where the doctor was questioning the patient about her autonomy, particularly her ability to continue her study and seek employment. “Your fiancé is also okay with you studying and wanting to work?” as well as “Also after you have children? You can still work?” clearly convey the doctor’s anxiety and highlight what qualities

that are considered to be preferable for the patient to possess. The patient evidently understood both the concern and the preference as she proceeded to placate the doctor's concern, "Yes, he [fiancé] works too. [...] So he understands. My father also said that it's important for him that his daughter finishes her study."

Apart from giving advice and expressing concern, doctors also use praise to emphasize the qualities they consider important. Doctors praise their patients when they are seen to possess or exhibit other 'preferable' qualities. "You're a strong woman," or "You are independent," are common praises. More frequently, the doctors also respond with a simple, "Good!" when they deem the patient to have expressed a commendable trait such as severing ties with a controlling boyfriend or, once more, having paid employment.

The vignette where the doctor stresses the importance of autonomy is also a good example of praise as a way to highlight a 'desirable' quality. At the beginning of the conversation, the physician was observed to offer a compliment to the patient, "You're such a smart woman. I find it weird that you want this operation." It is worth noting that in this statement, not only was the doctor commending the patient for a quality she possesses (being smart), but the doctor also highlights how such a trait is incompatible with desiring hymenoplasty. This vignette succinctly illustrates how Dutch doctors perceive certain qualities and characteristics to be irreconcilable with wanting the operation. The physicians then aim to inspire the patients through the consultations to embody these traits which they hope will eventually persuade the patients to decide against undergoing the surgery.

### To be Modern

Dutch doctors have a word that they often use to encapsulate all of the aforementioned 'desirable' qualities. This word is 'modern'. Going back to the vignette on autonomy, one statement by the doctor is evident of this: "I have seen a lot of modern women after marriage simply stay at home." This statement was made in the context of the doctor being concerned that an educated woman would not be able to continue working. This statement, as well as the rest of the vignette, highlights how a smart woman, a woman who is highly educated, a woman who works professionally and a woman who is independent and strong would be the type of women doctors consider modern. Being modern is seen as incompatible with desiring the surgery. It is because being modern is also equated with not demanding a woman be a virgin before marriage as well as being open to the exploration of sexuality including pre-marital explorations. The following vignette clearly illustrates this.

Doctor:            "*Okay. And your older brother is strict (streng)?*"  
 Patient:            "*No. not at all.*"



- Doctor: *“So he plays no role in this story?”*
- Patient: *“No. It’s my own life. I have my own life, my own thinking.”*
- Doctor: *“Okay but you know that in quite some culture the oldest brother is the honor.”*
- Patient: *“No no. My father also doesn’t think that way. Everyone is educated (afgestudeerd). They don’t think...”*
- Doctor: *“All modern people...”*
- Patient: *“Yes, modern.”*
- Doctor: *“Except for this thing.”*
- Patient: *“Yeah (laugh). But it is actually the culture that I’m afraid of, not my parents.”*

This “thing” the doctor refers to is the expectation put on the patient to be a virgin on her wedding night. The vignette clearly highlights how being modern is seen to be irreconcilable with this expectation. Here, it is also evident that being modern is not solely a trait the patient can aspire to. It is a quality that other people in her life can also embody through education.

Hence, whenever a patient comes in for a hymenoplasty consultation and she is deemed by the consulting doctor to possess some, if not all, the characteristics that qualify her as being modern, it is not uncommon for the physician to express amazement.

- Doctor: *“The woman who sits in front of me is a modern Dutch woman who is under a cultural pressure.”*
- Patient: *“Yeah... I’m not really pressured. But I don’t want it afterwards...”*  
(trailing off)
- Doctor: *“But now the case is you want to be operated even if you know well that blood loss is not guaranteed.”*
- Patient: *“No, that’s correct.”*

At the beginning of the vignette, the doctor made a notable comment about the patient being both modern and Dutch. Previous sections have explored how the possession of certain characteristics is being conflated with being Dutch. Since the aspired qualities are perceived by the physicians to result in being modern, it is unsurprising that being modern and being Dutch is also conflated as in this vignette.

The vignette also clearly highlights the surprise the doctors’ experience when confronted with a woman who they deem as modern but who still desires hymenoplasty. This study finds that Dutch doctors often are confronted with this self-afflicted irony. In fact, almost all patients who consider undergoing the operation can be seen as modern—according to the doctors’ own criteria. These patients are either working, currently in school or just recently completed their tertiary study. However, despite

being challenged by this paradox, Dutch doctors' conviction that a modern woman would not desire the operation prevails. To account for this, it is useful for us to go back to one of the doctor's comments highlighted previously, "She's half Dutch already!" When doctors meet a patient who they consider to be modern but who still desires hymenoplasty, instead of modifying their assumption that only non-modern women seek the operation, they adjust their assessment of the patient. Clearly, the patient is modern, but not modern enough to do away with hymenoplasty. In other words, she is only half Dutch.

### **Empowering Patients through Consultations**

Hence, Dutch doctors in this study treat their hymenoplasty consultation as more than just a provision of a medical service. They often remark, except for one doctor, that they aim to educate, framing their meeting with the patient as *voorlichting* (education). This education goes beyond just replacing the belief women hold concerning the hymen and virginity with the ones that are considered by the doctors to be 'medically correct' or 'modern'. Hymenoplasty consultation becomes an opportunity for Dutch doctors to instill the characteristics they deem to be preferable in the patients they are meeting with. All doctors, including one who does not aim to educate, see this chance as a way to empower patients to aspire and acquire the qualities they consider to be desirable.

This aim to empower is readily observable from the encouragement doctors give patients. It is also palpable in doctors' advice as well as in their concerns about the kind of woman they hope the patients can become. At the moment of the consultation, the patient might have been smart but she might still hold a 'medically incorrect' understanding of virginity. She might be a strong woman but she could trust herself more. She might be independent but she could make better decisions to make sure her life is not dictated by others. She could speak up more, stand up more and act more. In essence, the patient could become more 'modern'. Doctors view each patient to have the potential for this improvement. Fundamentally, every patient can be and is encouraged to be more 'modern' and consequently more Dutch.

### **Other People See Patients as Dutch**

However, what the doctors in the Netherlands often do not take into consideration is that the patients might have been seen by others, particularly by people of similar ancestry, to be Dutch. At the very least, the patients are frequently perceived, if not suspected, to have started to open up to or even adopt what other people in their social circles consider to be an unquestionable Dutch trait: the acceptance of exploration of sexuality, including and particularly pre-marital. Ironically, this spec-

ulation by others about the patients is not uncommonly what directly compels them to contemplate getting hymenoplasty. One patient explains, “He [my fiancé] is a bit strict. But not only him, the entire family is strict when it comes to virginity. Because I live here in the Netherlands, they are all afraid that I’m no longer a virgin.” Echoing the same sentiment, an exchange between one patient and the doctor illustrates this further.

Patient: *“Well, yes, over there it’s a bit different. Afghanistan is a strict country. You can’t even be with a man. But here, it is a free country. So, people think about what you must have done.”*

Doctor: *“So you think that in Afghanistan women are adequately preserved/protected (bewaard) ...”*

Patient: *“Yes.”*

Doctor: *“...and even if she didn’t bleed, people can still believe that she is still a virgin.”*

Patient: *“Yes.”*

Doctor: *“And this is a free country, so we must have a stronger control.”*

Patient: *“Yes.”*

Both patients in these cases are concerned that their chastity will come under close scrutiny and then they decided to entertain the possibility of undergoing hymenoplasty. Furthermore, the contrast between perceptions put on the patient by the doctors and by others in her social circle is readily observable. For the physicians, the patient is not Dutch enough which becomes the core reason, in the eyes of the doctors, why she is entertaining hymenoplasty. For people in the patient’s social circle, however, she is seen as Dutch enough to warrant an inspection of her virginity on the wedding night.

### **Responding to Dutchness**

What is also important to note here is that even if doctors do not see their patients as ‘fully’ Dutch yet, previous sections have demonstrated that they do acknowledge when their patients exhibit characteristics they consider ‘rightly’ Dutch. When the doctors are confronted with the Dutchness of their patients, they then act accordingly and are almost compelled to respect it. This explains why despite not favoring the operation, Dutch doctors still perform hymenoplasty when the patient ultimately decides to undergo the surgery. “The patient is the boss,” remarks one doctor often at the start of the consultation, “if she says “I want to be operated”, then we operate.” This is the doctors’ way of valuing the autonomy of the patient in making her own decision—a trait that the physicians consider to be preferable in a woman and when that trait is exhibited, it needs to be respected.

It is not infrequently the case that the patient's decision to continue on with the surgery is communicated to the doctors towards the end of the consultation. The patient typically has sat through 20 minutes to 45 minutes of meeting with the doctors during which medically correct knowledge about virginity and the hymen was imparted to her. Patients' decision to undergo the surgery after the consultation was then seen by the doctors as being made knowledgeably and with all the accurate and needed information. The physicians respect this 'informed' decision by performing the surgery.

## 6.6 Conclusion: Being Dutch as the State of Flux

This article has shown how Dutch national ideals and nationalism permeate everyday practices and how national identity is conveyed and promoted by Dutch citizens and 'street level bureaucrats'—in this case doctors. What we observe here is everyday nationalism chiefly taking the form of talking (Fox and Miller-Idriss, 2008) and arising when a 'native' individual (the physicians) encounters a person of migrant background (the patients). It is reminiscent of Brubaker's study that looks at how encounters between two people momentarily takes the form of an interethnic interaction (2006). What is unique in the case of hymenoplasty consultations is that the interactions take the form of evaluations by the doctors of the patients in which the perceived 'deficiencies' of the latter are attributed to a lack of national identity and therefore recommended as a solution. Dutchness becomes part of the medical advice prescribed by Dutch doctors to their hymenoplasty patients.

Many Dutch citizens prefer that immigrants accept the official discourse of religious, sexual and moral 'progressiveness' (de Koster et. al., 2014; Houtman, Aupers and de Koster, 2011). In other words, when it comes to issues of public morality and personal values, citizens in liberal countries do not necessarily favor diversity in opinions and cultural repertoires. Quite strikingly, liberal values are not defended as universal human rights but as characteristics of a national identity: Dutchness. This is where we differ slightly from Kaufmann's idea of multivocalism where he argues that differences in understandings of national identity only energize rather than detract (2017). While acknowledging that different individual understandings of national identity could exist side by side, a struggle for validity can emerge when two or more competing ideas meet. The case of hymenoplasty consultation in the Netherlands illustrates this.

Dutch physicians' idea of national identity mirrors a more general development in Dutch society in which citizenship is increasingly defined in cultural terms, in con-

trast to the cultural Other, in particular the Muslim immigrant (Duyvendak, 2011; Van Reekum and Duyvendak, 2012; Duyvendak, Geschiere, Tonkens 2016). Secularism, gender equality and the acceptance of homosexuality serve as ideological benchmarks to test whether immigrants have entered 'modernity', the singular condition according to which they are allowed to belong in Dutch society (Mepschen, Duyvendak and Tonkens, 2012). Scholars have argued elsewhere that Dutch people who are labeled *allochtoon* (coming from outside the Netherlands) are commonly seen as non-Dutch but are capable of acquiring a certain degree of Dutchness (Essed and Trienekens, 2008). Hymenoplasty consultation becomes a venue to negotiate Dutchness and what it is to be Dutch between the doctors, who are of 'native' upbringing, and the patients, who are of migrant descent. Conversations between doctors and patients in hymenoplasty consultations highlight that being Dutch is interactional and situational in nature. Patients' Dutchness is acknowledged at certain times but it is overlooked in other circumstances by others including the physicians and people in the patients' social circle. Dutchness in this context is parallel to van Reekum and van den Berg's (2015) 'dialogical Dutchness' where being Dutch is situated in an interactive network of meanings.

This paper has demonstrated that Dutch people of migrant descent are seen to permanently have a link with their non-Dutch background; hence they are perceived to be not (yet) 'entirely' Dutch. Other scholars on migration and integration in the Netherlands have reported similar observations (Roggeband and Verloo, 2007, Ghorashi, 2010). Therefore, there is a gradation of Dutchness where one can move from being less Dutch to becoming more Dutch. This scale of being is arguably not precise or linear yet it has its measurements in the form of characteristics and values that are seen as both favored and 'rightly' Dutch. The more these traits are observed in a person, the more that person is deemed (more) Dutch.

What this paper has also demonstrated is that the Dutchness of the same person might be evaluated differently by various people. In the case of hymenoplasty patients, the physicians see them as not Dutch enough while some people in their immediate social circle perceive them to be (too) Dutch. We have also witnessed how patients themselves challenge the physicians' evaluation of their Dutchness. Moreover, we have observed occasions when Dutch doctors seem to contradict their own assessment of the Dutchness of their patients: being surprised when a patient is seen to be quite Dutch and performing hymenoplasty on patients because she exhibits the Dutch characteristic of autonomy. This is where national identity exhibits its profound nature of ambiguity. Multivocalism chiefly points to how the understandings of certain national identities can be different from one individual to the next; as such we have demonstrated in the case of hymenoplasty in the Netherlands. However, more im-

portantly, we have also shown a complexity to the idea of national identity that goes beyond just varieties between individuals. There can exist inconsistencies in one's person understanding of a particular national identity; two people can have similar understanding of what a national identity entails but when that understanding is used to evaluate a third person, their assessments differ; and the same person can be considered to not exhibit enough national identity in one occasion but seen as adequate in a different one.

What this paper has made abundantly clear, assuming a particular identity, in this case being Dutch, also becomes about values and norms and not only about birth, formal citizenship or upbringing. Hence, one can always have and exhibit a degree of Dutchness, albeit perhaps very little. At the same time, one can also be perceived to be not yet entirely Dutch, even ever so slightly. Being Dutch, or not-Dutch for that matter, takes up a quality of being in a state of flux where one can simultaneously be Dutch and also not Dutch. In the context of everyday nationalism, the same individual can be deemed by others during different micro-encounters to exhibit too much national identity, too little or somewhere in between, highlighting a view of nationhood that is heavily multivocal, interactional and contextual. Exchanges between doctors and patients during hymenoplasty consultations suggest that being Dutch or not-Dutch becomes less of an absolute binary position and more of a continuum.

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## **CHAPTER VII:**

# WOMEN EMPOWERMENT AND HYMENOPLASTY

## **7.1 Article Title**

Telling the Truth and Looking into the Mirror: Hymenoplasty Consultations Framed as Efforts of Empowerment by Dutch Physicians

## **7.2 Abstract**

This paper looks at the effort of empowerment Dutch doctors provided their hymenoplasty patients during medical consultation on the procedure. The empowerment efforts Dutch physicians offer their patients are informed by 'deficiencies' they consider their patients to be in. These deficiencies boil down to two main aspects: (1) patients' perceived lack of knowledge about the hymen and virginity and (2) patients' deemed inability to rectify her dilemmatic social situation. Dutch doctors aim to rectify these lacks during their hymenoplasty consultations. Through closely examining different approaches and techniques of empowerment employed by the physicians when interacting with patients, different concepts of empowerment are revisited. Ultimately, this article looks at the kind of woman subject that is created through empowerment efforts attempted by Dutch physicians in hymenoplasty cases.

### 7.3 Introduction

This paper looks at the effort of empowerment Dutch doctors provided their hymenoplasty patients during medical consultation on the procedure. Hymenoplasty is a surgery often requested by women who wished to ‘repair’ a membrane in their vaginal canal, commonly known as the hymen, which they believe to have been ‘broken’ due to penile penetration (Ayuandini 2017b). The procedure is done by physicians and it is aimed to alter the shape of the hymen, usually by minimizing the aperture (Ahmadi 2013, Renganathan, Cartwright and Cardozo 2009, Cook and Dickens 2009). In the past 15 years, the demand for the operation has been increasing in the US, in European countries, as well as in Canada and China (van Moorst et al. 2012, Amy 2008, Steinmüller and Tan 2015). In the Netherlands, the operation is often requested by Dutch women of migrant ancestry who are often expected to ‘prove’ their virginity during the wedding night (Ayuandini 2017a, van Moorst et. al. 2012, Loeber 2015). Surgery seeking women dread the failure of fulfilling the expectation, fearing unwelcomed consequences, ranging from being shunned by their family to experiencing physical harm, including death (Eich 2010, Amy 2008).

Literature on hymenoplasty have often emphasized on the ‘subordination’ of women as the root cause of the desire for the operation (Bhugra 1998, Paterson-Brown 1998, Kogacioglu 2004, Parla 2001, Helgesson and Lynoe 2008). Hymenoplasty seeking women are perceived by scholars and medical professional alike to have to navigate sexual norm double standard. Men of their ancestry are often lauded for their sexual adventures, including pre-marital ones, while women are expected to keep their chastity before marriage (Loeber 2015, Bhugra 1998, Wild et. al. 2015). Due to this concern, opponents of the procedure urge doctors to abstain from performing the surgery, fearing promulgation of women ‘oppression’ as a result of service provision (Raphael 1998, Raveenthiran 2009, Roberts 2006). Those who recommend medical professionals to at least meet with women contemplating the procedure reason that they are in the perfect position to provide help and to prevent future possible harm to the women (Paterson-Brown 1998, Ross 1998, Logmans et al. 1998, Ahmadi 2015, Ross 1998, Juth and Lynöe 2015, Kaivanara 2016).

In the Netherlands, doctors performed hymenoplasty and consulted patients requesting the operation despite the recommendation of the Dutch professional body of obstetric and gynaecology to do otherwise (Fietsma and Kagie 2004). Physicians claim to be compelled to provide assistance, based on their understanding that the women might be in trouble if not assisted (Ayuandini 2017b). The help they offer is framed by these doctors in the rhetoric of empowerment and the physicians aim to assist surgery seeking women beyond what might be needed medically. In this context

of advices provided in a clinical setting, this article answers the following questions: (1) What assumptions about surgery seeking women inform Dutch physicians' understanding of the needed empowerment provided during hymenoplasty consultations? (2) What goals are hoped to be accomplished by the doctors through providing empowerment to their patients? (3) What roles do Dutch doctors see their patients play in influencing the rate of demand for the operation? And ultimately (4) How are women as a subject shaped and reshaped through hymenoplasty consultation and the effort to empower by Dutch physicians?

In the process of answering these questions, this article will revisit different concepts of empowerment—particularly that of women empowerment. Drawing from feminist theory, Freire's idea of pedagogy and from neoliberal perspective, I examine which repertoires of empowerment resonate with the case of hymenoplasty consultations. It is important to acknowledge that this article by no means is intended to be normative let alone determine whether a certain doctor's practice in the case of hymenoplasty is right or wrong. It is however aimed to be analytical and find parallels between different theories of empowerment and the routines of hymenoplasty providers in the Netherlands. By ultimately looking at the creation of specific women subject this article also touches on the contrast between two different understandings of an empowered subject: that of the feminist lens and from a neoliberal perspective.

### **Empowerment as Process – A Brief Overview of Theories of Empowerment**

Empowerment as a focus of research have been undertaken by scholars from different study concentration, ranging from development studies to social work to psychotherapy (Mosedale 2014, Bransford 2011, Pease 2002, Mattsson et. al 2000, Gutierrez 1990, GlenMaye 1998, Bransford and Bakken 2002). Empowerment is mostly framed in the scholarships as a process with some studies declaring it to also be a result (Gutierrez 1995, East 2000, Carr 2003, Staples 1990, Conger and Kanungo 1988). One of the more explored processes of empowerment concerns that of women empowerment in which the feminist theory of the issue takes center stage. Feminist theory recognizes knowledge as a central element in the process of empowerment and emphasizes on the concept of women as the ones who are the most knowledgeable of their own body (Jordan 1997, Gartner and Riessman 1982, Kline 2010). However, what is more paramount to have followed from this point of view is a notion of claims of knowledge that are diverse, contextual but also have potentials to be in conflict with one another (Harding 2004). It is a recognition that one own's experience of being a woman is simultaneously different yet similar with those of other women (Mosedale 2014). This understanding of knowledge also signifies an acknowledgement that any

position or situation a woman is in, including her marginalization or oppression, contributes to the production of valuable knowledge which potentially “nourishes one’s capacity to resist” (hooks, 1990, 150).

However, feminist theory argues that women empowerment cannot be achieved simply by women possessing knowledges as a result of their unique position. It is equally important for women to be aware of their singular situation and positionality which have led to the production of such knowledge (Carr 2003). What follows is a concept of consciousness-raising, an idea that was put forward by Freire in pedagogy (1970). Freire argues that for the oppressed to be emancipated it needs to start from building their own awareness of the structure of oppression they are in. Reflections of one’s position is critical which will lead to necessary actions for change. Freire further emphasizes on the need for both reflection and action to be done individually as well as collectively in a dialectical process. It is also crucial that the process is started by the oppressed themselves and by those in solidarity with them. Outsiders involved in the process cannot impose or dictate how change needs to happen as it will negate the entire spirit and progressions of emancipation itself.

Freire’s ideas were taken up by the second wave feminism particularly in the late 1960s and early 1970s and continued to be practiced by third wave feminism of today (Carr 2003, Sowards and Renegar 2004). The development of consciousness raising was often attributed to Sarachild who assembled small groups of women who were facilitated to share their experience through verbal personal testimony in order to relate to one another (Rosen 2000, Sarachild 1970). This deliberately cultivated rhetoric strategy was aimed to relieve women of self-blame in looking at their situation and to recognize common and shared experience between them (Kamen 1991). Again, we see the duality of awareness as a part of empowerment here: simultaneously better understanding one own’s situation while being cognizance of the wider context of collective marginalization of women (Worell and Remer 1992, Bricker-Jenkins and Hooyman 1986). By equally acknowledging the singularity of one’s experience while realizing commonalities in it with others, women identify the political dimension of their personal problems. This complex awareness is the very basis of the concept of consciousness raising, arguably one of the most important cornerstones of feminists’ understanding of women empowerment (Carr 2003).

The idea of consciousness raising cannot be divorced from the understanding of “the personal is political” (Hanisch 1969) which recognizes power relationships in every individual’s experience. The recognition of one own’s sociopolitical situation is therefore identified as a paramount step in the process of empowerment (Zimmerman 1995, East 2000). What this understanding then brings is the notion of praxis in which empowerment is achieved through dual approaches of action and reflection

(GlenMaye 1998, Carr 2003, Mies 1983, MacKinnon 1989, Maguire 1987). Reflecting on one own's position and its sociopolitical nature is an active strategy and the first step to taking action into moving towards other possibilities (Carr 2003, Alcoff 1994). Therefore, the recognition of one own's position has a certain goal which is to assume control of one's situation and to take action that will ultimately result in change (Zimmerman 1995).

The notion of reflection, action and change as the ultimate aim of empowerment in feminist theory is particularly unique as it aims for a collective nature of the goal (Stein 1997). Empowerment as praxis is seen by feminists as an interpersonal process in which dialogs and acts towards positive transformation are collective and social (Carr 2003). This is not to say that change is not aspired within individual's situation but it is to emphasize the importance of connection building between and among women. It is also to highlight how transformation to betterment needs to be mindful of structural and sociopolitical context of the collectives that extends beyond personal situation of any singular woman. The responsibility for change does not solely lie on any individual woman's shoulder (Butler 2004, Scott 2007, McRobbie 2009).

In some contrast, the concept of neoliberal empowerment has always been centered around the idea of a self-governing individual (Cruikshank 1996). Each of these empowered individuals are then capable to be a fully functioning citizen which is an essential element to achieve the goal of "free market, good governance, democracy and the rule of law and rights" (Sharma 2008: 17). The philosophy of neoliberalism is based on a three pronged strategy of empowerment, self-help and self-esteem which creates neoliberal subjects who voluntarily participate in the process of self-regulation motivated by their own self-interest (Sharma 2008, Rose 1996). This concentration on the self is not to neglect the focus on the collective but rather to merge the two as fulfillment of individual goals is equally seen by neoliberalist as a social obligation (Cruikshank 1996: 232). Empowered individuals who are each actualizing their own self-interests aggregately results in a society with an enhanced collective well-being (Sharma 2008).

This article looks at the case of hymenoplasty in the Netherlands where surgery seeking women are considered by Dutch physicians to be in need of being empowered. This situation is a rich case study to look at how empowerment is attempted in an institutional context of medicine. Through closely examining different approaches and techniques of empowerment employed by Dutch doctors particularly during hymenoplasty consultations, different concepts of empowerment are revisited. Ultimately, this article looks at the kind of woman subject that is created through empowerment efforts attempted by Dutch physicians in hymenoplasty cases.

## 7.4 Methodology

The study was conducted in two medical establishments in the Netherlands. The first establishment is a public teaching hospital and the second is a private clinic. The hospital is located in one of major Dutch cities while the clinic can be reached by train about an hour ride away from the capital. The hospital receives around 30-50 hymenoplasty patients a year while the clinic sees double that number of patients. All excerpts presented in this article come from observations conducted in these two establishments except for one. One vignette was taken from an observation done in a third, another hospital in the same city as the first hospital. Permission to conduct the study was also obtained from this hospital. However, during data collection period, there was only one hymenoplasty consultation observed in this establishment. This is mainly due to the lead doctor's extended leave of absent which did not allow many opportunities to meet with patient. Hence, this article will only focus on hymenoplasty consultations done in the first hospital (henceforth: hospital) and in the clinic. The one vignette from the third establishment is however important to be included as it illustrates the situation under discussion.

Findings presented in this article come mainly from participant observation of hymenoplasty consultations from 2012-2015 in the Netherlands. In total, 70 hymenoplasty consultations were observed. Since the 1970s, observation of doctor-patient interaction has been viewed as a productive method in the (social) study of medicine (see for example Korsch and Negrete 1972, Pilnick and Dingwall 2011 and Arora 2003). However, due to the high need for discretion to protect identity of patients, ethnographic observation of hymenoplasty consultations has never before attempted and therefore unique to this study.

Hymenoplasty patients were identified as they make appointment to meet with doctors. In the hospital, this was usually either through contacting the receptionist or by means of a referral from their huisarts (a general practitioner akin to a family doctor). In the clinic, patients tend to phone in to schedule an appointment. When patients visit the establishment and before they meet with the doctors, they are asked of their consent for their meeting to be observed. Consent is done verbally to ensure no superfluous documentations link patients' identity to their intention of undergoing the surgery. This consent process is approved by Washington University Institutional Review Board and by the hospitals' ethical board. A different consent was sought for the consultation to be recorded. Without patients' agreement, extensive notetaking takes place instead. Excerpts presented in this article comes from transcribed recordings and carefully reconstructed field notes, both translated from Dutch to English.



Analysis is done immediately after the collection of findings and cyclically to feed immediate discoveries back into data gathering. In line with the spirit of qualitative research and constant comparative method, the progress of explorations was closely informed by emerging key themes and concepts (Glaser 1965, Boeije 2002). Grounded theory approach was then used in later stages of the study as a basis of formation of main arguments (Strauss and Corbin 1994). A computer-assisted qualitative data analysis software Atlas.ti was used when necessary to support a more thorough examination of data. Codebooks were developed both in vivo and with abstractions to aid the process of synthesis and the writing of this article, specifically (Kelle 2004).

## 7.5 Findings

### Compelled to Help

Dutch doctors involved in the provision of hymenoplasty are commonly with the understanding that women who seek the surgery do so because they are in a difficult situation. Not infrequently it is the women themselves who volunteered information of the social dilemma they are in. Women contemplating hymenoplasty often desire the surgery because they see themselves as no longer sexually untouched while at the same time they will be required to ‘prove’ their virginity, customarily during the wedding night. Inability to fulfill this expectation—in most cases by failing to bleed after the first sexual intercourse with the newly wedded husband—can result in unintended consequences ranging from being ostracized to experiencing physical repercussions. Laila, a Dutch woman with South Asian ancestry told the doctor almost as a matter of fact of what awaits her if she does not to bleed in her wedding night.

Doctor: *“... Let’s say [...] you don’t bleed. What will you do then?”*

Patient: *“Then I’ll go to another world.”*

Rik: *“Then you’ll be dead?”*

Patient: *“Yes.”*

Laila’s predicament might sound extreme but her story is not unique. Through years of practice Dutch physicians are aware of similar dilemmas some Dutch women, typically of migrant descent, are facing as they are getting married. Doctors then feel compelled to lend a hand in order for the patients to overcome the problems they are in. In fact, the physicians I talked to almost always claim that the reason they consult on and/or perform hymenoplasty is to help patients. This is commonly the rationale behind doctors in the Netherlands still offering the surgery despite being aware of the recommendation by their professional association to abstain from the provision (Feitsma and Kagie 2004).

In providing help to these women, Dutch doctors' actions are motivated by a set of assumptions and logic that in turn shape the kind of assistance that is offered. It is important to note here that the doctors are offering solutions to the patients in the aim to not only 'fix' a biological 'problem' the patient is having, i.e. having a perceived 'unintact' hymen, but they ultimately target to remedy the social dilemma the patient is facing. Accordingly, physicians' ideas about factors that lead to the existence of the (social) dilemma the patients are in color the advice they are giving during hymenoplasty consultations. One of the most common perspective Dutch physicians have about women seeking hymenoplasty is that they are in the position of deficiency. This position leads them to be in the problematic situation they are in and simultaneously trigger the desire for the operation. Therefore, doctors' recommendations address such perceived lack in order to rectify it.

Two main deficiencies are frequently considered by Dutch physicians to lead to their patients wanting the operation: (1) Women's lack of understanding of the 'medically correct' knowledge of virginity and the hymen and (2) Women's inferior position within her immediate social circle that makes her subject to burdening sexual expectations. Hymenoplasty consultations become an opportunity to remedy these deficiencies. Hence, Dutch doctors often identify their meeting with patients who are contemplating the surgery as not only a medical appointment but also a counselling session. More importantly, they also see it a means to empower the women they are consulting. In line with the two perceived deficiency of hymenoplasty patients, Dutch doctors' efforts to 'empower' focus on two aims: (1) To educate women with the 'right' knowledge of the hymen and virginity and (2) To equip women with the skills and attitude that will rectify her inferior positions in her immediate social circle.

### **Educating Women of the Hymen and Virginity**

Many Dutch physicians are convinced that the desire for hymenoplasty stems from a misunderstanding of the hymen and its connection to observable virginity. The majority of women meeting the doctors to contemplate hymenoplasty imagine an 'intact' hymen to be either a wall like structure that blocks the vaginal canal or a ring like membrane with annular and regular edges. The use of the word imagine here is intended as most, if not all, patients have never observed their own hymen. Although some admitted to have seen either photos, pictures or illustrations of it, commonly on the internet. Dutch physicians' professional experiences, particularly from doing pelvic exams, present a different understanding of the hymen. The membrane does not have a 'standard' shape and its condition can be very different from one woman to the next, regardless of her sexual history. An 'intact' hymen, a vaginal membrane that has not yet experienced penile penetration, does not always lend to it appear-

ing 'tidy' with annular edges and a small opening. Some women that are sexually untouched possess a hymen membrane with small amount of tissue, relatively larger opening and/or notches and clefts on the edges. The hymen is also highly flexible in nature which means sexual penetration does not always result in its integrity being compromised. Hence conversely, women who had had sexual intimacies previously can be proven to have 'an intact looking' hymen, absent of clefts or large aperture and with plenty of tissue. Doctors and physicians around the world have often maintained that due to this high variability of the hymen's shapes and forms, discerning a woman's sexual history through observing her hymen is far from definitive and, in an overwhelming majority of the cases, highly unlikely (Ayuandini 2017a, Adam, Botash and Kellogg 2004, Edgardh and Ormstad 2002, Bravender et. al. 1999).

Women contemplating hymenoplasty and people in their immediate social circle tend to view the hymen and virginity in contrast with the physicians' perspective. Many are under the impression that the hymen will always 'break' following the first coitus, resulting in bleeding. Hence, the view that a virgin woman bleeds after her first sexual penetration prevails and blood on the marital bedsheet being considered as a sign that the bride was sexually untouched is a common view across the globe (Logmans et. al. 1998, Buskens 1999, Skandrani et. al. 2010, Cinthio 2015, Ghanim 2015). This perspective and the customary practice to check the marital bedsheet for the sign of blood to 'confirm' the newly wedded woman's chastity are what often compelled hymenoplasty patients to seek the surgery. Many patients consider themselves to be no longer sexually untouched. They perceive their hymen to already be 'broken' which makes them unable to bleed during the wedding night. They then turn to hymenoplasty to 'restore' their hymen and their ability to bleed.

In contrast, Dutch physicians and many doctors around the world consider the connection between chastity and an 'intact' hymen to be weak (Ayuandini 2017a, Adam, Botash and Kellogg 2004, Edgardh and Ormstad 2002, Bravender et. al. 1999). Doctors are also still in disagreement of what the biological function of a hymen is. Furthermore, studies have shown that women do not always bleed the first time they experience penile penetration (Raveenthiran 2009, Hegazy and Al-Rukban 2012, Christianson and Eriksson 2013). Dutch physicians have also learned from their decades of experience providing hymenoplasty, that the operation does not guarantee bleeding during the first coitus after the surgery (van Moorst et. al. 2012) Consequently, hymenoplasty is seen by physicians and other medical professionals to not only be absent of any medical necessity (Ayuandini 2017a) but also ineffective to serve patients' goal which is more often than not to be able to bleed during their wedding night.

Coming from this position, some Dutch doctors are convinced that if only the women who are contemplating the surgery share their professional knowledge about

virginity, the hymen and hymenoplasty, then they would decide to no longer seek the surgery. It is important to stress that Dutch doctors' reluctance of performing the operation mostly stems from their point of view that the surgery is medically unnecessary. Some physicians even call it nonsense in few occasions, which makes the act of incising a healthy body to be considered too severe and that it compromises bodily integrity needlessly. This basic reason is important to underscore and I will come back to this point later on in the article.

Therefore, during hymenoplasty consultations, Dutch doctors constantly impart information about the hymen particularly debunking the connection between its perceived intact condition with virginity and that virgin woman bleeds at first coitus. The following conversation is a typical exchange between a doctor and a hymenoplasty patient.

- Doctor:            *"What do you know about the hymen?"*  
 Patient:            *"Not a lot."*  
 Doctor:            *"What is often said is that people can see whether someone is a virgin or not. You can't see it."*  
 Patient:            *"You can't see it?"*  
 Doctor:            *"No. I have examined thousands of women and I cannot see whether or not they're virgin."*

As apparent, the doctor here is convincing the patient that a woman's virginity cannot be discerned by examining her hymen. This statement is sometimes made as a response to the patient making a comment that a physician, or a senior older woman she has heard about, can 'tell' whether or not a woman is sexually untouched just by 'looking'. Dutch doctor also explains how hymenoplasty is done and what can or cannot be expected from the surgery. They emphasize that the operation is not a guarantee for the ability to bleed during the wedding night. The imparting of this information is often also supplemented with visual aid. Computer slide show or a brochure or a pelvic model is used to explain to the patient what the hymen looks like, where it is located and the differences of it in shapes and form, independent from the sexual history of the woman who owns it.

In most cases, hymenoplasty consultations in the Netherlands also include a gynecological examination. This examination is normally done by a female physician—both due to patients' requests as well as because the gynecologists involved in the provision of hymenoplasty in the medical establishments at which I did my study happened to be all women. The gynecological examination has two aims; one practical and the other educational. In the case where surgery is to be performed, it is necessary for the physician to be familiar with the condition of the patient's hymen in order to be able to know what needs to be done during the operation itself.

However, gynecological examination is still strongly recommended by some Dutch doctors to their hymenoplasty patients as a part of the entire hymenoplasty procedure regardless of whether or not the patients lean towards getting the operation. This is particularly true if the patients are still unsure of the decision regarding the surgery. Gynecological examination is used as another tool to 'educate' the patients to rectify the lack of knowledge that is perceived by Dutch doctors to lead to them wanting hymenoplasty. In this case, patients are 'taught' of their own body, their intimate organs, and about how to 'control' them. As has been mentioned earlier, many hymenoplasty patients have never seen a hymen, particularly their own. Some Dutch physicians are convinced that if the patients see with their own eyes how their own hymen looks like, they will at the very least cease to be under the impression that their hymen is 'broken' or 'loose'. Dutch doctors have narrated to me how patients become empowered after inspecting their own vaginal canal, simply because now they are equipped with a knowledge they did not have before. This is also due to the relief they experienced upon finding out that their hymen is not as 'broken' as they thought it was.

During the gynecological examination, patients are encouraged to observe through the mirror their own hymen. This exercise at times creates some distress to the patients as many prefer not to look at their intimate organs. The following fragment illustrates such situation.

Gynecologist: *"Okay, we will do the examination now. We will see what it looks like down there."*

Head Doctor: *"And you have to see it yourself."*

Patient: (Laugh) *"Noooo, I don't want to see it. I don't want to see anything!"*

Gynecologist: (Performing examination on the patient)

Patient: *"Can you tell whether I'll bleed or not?"*

Gynecologist: *"No."*

Patient: *"I don't want to see anything."*

Gynecologist: *"Have you seen it yourself?"*

Patient: *"No."*

Head Doctor: (Picking up a mirror) *"You have to look into the mirror. If not, you'd see nothing. See how it is closed? That's your external. And that's your internal. See how there's no big hole? See how small it is? There, that folded thing. Do you see that? So small. It is not entirely closed, of course. Now, let's try to contract your muscle."*

As much as seeing the hymen being considered by Dutch doctors to be an important empowering experience for the patients, the aim of the gynecological examination does not stop there. As can be seen from the last sentence uttered by the head

doctor, the examination also provides an opportunity for the patients to practice contracting and relaxing their pelvic muscles. This exercise is seen by Dutch physicians to be important for the patients to understand. Many of the patients not only hoping that hymenoplasty will help them bleed during the wedding night, they also wish for the operation to 'tighten' their vaginal canal. Patients are often under the impression that their vaginal opening has been 'loosen' due to the sexual penetration they experienced, especially if done multiple times. Dutch physicians are keen to 'debunk' this point of view. They inform patients that the tightness of the vaginal canal comes from the contraction of the pelvic musculatures. They also emphasize that a sexually inexperienced woman tends to be 'tighter' because of the anxiety of experiencing sex for the first time which results in subconscious contraction of the pelvic muscle.

To further ground this point of learning, Dutch doctors introduce to their hymenoplasty patients how to achieve the contraction and the relaxation of the muscles. During gynecological examination and by using a mirror to show the effect, patients are encouraged to contract and relax their pelvic muscles. While patients are doing the exercise, physicians draw attention to how the vaginal opening seem to narrow and to widen accordingly. Patients are then advised to repeat the exercise at home, using one finger inserted into the vaginal canal to discern the tightness of the muscles. The thinking behind this recommended exercise is for the patients to then be quite used to control the narrowing of their vaginal canal. It is hoped that they can then do so easily come the time of coitus with the husband during the wedding night, giving the impression that they are still virgin.

### **Knowing Your Body**

The notion of women as the most knowledgeable of their own body has been argued and demonstrated often in many studies. These studies range from Jordan's critique of hospital births that alienate women from their own bodily information during labor (1997) to studies that looks at the core principle of feminist clinics of self-help and know-your-body (Gartner and Riessman 1982, Kline 2010). The most famous example of literature on self-knowledge is arguably a book called *Our Bodies, Ourselves*, first published in the 1970s, now in its fifth edition (2011). The book was originally a result of discussion papers written collectively by a group of women later known as the Boston Women's Health Book Collective, gathering for the first time in 1969 (Davis 2002). Since then, the collective has also incorporated views from women from different places in the world. The book becomes a compilation of critical knowledge of the women's body, by women and for women. It celebrates a universal understanding of what it means to be a woman while at the same time acknowledging the plurality of individual woman's experience (Kline 2010, Davis 2007).

The basic premise of all of these writings are similar: “women’s experience ... represented the most empowering, most liberating source of knowledge” (Kline 2010, p. 42). To bring it back to the context of hymenoplasty, pelvic examination done during gynecological visit as a part of hymenoplasty consultation has been framed often in other studies to be a potential source for empowerment (Larsen, Oldeide and Malterud 1997, Mattsson 2000, Wijma and Siwe 2004). Specifically, the practice of observing your own vaginal canal has been argued elsewhere as an empowering experience. Kline (2010), upon writing on the historical account of pelvic exam, recounts a pelvic exam instructor’s comment on the process, “We encouraged every doctor to have a mirror on hand—it is a really exciting experience to see one’s cervix and vagina, especially for the first time” (p. 54). This statement was made during the time when pelvic exam went through modification of conduct in order to provide better respect and a more dignified experience for women who undergo them.

What is intriguing in the case of hymenoplasty is that we are observing women being deemed to not knowing their body enough which leads to them resorting to extreme measures such as surgery. In the Netherlands, physicians then act as motivators and facilitators to allow patients to ‘experience’ their own vagina and hymen and therefore the ‘right’ understanding of them. As arguably these surgery-seeking women have had sexual encounter even coitus and therefore have ‘experienced’ their intimate organs previously, we are witnessing the championing of knowledge even bodily experience in the framework of clinical setting. To understand the significance of this context, it is important to highlight that the ‘wrong’ knowledge women have about their hymen. This ‘wrong’ knowledge is either their understanding that the hymen is closed wall like structure or that it is always wounded after the first penile penetration. However, this ‘knowledge’ only becomes problematic when it leads women to see the situation as a predicament and want to fix it, particularly through surgery. Hitherto, there is no systematic information on whether women who do not desire hymenoplasty have the ‘right’ knowledge of the hymen. But since these women do not attempt to go under the knife, it has not turned into an unproblematic situation at least for the physicians. Dutch doctors do lament that the circulation of ‘incorrect’ knowledge of the hymen and virginity contributes significantly to the desire for hymenoplasty. In this context, even non-surgery seeking women have a part in the propagation of the knowledge. However, what is crucial to note here is that the surgery itself becomes the focal point in the perception of the problem of lack of knowledge of women about the hymen and virginity. In other words, if the demand for surgery ceases completely, the lack of knowledge might not be flagged as problematic either by scholars or medical professional alike.

In general, hymenoplasty scholars have been vocal in recommending ‘education’

to increase knowledge of the surgery seeking women and also people in their social circle about the hymen, virginity and the surgery itself as an answer to the increasing demands for the operation (Christianson and Eriksson 2013, Wild et al. 2015, Essen et al. 2010). It is believed that with ‘medically correct’ knowledge of the hymen and virginity, women will refrain from getting hymenoplasty. A study has argued that there are at least correlations between two as only one third of hymenoplasty patients in the study decided for the surgery after series of consultations designed to impart knowledge of the hymen and virginity (van Moorst et. al. 2012). Some Dutch doctors even consider their hymenoplasty consultations successful if the patients ultimately decide to not go forward with the surgery. What these doctors then recommend are ‘alternative solutions’ or what the physicians often refer to as ‘tricks’ (Ayuandini 2017b). These tricks will allow patients to achieve the goal they commonly hope from hymenoplasty which is to produce blood stained bed sheet on their wedding night without having to resort to surgery. The ‘tricks’ range from pricking own finger with a needle to taking out own blood to be put into a vial which can then be spilled onto the bedsheet at an opportune moment.

The introduction of these ‘tricks’ are also seen by Dutch physicians as necessary as the surgery does not guarantee a 100% chance of bleeding. In some occasions, the ‘tricks’ are considered a ‘better’ solution to what the patient hopes to achieve during her wedding night. For these reasons, even Dutch doctors who do not have a fundamental objection to performing the operation inform their patients of the existence of the tricks. However, for physicians who consider the surgery as ‘nonsense’, the ‘tricks’ are welcomed alternatives. They allow doctors to persuade patients not to undergo an operation they consider medically unnecessary. What is clear from the Dutch physicians’ choice of actions in consulting on hymenoplasty thus far is that their aim to ‘empower’ women through the imparting of ‘medically correct’ knowledge about the hymen and virginity is to eventually dissuade women from getting the operation. Patients are considered more empowered when they possess the ‘medically correct’ knowledge of the hymen and virginity. However, that empowerment should serve as a means to achieve the ultimate condition of being empowered: no longer wanting the operation.

Consequently, when patients who meet with the doctors demonstrate that they possess all ‘medically correct’ knowledge of virginity and the hymen but insist on getting the operation nonetheless, some Dutch physicians are left astounded. The following exchanges illustrate this:

- Doctor:            *“But now the case is you want to be operated even if you know well that blood loss is not guaranteed.”*
- Patient:            *“No, that’s correct.”*



- Doctor: *“And that being tight is something you can make sure of by yourself.”*
- Patient: *“Yes, correct. But I still choose the operation.”*
- Doctor: *“And why?”*
- Patient: *“Yeah, my cousin underwent it. I have heard a good story about it. And I choose for it.”*
- Doctor: *“Even though it’s nonsense.”*
- Patient: *“Yes, it is nonsense. But I need to protect myself against my fiancé.”*

It is clear that the doctor in this case was baffled by the decision of the patient who still desires hymenoplasty despite understanding that the surgery might not provide her with the result she was hoping for. The doctor ended up ‘granting’ the patient the surgery, keeping his promise at the beginning of the consultation that if the patient still desires the operation after the consultation is completed, she will be operated.

The request for hymenoplasty is not always granted and Dutch physicians have refused to operate on patients in their career. One doctor recalled a situation when she almost refused a hymenoplasty request from a patient. She remembered the patient well. The woman was, according to the doctor, “[v]ery modern, very open, very sexual[ly] experienced.” The patient came with her sisters, laughing all the way through the consultation and admitting to multiple consensual sexual encounters before being engaged with her current fiancé. The patient did not come across as being in distress or in any danger of unintended repercussions because of her past. The doctor was very troubled with the patient’s decision for wanting the surgery and considered strongly to refuse her request. The patient finally decided against the operation so the doctor was saved from having to reject her. A different doctor has also rejected patients before. One he particularly remembered was a Creole woman in her 40s with one adult child. The woman was marrying her longtime boyfriend who she has been intimate with in the last 10 years. She desired to bleed during her wedding night and wanted the operation for that purpose. Her request was denied.

### **Men Do Not Know**

From the last exchanges between the doctor and the patient, it is important to draw our attention to the patient’s last sentence, “But I need to protect myself against my fiancé.” One particular doctor who has been performing hymenoplasty two even three times a week for the past four years has heard similar statements from other patients. Because of this, the doctor argues that ‘educating’ the patient with the ‘right’ knowledge of the hymen and virginity is not sufficient to help her overcome the problem she might be facing at home. The patient might be ‘enlightened’ but other people in her immediate social circle, particularly her future husband, are still not aware of

the ‘medically correct’ knowledge about the hymen and virginity. As such, they will still demand the patient to ‘demonstrate’ her virginity during the wedding night. This particular doctor tends to view hymenoplasty differently than other physicians in the Netherlands. She considers hymenoplasty medically unnecessary but has no fundamental problems in performing it, equating the operation as just another ‘trick’ to put blood on the bedsheet. The doctor claims that providing the operation is what really empowers the patient, not by simply ‘educating’ her.

Other doctors have not been entirely in agreement with this point of view. In one of the semiformal gatherings of Dutch sexologists conducted every six months or so, arguments broke between the doctor and another physician on this issue. The other physician is concerned that the consultation the doctor does is too short in duration for the patient to fully consider her options and to receive proper counselling. As a result, patients lean towards getting the operation most of the time. This other physician is one of Dutch doctors who strongly views educating and imparting ‘medically correct’ information about the hymen and virginity to the patients as a means of empowerment to those patients.

The doctor disagrees. “What they’re doing is dissuading the women from getting the surgery. Well, is that really empowerment? These women, they want to move on. They want to get married and have kids. And not being a virgin is the only thing that blocks them from doing that. So I see this as helping them to be able to do that. That’s empowerment,” the doctor stated to me the day after the gathering. Here we see a different view of what empowerment is. Empowerment in this case is seen as providing a way for another person to be able to experience change for the better which will allow her to then achieve goals in her life. Hymenoplasty for this particular doctor is a way to provide this ‘better’ situation to the patient. Hence, hymenoplasty is framed by the doctor as empowering.

Even if other Dutch physicians I work with do not agree with how ‘freely’ the doctor is seen to provide service to perform hymenoplasty, they do see a change in the life situation of their patients to also be something preferable. Addressing this, Dutch doctors provide recommendations and advices to their patients on what can be done to improve the situation the patients are in. Among the advice, doctors commonly promote certain characteristics they believe if possessed and demonstrated by the patient will help them to achieve a ‘good’ life. Some of the more common characteristics to be encouraged are being highly educated, staying in school and having paid employment. These traits are considered very important by Dutch doctors, it is not uncommon for them to check with the patients whether they will still be able to possess or do them after marrying. The following vignette illustrates this:

Patient:           *“Well (smiles) I’m still busy with my study. I’m not working yet.”*

- Doctor: *“Your fiancé is also okay with you studying and wanting to work?”*
- Patient: *“Yes, he works too. [...] So he understands. My father also said that it’s important for him that his daughter finishes her study.”*  
[...]
- Doctor: *“I have seen a lot of modern women after marriage simply stay at home.”*
- Patient: *“Yes, but you change after you are married. You have more responsibility.”*
- Doctor: *“Yes, but what I meant was autonomy [autonomie].”*
- Patient: *“Yes. Yes... I think. It’s still possible.”*

The doctor’s last sentence in the above excerpts is particularly important. Dutch physicians highly value formal education and paid employment for their patients because they believe it will allow the patients to have autonomy in their life. Autonomy is seen by Dutch doctors to be a significant factor that will allow the patients to have more control in their life and in turn the patients will not have to always submit to other people’s demands. This will ‘free’ patients from requirements such as that of virginity before marriage that puts them in the difficult situation they are in currently.

Among all the people Dutch physicians perceive the patients to be beholden to, it is the future husband they considered to present the biggest potential future problems. Future husbands are also the ones they see to be the source of most patients’ current predicament. Accordingly, Dutch doctors question their patients from time to time whether they are sure of their choice of spouse.

- Patient: *“I don’t think he [future husband] is a virgin. I want to tell him [about my past] several times but he always has such strong reaction and maybe he will think that it’s bad.”*
- Doctor: *“Women find it hard to explain because they are not sure how the men would react.”*
- Patient: *”Yes, I don’t know how he would react.”*
- Doctor: *“Still you want to marry him?”*
- Patient: *“Yes. (laughed)”*

In the above exchanges, the doctor acknowledges the difficulties in explaining about one’s past to the intended man. However, interestingly, ‘talking’, particularly to one’s betrothed is still a very frequent advice Dutch doctor will give to their hymenoplasty patients to amend the situation they are in.

### **Talk to the Man**

Dutch doctors are in agreement that the virginity demands put upon their patients by people in her immediate social circle are undesirable and often unfair. This

is in part due to their understanding that men with similar ancestry to the patients are not held to the same standard of chastity before marriage. But also because they have often come across patients whose loss of virginity was due to an episode of sexual violence. Therefore, Dutch doctors are often of the thought that if only people in the patients' life, particularly their boyfriend or fiancé, can understand and be accepting of the patients' past, the patients will no longer be in a difficult situation. Accordingly, as it is important for some doctors, the patients will no longer require surgery. Dutch physicians reason that one of the best ways to achieve this understanding is by patients having conversations about their sexual past not only with their betrothed, but also with other people in their social circle.

'Talking' is one of the most frequent advices Dutch doctors suggest to their hymenoplasty patients in order to rectify the dilemma the patients are in. This recommendation comes in the context of patients often admitting that they and their boyfriend or fiancé have never actually talked about intimacy or sex. This is despite the patients being aware or suspecting that their intended will expect them to 'showcase' their virginity during the wedding night. Dutch physicians frequently entertain the idea that there is a chance the fiancé or boyfriend of their patients might not actually expect the patients to 'prove' their chastity and that his suspected demand is 'incorrectly' deduced by the patients themselves. Accordingly, Dutch doctors encourage their hymenoplasty patients to clarify this expectation. "Telling him is another option," said one Dutch doctor to a patient, "... I have also talked to women who did talk to their boyfriend and found that it's [not bleeding] not a problem at all." Another physician remarked, "I have met some women. Also from Muslim background. They say, 'Well, I will just say the truth. If it becomes a problem than he is not worth it'"

Talking or telling the truth is also considered by Dutch physician as empowering. This is particularly because talking is seen by them to have the power to rectify the difficult situation the patients are in. Apart from that, as can be partly discerned from the last doctor's statement, talking is considered a way for patients to recognize and announce their own worth to the other person hence becoming brave and confident in doing so. Talking or speaking up has long been recognized as a means of empowerment for women. This is specifically true in women empowerment programs that are organized and promoted by the government, aid agencies or international organizations as parts of development initiatives in countries often referred to as 'the third world'. Talking or speaking up is advocated in this context to build up the 'agency' of women, "the ability to define one's goal and act upon them" (Kabeer 1999, p. 438). Being able to speak up in itself is also frequently considered to signify greater level of empowerment of any individual woman, especially when the talking is done on a public forum (Burnet 2011, Baily 2011).

The importance of ‘talking’ as empowerment for women can be traced back to black feminist thinkers such as bell hooks or Carol Boyce Davies where the importance of ‘voice’ for black women is highlighted as historically entrenched. Davies states, “... Black women were seen/are seen/have been seen as having nothing important to say” (1994, p. 5). In advocating for black women to open up about their experience and to not keep certain things secret in the effort to not inconvenience others, bell hooks coined the term ‘coming to voice’ (1989, p. 12). Drawing from her own revelation she writes, “In all this talking, I was concerned that I not lose myself, my soul, that I not become and object, a spectacle. Part of being true to me was expressed in the effort to be genuine [...] to be real [...]” (hooks 1989, p. 3).

However, talking is not always considered by hymenoplasty patients to be preferable, particularly because talking can come at a price.

Doctor: *“Is it not possible to tell your fiancé about your past?”*

Patient: *“No, he wants a virgin woman.”*

Doctor: *“So if a woman is violated, that’s her fault?”*

Patient: *“No. But she’s not a virgin anymore. I’m not sure how he would think of it. [...] Maybe I’m just afraid to lose my fiancé.”*

Patients are often worried that speaking up or even vaguely inquiring about the expectation of virginity before marriage might alarm their fiancé. It might then cause the man to be suspicious which might lead to him severing the relationship. A boyfriend of a patient, who wanted the surgery because she was required to marry a different man by her family, exclaimed in anxiety when the idea was introduced during consultation with the doctor. “But you can’t bring it up! (speaking to his girlfriend) If you did he will definitely suspect something. I would. (Turning to speak to me) Men are like that. If she said anything, they will immediately finish everything [break the relationship].”

Dutch doctors are aware of this predicament. They also recognize that the expectation to ‘prove’ virginity is also often particularly required of patients by others in her social circle and not specifically by the fiancé. However, the physicians’ recommendation to rectify the situation remains similar: talking. Patients are also encouraged to talk to their family, particularly their mothers, with the same logic that if only the family fully understands the dilemma the patients are in, they might help amend the situation, changing it for the better. Talking is seen by Dutch doctors as the first step to make changes and therefore it is also perceived as the patients taking action and responsibility to improve their situation. Both signify the patients being empowered. Talking is also ‘prescribed’ to patients to address other sources of problems in their life. Patients who are still haunted by their sexual violation are advised to talk about their trauma to a psychologist. Patients who are dealing with emotional distress are

suggested to open up. “Talk to your family doctor (huisarts). Tell her that, ‘I’m occupied with sadness.’ Tell your huisarts that your mother wants you to get pregnant. [...] You need to talk about it with someone,” recommended one doctor to a patient who was visibly upset during her hymenoplasty consultation.

### Change the Expectation

What is important to note here is that it is almost implied by the doctors that it is the responsibility of the patients to make the family understand of their situation. Patients are seen to have the potential to make alterations in their circumstances, both in regards to her current predicament and to her future state. Moreover, patients are also seen by Dutch physicians to be able to affect change in a context bigger than just her own personal life. When it comes to the desire of having hymenoplasty, Dutch doctors consider the root cause of it to be closely intertwined with the sexual norms, beliefs and values circulating among people of similar ancestry with the patients. Patients are then perceived by the physicians to be able to amend this cultural context, chiefly by (again) ‘talking’ with others. Patients are expected to relay the ‘medically correct’ knowledge they just received about the hymen and virginity to inform people they know. Accordingly, the aim of Dutch physicians in imparting information of the hymen and virginity to their patients is not simply to ‘enlighten’ only the patients. Doctors aspire for their consultation to also ‘educate’ other people of the patients’ ancestry—starting with the patients’ intended and her immediately family—with the patients as the messengers to spread the ‘education’.

One doctor alludes to this ‘spreading of information’ when pondering about the recent demographic of hymenoplasty patients in one public hospital in the Netherlands. This doctor claims to have observed a decline in numbers of patients particularly among those coming from Moroccan and Turkish background. The doctor’s assertion is that hymenoplasty protocol that includes enough time to counsel and ‘educate’ the patients might have made an impact among Dutch Turkish and Dutch Moroccans, resulting in fewer patients seeking hymenoplasty. The doctor assumes that this is partly because former patients might have spread the ‘medically correct’ knowledge of the hymen and virginity to the people of their ancestry. To make sure that patients do relay the information they receive in the consultation room, Dutch doctors from time to time actively encourage their patients to do so, as can be seen in the following fragment.

Patient: *“He thinks that a virgin is completely closed. So when he found out about the hymen from the internet he asked me, “Oh, so there’s actually a hole there?” I replied, “Well, where do you think menstruation blood comes from.”*

Doctor: *“Good for you. [...] You have to enlighten him.”*

Some doctors even attempt to inspire the patients to do something even more drastic: a complete overhaul of the cultural norms the physicians perceive to have informed the desire for the surgery. “Yeah, culture you make yourself,” replied one doctor to a patient who referred to her ‘culture’ for the reason why women of her ancestry are expected to abstain from sex before marriage while men are not. Exchanges below, with the same doctor but a different patient, further illustrate this.

Patient: *“If it depends on me, I find it very bullshit [sic] but yeah... But I can’t do anything about it, I can’t change that. It’s the culture.”*

Doctor: *“But over time all Moroccan women and men can stand up (in opstand komen) together.”*

Patient: *“I don’t know whether that would be possible. Yeah, my sister said, “Moroccan women they are all a bit...” yeah how do you say that...”*

Friend: *“Didn’t dare...”*

Patient: *“Yeah, even for people who were born here... it’s the same”*

Doctor: *“Yeah, I know a Moroccan woman who has, after we met, considered it and said, “Yeah, this is all bullshit [sic] And I will tell that to him [fiancé]. And if he reacted badly I will tell him that it’s [bleeding after first coitus] a myth.””*

As evident here, patients are seen by Dutch physician to have a significant role to play to deal with the root cause of requests for hymenoplasty and that it is the patients that should take action to initiate the change. Empowerment efforts Dutch doctors see them providing for the patients ultimately aim to not only change the patients for ‘the better’ but also to influence a change of perspective of other people of patients’ ancestry, particularly on the issue of the hymen and virginity.

### Shaping Future Generation

The extent of the patients’ ability to affect change, as perceived by Dutch physicians, does not stop there. Not only that the patients are encouraged by the doctors to influence other people who are currently in their life, they are expected to also influence those who will be in their life in the future: their unborn often yet to be conceived children. Dutch doctors aspire to make sure that the next generation of the patient’s ancestry would not buy into the same ‘false’ understanding of the issue of virginity and the hymen as their parents or grandparents. The patients are then casted in the role of educators for the future generation and inseparably, in the role of mothers. Patients are expected to educate their children, particularly their sons, to not only understand the ‘medically’ correct knowledge of virginity and the hymen, but also to

not have different sexual expectation for women and men.

Patient: *"I have to convince him [her fiancée] that I'm a virgin."*

Doctor: *"Is he [patient's fiancé] a virgin?"*

Patient: *"I don't think so. I really find that not so nice."*

Doctor: *"Well, you can raise your children differently."*

The same doctor remarks to a different patient, "In any case, you need to raise your children differently. Respect should not come from whether or not someone bleeds." When it comes to how Dutch physicians bring patients' future daughter into the picture, the conversation takes a slightly different tone. Patients are often asked by the physicians, "What will you tell your daughter?" or queried about how they will react if their daughter tell them that she is no longer a virgin. These questions are not only aimed to ensure that the 'medically correct' knowledge of the hymen and virginity reach the next generation of women, they are also meant to 'prevent' the patients themselves to be the future 'demander' even 'oppressor' of this next generation women.

### **Empowering Migrant Women**

The case of hymenoplasty consultations in the Netherlands come with the context of the patients being almost exclusively Dutch women of migrant ancestry. Women with migrant background in the Netherlands have increasingly been the focus of Dutch integration outlook, efforts and policies in the past 20 years. It is perceived by policy makers that the integration of people of migrant descent in the Netherlands are not complete until migrant women in the country have the same level of freedom enjoyed by their Dutch counterpart (Roggeband and Verloo 2007, Ghorashi 2010). The assertions of these policies are based on the idea that spouses and family of a migrant women are the main obstacles to the women's autonomy (van den Berg and Schinkel 2009, Schinkel 2011). This is the reason why the condition of migrant women is seen by policy makers to be the hallmark of whether or not the integration of people of migrant descent into Dutch society can be considered successful.

With this perspective, women of migrant ancestry are casted in the role of the victims who are passive, oppressed by men and are lack of skills to fully participate in Dutch society or to find solutions to their own problems (Lutz and Moors 1989, Spijkerboer 1994, Ghorashi 2010). Men of migrant background, particularly Muslim men, are perceived to be the oppressor, not only in the Netherlands, but generally across Europe (Ewing 2008, Razack 2004, Scheibelhofer 2012). People of migrant ancestry's ways of life, customs and culture, particularly those that are perceived to be patriarchal and championing conventional gender roles, are considered in national conversations to be incompatible with the 'Western' or European ideals (Adamson, Triadafilopoulos and Zolberg 2011, Stolcke 1999, Hollomey 2011). Women of migrant background,



especially their body, becomes the demarcation between liberation, which is European, and oppression, which is foreign (Razack 2004). In the Netherlands specifically, these women are seen by policy makers to be in need of help and empowerment to be as ‘fully emancipated’ as the Dutch ‘native’ women (Roggeband and Verloo 2007).

What is also worthy of note is that women of migrant background, particularly in the Netherlands, are often casted into a dual role: as a passive victim but also as the key to rectify the ‘oppression’ (Koffman, Saharso and Vacchelli 2013, Roggeband and Verloo 2007). This is particularly because women of migrant ancestry are considered to be future mothers who will be responsible of the education and upbringing of the next generation Dutch. These young people are in danger of also not acquiring the skills needed for participation in Dutch society as their elders (Joppke 2007). With the motto of ‘if you educate a woman, you educate a family’, mothers of migrant background are also seen by political parties in the Netherlands to be the person who will be able to instill the ‘right’ values and norms, including that of sexuality and gender equality, to their children (Prins and Saharso 2008, van den Berg and Duyvendak 2012).

How women are viewed and assisted in hymenoplasty consultations reflect very closely the wider context of migration in the Netherlands. These women are considered to be in need of help and should be empowered in order for them to not only be able to get out of their ‘oppression’ but also to be able to fully participate in Dutch society. Hence, it is not enough to inform them of the ‘medically correct’ knowledge of the hymen and virginity, they also need to be encouraged to pursue higher education and to have paid employment. Furthermore, women contemplating hymenoplasty, seen by Dutch physicians to be the future mothers of the next generation Dutch, are then expected to ‘educate’ their unborn children. This is in order for these young people to not continue to ‘believe’ a ‘mistaken’ view about the hymen and virginity. Surgery seeking women are also persuaded to not continue the ‘oppression’ on women of migrant ancestry by not expecting their daughters to stay a virgin before marriage.

## 7.6 Discussion—Shaping the Women Subject

Recognizing the dilemma their hymenoplasty patients are in due to the virginity expectation the patients anticipate to have to fulfill during the wedding night, Dutch doctors are compelled to provide help. The help the physicians are offering during consultations is perceived and framed by themselves in the rhetoric of empowerment. So passionate are Dutch doctors about empowering women through their hymenoplasty consultation, they disagree and debate each other on the best way to provide

this empowerment. Instead of evaluating whether or not the attempts of empowerment Dutch physicians claim to do in their hymenoplasty consultations are successful, it is more productive to interrogate what assumptions the doctors have about the patients, who are almost exclusively women of migrant ancestry. It is also important to look critically at the goals Dutch doctors have for the patients they are consulting. The discrepancy between the assumptions, stemming from an evaluation of the current condition of the patients, and the aspiration for the patients' immediate and future situation inform and shape each of Dutch physicians' efforts in empowering their patients. In turn, it is equally important to investigate what kind of women subject are shaped and reshaped through the assumptions and the resulting consultations (Sharma 2006).

A few things are apparent from the assumptions and the assistance, or what Dutch doctors also considered empowerment, in the case of hymenoplasty patients. When the patients first meet with the doctors and express their intention to undergo the operation, they are immediately, almost automatically, considered to be incompetent to make such decision. The patients are perceived by Dutch physicians to be unable to have the 'right' solution to the dilemmas at hand. This point of view is again parallel to Dutch policy makers' view of a woman of migrant ancestry in the Netherlands in which she is considered incapable to come up with her own solution to her 'problems' (Ghorashi 2010). What this means is that the only way for a woman of migrant ancestry to have a better situation is to be helped by others, in which in this case by Dutch physicians. This mindset is reminiscence of both Spivak's critic of 'white men saving brown women' (1988) and Abu-Lughod's challenge of views that see Muslim women to always need saving (2002).

To be precise, the patients are perceived by Dutch doctors to yet have the abilities to come up with her own solution. In order for them to gain these abilities, they need to be empowered. When they are considered more empowered, albeit simply by going through the consultations with the doctors, the patients are viewed by Dutch doctors to be more able to make a decision on what to do to deal with her problems. However, some Dutch physicians ultimately hope for the patients to make the 'right' decision: forgoing the surgery. When they do not and still desire the operation, some doctors are often left confused and at times disappointed. Even more telling is the doctors' decision when a patient who desires the operation seems to require it although she is not in any 'difficult' situation. As has been illustrated before, Dutch doctors are inclined to refuse this type of hymenoplasty request and have rejected patients of this nature in the past.

It can be discerned from the decision to reject hymenoplasty requests that the operation is seen by Dutch doctors to be acceptable to be performed if and only if it is

done in the context of potentially helping the patients. This decision has to be viewed in the context of, again, doctors avoiding what they consider an unnecessary compromise of the integrity of a healthy body through the act of incision. Hence, to take into account medicine code of ethics, the act can only be seen justified if it is done in the name of beneficence, a medical ideal that champions providing help for a patient in need (Beauchamp and Childress 2012). It is an important element to highlight that a request of hymenoplasty made without a condition of distress tends to be seen as unfounded and denied by Dutch physicians. This is where the logic of empowerment used by Dutch doctors during hymenoplasty consultation comes to its peculiar circle. The distress a hymenoplasty patient is experiencing is considered by Dutch physicians to signify a condition of ‘powerlessness’, therefore it is in need of addressing through the effort of ‘empowerment’. If after the ‘empowerment’, which takes the form of medical consultation, the patient still requires the operation, her request is granted, albeit with some bafflement on the side of the doctor. However, a hymenoplasty patient who is not in distress seems to still not seen by Dutch physicians as able, or at least justified, to make the decision to undergo the operation.

In short, the doctors’ assessment on whether or not a surgery is needful seems to be the determining factor to hymenoplasty to be performed on a patient. As the procedure itself is considered to be absent of medical necessity, Dutch physicians look to ‘social’ needs to ‘justify’ the surgery. The ‘social’ needs mostly take the form of the patient being in a difficult situation, having a possibility of experiencing unintended consequences if the operation is not performed or at least contemplated. Without this ‘social’ need, Dutch physicians see no just cause exists to move forward with the procedure. The patient’s wish to undergo the surgery, unaccompanied by distress, is considered by the doctors to be an insufficient ground to perform the operation. With this line of thinking, in the eye of the Dutch physicians, there is almost a formulaic dynamic between a doctor and a hymenoplasty patient in the Netherlands: the former to provide help, the latter to be helped; the former offers empowerment, the latter is in need to be empowered. Without this dynamic, surgery is seen to be superfluous and medical engagement between the two is terminated. Hence, it can be said that the Dutch doctors themselves pick and choose which woman can then be a patient or a candidate for hymenoplasty. By choosing only women who are in distress to be patients, Dutch doctors firmly cast women in the context of hymenoplasty in the position of inferiority. Ultimately, the ‘empowerment’ effort provided by Dutch doctors to their hymenoplasty patients can be argued to be more driven by the physicians’ need to empower rather than the patients’ need to be empowered.

What might be ironic is that the empowerment provided to the patients are meant for them to be able to ‘help’ themselves out of the difficult condition they are

currently in. Hymenoplasty seeking women are seen, at least by the physicians, to be self-responsible to alter her life situation that is causing them problems. The extent of the help provided by the doctors, accordingly the limit of empowerment effort and the physicians' responsibility, stops as the patient exits the medical establishment. Dutch physicians understandably have a limited engagement with the patients. Due to the high need for secrecy, doctors' exchanges with the patients are constrained both spatially as well as socially. It is not possible for the doctors, often specifically per request of the patients themselves, to engage with people in patients' life. Surgery seeking women are then addressed by Dutch doctors as both messengers and 'fixers'. They are expected to relay the knowledge received during consultation to others and in doing so, 'fix' the social situation that leads to them desiring hymenoplasty in the first place.

Two things are discernable at this point. Firstly, surgery seeking women are seen by Dutch doctors to be able to help themselves after, and I will argue only after, they are helped and empowered by the physicians. In this context, women are not perceived to be capable to decide how they are to address their own situation, particularly the first time they meet with the doctor. Women's ability to choose to undergo a surgery is dismissed, either temporarily for those who are in distressed or permanently for those who 'simply' want one. Whether the desire for the operation is deemed by the physicians to have come from the position of lack of knowledge or lack of power or something else, it is clear that there is something perceived insufficient in a woman who contemplates hymenoplasty to then be 'allowed' to make that choice.

The perceived insufficiency could also potentially be informed by Dutch physicians' assessment of the sociocultural situations of the surgery seeking women. Hymenoplasty patients are seen by Dutch doctors to suffer from unequal gender expectations, particularly in terms of virginity and pre-marital explorations of sexual intimacy, from the people of their immediate social circle. Through their direct and indirect demand of the patients regarding the maintenance of chastity, patients' in-laws, mothers and particularly the men the patients are marrying are understood by Dutch doctors to be the source of patients' problems. Doctors I talked to never used the terms 'oppressed' when talking to me about their patients, however physicians' way of framing the fundamental reason why women were contemplating the surgery alluded to such understanding. In the reasoning of Dutch physicians, it was the situation the patients were in that caused them to be unempowered.

Secondly, surgery seeking women are considered by the doctors to ultimately bear the responsibility to change the situation she is in. Aiming for a change to take place is reminiscent of feminist theory that views empowerment as a process and as praxis (Carr 2003, Abu Lughod 2002, East 2000, Gutierrez 1990). This idea of positive change is commonly linked to the notion of consciousness raising in which the efforts

to empower need to also enable women to be aware of the (political) dimension of their struggle (Freire 1970, Alcoff 1994, Carr 2003). The double process of reflection and action allows women to see their position in the wider context of social and political life which in turn will make it possible for them to move towards other options, positions and alternatives in their personal lives (Carr 2003, GlenMaye 1998).

Dutch doctors' effort to 'enlighten' women of 'medically correct' knowledge of the hymen and virginity can be framed in the context of consciousness raising where women are provided an alternative view of the (absent of) link between the membrane and a woman's chastity. Demands put on the patients by people in their social circle to 'demonstrate' their virginity during the wedding night is closely related to the understanding that sexual purity and an 'intact' hymen are connected. What Dutch doctors expect to accomplish is that breaking the linkages between the two allows women to entertain alternative course of action to surgery to produce blood stained bed sheet. Blood stained bed sheet is a mark that is still considered as proof that the hymen of the newly wedded bride is 'intact' before penile penetration with the husband, signifying her a virgin (Ayuandini 2017b). The physicians then further hope that the patient will choose to resort to one of the alternatives and, in the process of doing so, take the first step to finally take matters into their own hand. Dutch physicians see deciding to prick their finger or using a vial of blood to create blood stained bedsheet signifies the patients being courageous and in control of their fate. This is in contrast to wanting the surgery because undergoing the operation is not only seen as a passive 'solution', it is also perceived, as has been mentioned before, to come from a position of ignorance and powerlessness.

Consciousness raising Dutch doctors attempted to do might be minimum and mostly confined to providing 'medically correct' information about the hymen and virginity, but it is done with a logic to trigger action through instilling bravery. What is important to underscore here is that with this kind of point of view, Dutch doctors not only inculcate courage, but they also advocate responsibility to their patients to do something about the situation they are in. After being 'empowered' surgery seeking women are casted to be self-responsible to deal with the problems they are facing even to the extent of making sure it ceases to exist. This view of responsibility is close to the notion of a neoliberal subject where one is responsible of one's situation regardless of the constraints one are faced with (Walkerdine, Melody & Lucey 2001). A neoliberal subject is built on an emphasis of the individual; one who understands oneself fully and in control of one's fate (Davies et. al. 2006). This individual is perceived to be calculative, rational and capable of self-regulation (Gill 2008).

A neoliberal subject is often seen by scholars to be in par with a postfeminist one whose championing of sexual freedom seems to be unattached to its circumstantial

expression, neglecting political and historical context of the action, relegating diversity to the background (Butler 2004, Scott 2007, McRobbie 2009). This view of a responsible sexually free woman is closely reminiscent to those advocated by Dutch physicians during hymenoplasty consultation. Empowerment provided by Dutch doctors is absent of consideration of the wider Dutch political situation, particularly that which is related to people of migrant ancestry and their offspring. The empowerment efforts are also missing a critical reflection of the doctors' own position both as the authority and medical experts as well as outsiders to the experience of the surgery seeking women. Dutch physicians' attempts to empower are in direct contrast to Freire's notion of pedagogy of the oppressed (1970). The case of hymenoplasty does not see empowerment that is initiated by those aspire to emancipate themselves. It is started by the physicians with a top down approach. This dictation of change by outsiders, according to Freire (1970), is counterproductive to the process.

Cruikshank cautions the importance to acknowledge that the process of empowerment is inherently imbalanced in which "[d]espite the good, even radical, intentions of those who seek to empower others, relations of empowerment are in fact relations of power in and of themselves (1999: 70). Cruikshank further emphasizes that accordingly, empowerment is always (1) a relationship established by expertise, (2) it is typically initiated by the one seeks to empower, (3) depends on the [lack of] knowledge of those to be empowered and (4) a relationship [that] is simultaneously voluntary and coercive (1999: 72). In the context of negligence of this reflection and understanding of empowerment, engagement between doctors and patients as well as advices provided was made under the "illusion of equality" (Pease 2002: 138). This illusion maintains the hierarchy of power between the two and brings up question whether the urge to empower eclipses the potential of physicians to help patients to decide the best way to empower themselves (Bransford & Bakken 2002, Simon 1994). Empowerment in this case is provided within the patriarchal framework and sustains the place of patients in the position of inferiority (Longwe 1998).

What is also important to emphasize here is that surgery seeking women are considered by Dutch physicians to be responsible actors in dealing with their own problematic situation, simultaneously being casted as victims of problems but also as solvers of such problems. They are also encouraged to be cognizant of their role in the life of the next generation Dutch. Again, in this regard, hymenoplasty patients are perceived by Dutch doctors to play a dual role: that of an educator and another of a potential oppressor. Patients, who are virtually exclusively of migrant descent, are considered by the doctors to have the capability to sustain or halt the continuity of regrettable customary traditions of their ancestry, particularly that which demands women to 'showcase' their virginity in the time of marriage. In this context, the phy-

sicians can be seen to attempt to save women from themselves; preventing future Dutch women to experience similar dilemma of their parents but also stopping surgery seeking women themselves from turning into the source of the problems. Here, we are reminded of scholars' critiques of tension between 'protecting' women and simultaneously 'policing' them (Pliley 2014, Odem 2000, Wynn and Trussell 2006).

## 7.7 Conclusion

Patients who come in to meet with the doctors to contemplate hymenoplasty in the Netherlands are commonly seeking the surgery with a certain amount of concern. If the fact that they are no longer sexually untouched is found out by people in their social circle, they worry that they will face unintended consequences ranging from ostracization to physical harm (Ayuandini 2017a, Eich 2010, Amy 2008). Hymenoplasty is the patients' way to avoid such consequences; their solution to the problem at hand. Dutch physicians consider this choice of solution to be problematic. They see the surgery to be medically necessary, hence the act of incising a healthy body becomes superfluous. More importantly, they consider the desire for the operation to come from a position of deficiency, in which if 'fixed' will result in the women no longer coveting the surgery. Dutch doctors reason that women are still contemplating hymenoplasty due to two lacks: (1) lack of the 'right' knowledge about virginity and the hymen and (2) lack of social ability to avoid possible unintended consequences.

To address the first lack, Dutch physicians use their consultation time to inform the patients of the 'medically correct' knowledge about virginity and the hymen. The knowledge includes, chiefly among others, how sexual history of a woman cannot be definitively discerned from the condition of her hymen, that the first coitus with a virgin does not always result in her bleeding and that the perceived 'tightness' of the vaginal opening of a virgin is due to muscles contraction rather than an intact' hymen. The imparting of information is mostly done verbally but strengthened with exercises including contracting pelvic musculatures and using a mirror to observe one own's vaginal canal. To address the second, Dutch doctors promote characteristics they believe if possessed by the patients will give them greater possibility for emancipation from people who have been 'oppressing' them. These includes, among others, working towards a high degree in formal education, having paid employment and having autonomy in one's life. Patients are also encouraged to talk to people who they consider to be the 'demander' of chastity requirement in order to change the other person's point of view of the demand.

In the effort to empower, it is important to underscore that for some Dutch doc-

tors, successful consultations are those where patients ultimately decide against the surgery. This is due to their point of view that hymenoplasty is medically needless and the desire for it comes from misrecognition of issues surrounding female virginity. The focus on avoiding surgery is also apparent in their refusal to patients who require it without seemingly being under difficult social situation. Sans social dilemma experienced by the patients, Dutch physicians lose their justification to take on a hymenoplasty case. This highlights how empowerment provided during consultation to be mostly motivated by the doctors' urge to help rather than the patients' need to be assisted in a particular way.

Empowerment efforts provided in the context of hymenoplasty consultations by Dutch physicians also demonstrate how surgery seeking women are evaluated not only of their present but of their potential future. In the context of future generation Dutch, surgery seeking women are seen by Dutch doctors to be future mothers, capable to either 'help' or 'hinder' their children. Simultaneously seen as prospective educators and likely oppressors, patients are encouraged to be the former and prevented to become the latter. In the context of patients' own immediate future, they are encouraged by the physicians to pass along their newly acquired 'medically correct' knowledge of virginity and the hymen to others in their social circle. Once empowered, patients are casted to be self-responsible to 'fix' their own problems and to even initiate a complete overhaul of customary view of virginity among people of her ancestry. Ultimately, empowerment provided to surgery seeking women in the case of hymenoplasty consultations in the Netherlands are shaped by physicians' perceptions of the patients. These perceptions are inextricable from the doctors' locally informed point of view of the 'plight' of a migrant woman in which her heritage presents the source of the problems and she needs to be helped to be able to help herself. This neoliberal postfeminist perspective on empowerment neglects the political context of the position of women of migrant descent in Dutch society, relegates the diversity of women's experience to the background, neglects physician's needed reflection of own's position of power and executes empowerment in a sustained patriarchal context.

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## **CHAPTER VIII:**

# SUMMARY AND CONCLUSIONS

## **8.1 Identity Markers in an Institutional Context – Conclusions and Summaries of Articles**

Hymenoplasty is still to date a highly controversial surgery. The secretive nature of the procedure in order to protect the anonymity of the patients presents a challenging access for social scientists to study the operation as a social phenomenon. Studies and research about hymenoplasty continue to be low in quantity although recently it has been experiencing a notable increase. The expansion of the scholarship however consistently focuses on two matters: (1) the widely argued oppression of women permeated in patients' sociocultural background and (2) medical professionals' ethical dilemma in service provision (Ahmadi 2015, Christianson and Eriksson 2014, Christianson and Eriksson 2015, Cinthio 2015, de Lora 2015, Earp 2015, Juth and Lynoe 2014, Kaivanara 2016, Loeber 2014, Saraiya 2015, Steinmüller and Tan 2015, Wild et. al 2015). A significant number of the literature on hymenoplasty have been contributed by medical professionals, written through medical lens (Raveenthiran 2009, Goodman 2011, van Moorst et al. 2012, Loeber 2014, Helgesson and Lynoe 2008, Bravender, Emans, and Laufer 1999, Christianson and Eriksson 2014, Christianson and Eriksson 2015, Logmans et. al. 1998, Ou et. al. 2008). Ethnographical explorations of the phenomenon allow a more nuanced understanding than these previous studies as it goes beyond looking at what is seemingly obvious. This study aspires to do just that. What this dissertation brings anew to the discussion and the scholarship is an exploration

of the phenomenon that is mindful of the contextual set up and not only the actors involved. Hymenoplasty seeking women and consulting physicians do not operate in a vacuum but rather in a context of medical setting where repertoires, norms and institutional logics influence the interactions between doctors and patients. During consultations, treatment and treatment outcomes are shaped and mediated through negotiations and deliberations of various sociocultural aspects where medical decision making goes beyond strict clinical considerations.

Hymenoplasty stands in the intersection of unbalanced sexual expectations between men and women, mobility across states and borders as well as normative and performative understanding of sexual purity which culminates in assistance seeking behavior in a clinical setting. These interconnecting issues of gender, religion and migration come into conflict as Dutch women of migrant ancestry attempt to maintain an appearance of virginity by soliciting service from medical institutions in the Netherlands. What we see in the context of hymenoplasty consultation is the highlighting of different identity markers, including religion, gender and migration status. These identity markers are brought forward through different contentious social issues during exchanges between patients of migrant ancestry and physicians of Dutch upbringing. The role of medical consultation as the context is crucial and fundamental in this case. It is through this institutional process differences are not only brought into the conversation, but it also becomes almost a necessity to address them. Medical consultation, particularly in this study, is a medium for physicians to learn more of their patients: the problem they want to solve, the goal they want to achieve and the reasons behind both. In the context of hymenoplasty in the Netherlands, regardless of their eventual aim, the immediate intention of the patients is to undergo a controversial operation. The need for the procedure is seen both by themselves and by the physicians to be questionable and controversial.

There are almost default differences between surgery seeking women and hymenoplasty service providers, not only in identity markers but also in the general understanding of virginity and the hymen. These differences become possible sources of explanations to why such a controversial surgery could be desired by the former while generally rejected in necessity by the latter. Again, this is where studying hymenoplasty by being mindful of the medical institutions as its context becomes fruitful. The 'logic' of medical institutions, where doctors are essentially gatekeepers to the specific form of help patients are seeking, facilitates the underscoring of differences in the process. In simple terms, patients have to present a case why it makes sense for them to want and 'be allowed' to have the surgery. Since the surgery in this case is commonly considered by physicians to be unnecessary, it is only to appeal to differences of circumstances between them and the doctors that patients have the room to plea necessity.

Hymenoplasty consultations mostly begin with patients having to bring forth their unique identity markers as ways of justifying their intention. Exchanges between patients and physicians continue with the entire process inevitably revolving around addressing these differences. Through and during the consultations, we observe how identity markers determine the way interactions between doctors and patients develop. Patients' gender becomes the reason of the need for them to be empowered. Patients' migration history are the fundamental reasons for their unfortunate situation and therefore to be amended. Patients' religion is to be defended and dissociated from the unfortunate medical procedure. Hence, as an answer to the overarching question of this dissertation, differences between doctors and patients, including gender, religion and migration history, are not only brought to light during hymenoplasty consultations in medical institution, but they are also specifically addressed and treated as integral aspects of both patients' motivation for the operation as well as the cornerstones of their problems in which when addressed will lead to the patients' 'salvation'.

Each of the articles that comprises the chapters to this dissertation deals with a singular aspect of interactions between doctors and patients in a clinical setting. Every article focuses either on a particular identity marker of the patient or a unique aspect of hymenoplasty consultations in the Netherlands. In the first article, I explore how the lack of formal recognition of hymenoplasty as well as the scarcity of public information about the operation affect consultations' result. I trace how the two conditions lead to differences of approach of hymenoplasty consultations in two medical establishments in the Netherlands. The first one is a public hospital and the other is a private clinic. Hymenoplasty costs a mere 10% of the price at the clinic than at the hospital. The lead doctors in both establishment aspire to provide help to surgery seeking women. In the clinic, this help also translates to a low cost of the operation. Despite having the same motivation to help, the lead doctor in each establishment has a contrasting approach to hymenoplasty consultation. The approach employed is closely related to the philosophy of care of the lead consulting physician, particularly their point of views of the surgery itself. The doctors conflicting point of views of hymenoplasty culminate in a contrast of surgical rate between the two establishments: the clinic performs hymenoplasty twice more often than the hospital. Ultimately, in the absence of systematic structural acknowledgement of hymenoplasty, patients' treatment and treatment outcome are fully dependent on the service providers, particularly the consulting doctors' philosophy of the surgery.

The second article examines how religion as an identity marker is highlighted and addressed in the context of hymenoplasty consultations. With 80% patients coming from Islamic background and many self-proclaiming as practicing Muslims, whether

religion has a role in the patients' desire for the operation punctuates conversations between doctors and patients. In the case of hymenoplasty, two realizations on the part of the patients are significant when it comes to how religion enters the picture: (1) patients consider the operation as necessary but the desire for it to be ultimately regrettable and (2) patients anticipate that the unfortunate wish might be connected with their highly valued and revered belief. Consequently, hymenoplasty patients create an artificial divide between religion and culture in order to be able to 'blame' the latter for their surgical intention and distance the former from it. In the context of hymenoplasty consultations, surgery seeking women make active and conscious efforts to argue against the possible correlation between their religion and their desire for hymenoplasty.

In the third article, I look at whether Dutch doctors' point of view that hymenoplasty has no medical necessity influences their recommendations to patients. As a way of exploration, I examine Dutch doctors' attempt to demedicalize the notion of the 'broken' hymen. To achieve this, the physicians' efforts are of two prongs: by decoupling medical definition from the understanding of the broken hymen and by offering alternative course of actions to patients contemplating hymenoplasty. The first half of the demedicalization effort is mainly attempted by Dutch physicians by imparting medical understanding of the hymen and its (absence of) correlation to virginity. But what is truly unique in the case hymenoplasty consultations in the Netherlands comes from doctors' address of the second half of the effort of demedicalization: the offering of alternative solutions to patients' problems. These alternatives are the medicalized version of cultural practices originating from the ancestral lands of hymenoplasty patients in the Netherlands. Hence, in their conviction that hymenoplasty has no medical basis, Dutch doctors effectively resort to medicalization—of 'cultural' means—in order to demedicalize the notion of the 'broken' hymen.

In the fourth article, I explore how patients' common background of having migrant ancestry is addressed and highlighted during hymenoplasty consultations. Patients' foreign ancestry is often perceived by Dutch doctors to be closely related to the social situations that lead them to contemplate undergoing hymenoplasty. Simultaneously, since the origin of the desire for hymenoplasty is considered to be ultimately foreign, Dutch physicians also perceive the situations and therefore the motivations to undergo the surgery be "not Dutch". Hence, physicians consulting hymenoplasty in the Netherlands encourage 'Dutchness' as a way for a patient to distant herself from the desire and the situation that will her to undergo the operation. In the eyes of Dutch doctors, the more Dutch a woman is, the less likely she will consider hymenoplasty. Ultimately, hymenoplasty patients in this study, whose background are exclusively of migrant ancestry, are encouraged by Dutch doctors during hymenoplasty consulta-

tions to become more and more ‘Dutch’ as part of the solutions to their problems.

The fifth article can be seen as a companion to that of the fourth as it addresses similar issue but from a needed angle of women empowerment. Here, I look at how the fact that all patients are women play into the way hymenoplasty consultations are conducted. Coming from the view that women who desire hymenoplasty do so because they come from the position of lack, both in terms of knowledge as well as social capitals, Dutch doctors aspire to remedy these deficiencies. How empowerment is done in the context of hymenoplasty consultations cannot be divorced from how surgery seeking women are viewed by the doctors. Patients are simultaneously perceived by Dutch physicians as victims and potential heroes who can change the perceived cycle of women oppression. They are also seen by the physicians as potential mothers who can either act as the ‘freer’ of the next generation Dutch or their ‘oppressor’. Ultimately, what I illustrate in this article is how women as hymenoplasty patients are assigned roles and shaped into different kind of subjects through Dutch doctors’ empowerment effort.

## 8.2 Looking Ahead – Possible Future Research

This dissertation project sets a necessary trajectory for future publications and explorations alike. The writing of this particular manuscript has been intentionally designed to focus on the specifics of the clinical setting of hymenoplasty consultations. As the last chapter on women empowerment has provided a glimpse of, there remains highly rich collections of findings for the basis of future writings. This is specifically true about data that deal with surgery seeking women’s perspectives and experiences in their quest for hymenoplasty. Complementary findings gathered through interviews and conversations with young and older women of migrant ancestry, similar to that of hymenoplasty patients, in the Netherlands is also largely untapped and ready to be turned into publications. Being mindful of the complexities of women’s narratives, whether seeking hymenoplasty or not, it is only just to aim for a book format to showcase the depth and breadth of the stories which will arguably be lost in the form of articles of which this dissertation is based.

Looking ahead for future studies as follow up, there are three necessary trajectories to continue the explorations which stem from asking the following questions: (1) which angle is yet to be fully explored in this hymenoplasty study? (2) what different context can this study be relevant to be extended? And (3) is there a wider societal context in which this study can examine? The answer to the first question is quite straightforward. As this particular study focuses itself on the interactions between doctors

and patients and also on experiences and point of views of women about hymenoplasty, there are less investigations on men's perspective of the procedure or of the issue of virginity in general. Data collection did include engagements with young men to get a glimpse of their opinions on the matter. Yet, a more focused exploration on this front will provide a productive and useful (possible) counternarratives to that of the women's. Many surgery seeking women allude to the men in their life, particularly their boyfriend or fiancé, to be a significant driving factor in their search for hymenoplasty. From the findings gathered hitherto, men are aware of the procedure. They are however convinced that their significant others—their wives, their girlfriends or their intended—will never entertain hymenoplasty. Equally intriguing, men who have been leading promiscuous life but aspire to repent at a certain point in their life turn to women as their 'ultimate salvation'. Yearning to start anew, men wish to be with women they consider 'pure' when entering marital life. These singular ways of looking at the desire of premarital virginity, which stand in potential contrast to the women's, are necessary counterparts to complete the picture of hymenoplasty as a controversial sociocultural as well as medical phenomenon.

When looking at the context of this hymenoplasty study, the fact that it was done in the Netherlands becomes a significant backdrop that colors the dynamic between doctors and patients. It also shapes the unique findings of this research. Doctors' view that the operation is medically unnecessary and that the desire for the surgery is a regrettable wish influenced by sociocultural background of the patients might be proven to be unique to the context of the Netherlands. It will be productive to see whether similar perceptions are held by physicians practicing in other geographical context where doctors are also largely of different sociocultural upbringing than their hymenoplasty patients. It will therefore be an equally important and productive exploration to conduct comparable study in a contrasting context where doctors might not fundamentally disagree with patients' initial assessment of their virginity situation. Anecdotal evidences from this study have pointed to doctors in different places outside of the Netherlands who might be and are often consulted for their 'ability to tell' whether or not a woman is a virgin through the appearance of her hymen. In this setting, it might not be impossible that doctors are able and comfortable to provide medical assessment and biological framework to the loss of virginity and its connection to the condition of the hymen; a correlation of which Dutch physicians mostly oppose. Furthermore, in consulting and performing hymenoplasty, Dutch doctor's frame their engagement with patients in the understanding of empowerment. They aspire to provide help not only in a strictly medical sense but also in the context of social dilemma the surgery seeking women are facing. Doctors' motivation in consulting hymenoplasty might be different from one context to the next, not impossibly financial

factor becoming a priority in certain cases. Due to the lack of standards in hymenoplasty surgery and consultation, physicians' rationale becomes an integral aspect to how engagements with patients are then conducted. It will therefore be a worthwhile exploration to conduct a study in places where doctors' drives in consulting hymenoplasty are potentially less altruistic.

The ethnographic explorations of hymenoplasty in the Netherlands come in the context where women of migrant ancestry are faced with specific sociocultural expectations which they hope to resolve through resorting to the services provided in Dutch medical establishments. Challenges and negotiations they encounter when dealing with Dutch medical professionals explored in this study might be unique to that of a search for hymenoplasty. However, there exists an important underlying phenomenon in this situation in need for further systematic examinations: people of migrant ancestry's quest for health care and medical treatment, particularly in a 'western' context but also in any migration receiving area. What will be important to explore includes, but not limited to, conceptions of illness and suffering as well as their resolution which might differ between doctors and patients, challenges specific to those who are not natural born citizen of the land in their quest for medical treatment as well as potential exclusions and blind spots in healthcare particularly in relation to people of migrant background and their children or children of children.

### **8.3 Extending the Scholarship – Final Thoughts**

What this study has presented is a unique ethnographic analysis on hymenoplasty based on never before gained access to hymenoplasty consultations totaling to 70 appointments. It is also an examination of underexplored topics surrounding the surgery; particularly those that focus on the context of the medical setting itself rather than strictly the dilemma of women in maintaining an appearance of virginity. In so doing, this dissertation has highlighted how actors in medical establishments, predominantly physicians and patients, grapple and address the sociocultural aspects of a procedure that is equally controversial among medical professionals and the general public alike. This study hopes to bring attention to other potential comparable medical treatments where considerations during medical appointments are not only strictly about patients' medical complaints but also about pertinent wider sociocultural issues surrounding the treatment seeking behavior. What this study has also presented is an investigation surrounding a surgery that is desired not only because of what it can provide for the physical body but also sought after due to its potential in addressing psychological distress. Arguably more importantly, it is also requested for

its believed capacity to remove social dilemmas faced by patients contemplating it. The findings and the analysis provided here are therefore relevant to other studies focusing on medical procedures that also addresses multiple axis of patients' problems.

The significance of sociocultural elements explored during any specific medical consultations become particularly salient when physicians and doctors generally come from different sociocultural background. This is specifically true when their differing background shape the (contrasting) ways they look at the drive behind the medical appointment, including if there is a valid reason to seek treatment and whether or not the desired resolution is acceptable. With this backdrop, observing medical consultations are not only useful to look at how different aspects of sociocultural life are dealt with but also to examine which ones come into conflict with the act of seeking help in a medical context. Particularly when the sociocultural backgrounds between physicians and patients are generally dissimilar, paying attention to how the diversities of upbringing might 'seep into' medical conversations are only a natural direction of observations for studies focusing on doctor-patient interaction with this nature. However, this study calls for extending the explorations to also examine whether there exist methods informed by cultural practices that are then adopted into medical recommendations. In the case of hymenoplasty, cultural 'tricks' are embraced and appropriated into medical solutions of the problems at hand. Investigations of other similar decisions made by medical professionals will only enrich the scholarship of medical anthropology as a whole and medicalization/demmedicalization specifically.

Consequently, this research has also widened the examinations of the extent of medical authority. This study wishes to emphasize an exploration of the nature of medical authority that is not only critical of its extension but is also aware of its reduction. This study analyses how authority expands, particularly by doctors incorporating cultural solutions as medical treatments. It also looks at how medical authority contracts, specifically through physicians denouncing the connection between a 'broken' hymen and loss of virginity. In the same line of thoughts, this research on hymenoplasty in the Netherlands seeks to put a spotlight on other similar medical procedures where standardization of practice is largely nonexistent. This will bring attention to how patients' treatments might heavily contingent upon the consulting doctor. As a whole, this study aims to be relevant to scholars focusing on the clinical setting, especially those dealing with controversial treatment. It also wishes to be useful to practitioners, including physicians, nurses and social workers alike. Particularly, this study hopes to be significant to those interacting with patients whose sociocultural background is different from them or whose medical problems cannot be separated from the social aspects of their daily lives.



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# DISSERTATION SUMMARY

## **Variability of Hymenoplasty Recommendations**

Essentially a writing about the setting of the research, this article outlines the practice of hymenoplasty in the two medical establishments, a hospital and a clinic, where I conducted my study. It can be seen as a comparative article in which I liken and contrast how hymenoplasty procedures are set up and followed through in each establishment. Specifically, I explore how the lack of formal recognition of hymenoplasty as well as the scarcity of public information about the operation affect consultations' result. I trace how the two conditions lead to differences of approach of hymenoplasty consultations in two medical establishments in the Netherlands. The first one is a public hospital and the other is a private clinic. Hymenoplasty costs a mere 10% of the price at the clinic than at the hospital. The lead doctors in both establishment aspire to provide help to surgery seeking women. In the clinic, this help also translates to a low cost of the operation.

Despite having the same motivation to help, the lead doctor in each establishment has a contrasting approach to hymenoplasty consultation. The approach employed is closely related to the philosophy of care of the lead consulting physician, particularly their point of views of the surgery itself. The doctors conflicting point of views of hymenoplasty culminate in a contrast of surgical rate between the two establishments: the clinic performs hymenoplasty twice more often than the hospital. Ultimately, in the absence of systematic structural acknowledgement of hymenoplasty, patients' treatment and treatment outcome are fully dependent on the service providers, particularly the consulting doctors' philosophy of the surgery.

## **Religion and Hymenoplasty**

The second article deals with one commonality majority of hymenoplasty patients share: about 80% of women contemplating the operation comes from Islamic background or profess to being a Muslim on some degree or another. This article takes a look at how this commonality enters discussions in hymenoplasty consultations particularly through the rhetoric of religion by the patients. The exploration in this article was inspired by a curiosity in finding out whether patients and physicians make connection between this commonality of religious belief with the desire to undergo the surgery. This interest is particularly pertinent given hymenoplasty is considered by medical professionals to have no medical indications. In short, the article asks: is the quest for hymenoplasty influenced by certain religious conviction?

In the case of hymenoplasty, two realizations on the part of the patients are significant when it comes to how religion enters the picture: (1) patients consider the operation as necessary but the desire for it to be ultimately regrettable and (2) patients anticipate that the unfortunate wish might be connected with their highly valued and revered belief. Consequently, patients take an active stance in distancing religion, in this case Islam, from their desire for the operation. Considering the need for the procedure to be regrettable, patients wish for Islam to not be associated with hymenoplasty. However, at the same time, they seem to recognize the need to explain, if not justify, their presence in doctor's appointment room. As a result, hymenoplasty patients create an artificial divide between religion and culture in order to be able to 'blame' the latter for their surgical intention and distance the former from it. In the context of hymenoplasty consultations, surgery seeking women make active and conscious efforts to argue against the possible correlation between their religion and their desire for hymenoplasty.

## **Demedicalization of the 'Broken Hymen'**

The third article stemmed from my observation of Dutch doctors' reluctance in performing hymenoplasty. Dutch physicians view hymenoplasty as a procedure with no medical necessity. With this as the context, I explored what physicians decided to do given their personal and professional convictions about hymenoplasty and whether such convictions influence their recommendations to patients. I found that despite viewing hymenoplasty as an unnecessary surgery, even on occasions referring to it as nonsensical, Dutch doctors are compelled to provide help for patients contemplating the operation. This urge comes from understanding that patients could potentially face unintended repercussions if found to be a non-virgin at the time of marriage. However, at the same time Dutch physicians still regret that desire for the operation exist. The optimum solution to this juxtaposition for Dutch doctors is to ensure that

the patients will not come to harm in the wedding night while at the same time persuading them that the surgery is not needed.

As a way of framing an academic exploration of this topic, I examine Dutch doctors' attempt in the context of demedicalization. Specifically, I look at how Dutch physicians demedicalize the notion of the 'broken' hymen. To achieve this, the physicians' efforts are of two prongs: by decoupling medical definition from the understanding of the broken hymen and by offering alternative course of actions to patients contemplating hymenoplasty. The first half of the demedicalization effort is mainly attempted by Dutch physicians by imparting medical understanding of the hymen and its (absence of) correlation to virginity. But what is truly unique in the case hymenoplasty consultations in the Netherlands comes from doctors' address of the second half of the effort of demedicalization: the offering of alternative solutions to patients' problems. These alternatives are the medicalized version of cultural practices originating from the ancestral lands of hymenoplasty patients in the Netherlands. Hence, in their conviction that hymenoplasty has no medical basis, Dutch doctors effectively resort to medicalization—of 'cultural' means—in order to demedicalize the notion of the 'broken' hymen.

### **Enacting Dutchness in Hymenoplasty Consultation**

In the fourth article, which I co-authored with Jan Willem Duyvendak, I explore how patients' common background of having migrant ancestry is addressed and highlighted during hymenoplasty consultations. Patients' foreign ancestry is often perceived by Dutch doctors to be closely related to the social situations that lead them to contemplate undergoing hymenoplasty. Simultaneously, since the origin of the desire for hymenoplasty is considered to be ultimately foreign, Dutch physicians also perceive the situations and therefore the motivations to undergo the surgery as "not Dutch". Hence, physicians consulting hymenoplasty in the Netherlands encourage 'Dutchness' as a way for a patient to distant herself from the desire and the situation that will her to undergo the operation. In the eyes of Dutch doctors, the more Dutch a woman is, the less likely she will consider hymenoplasty. Ultimately, hymenoplasty patients in this study, whose background are exclusively of migrant ancestry, are encouraged by Dutch doctors during hymenoplasty consultations to become more and more 'Dutch' as part of the solutions to their problems.

The fourth article highlights how people of migrant descent in the Netherlands are consistently seen to always be connected to their ancestral country, despite being born and raised in the Netherlands. Hence, a Dutch person with foreign ancestry can potentially be seen to always have a degree of non-Dutchness in them. At the same time, the person can also be seen to have or demonstrate some level of Dutchness,

making them simultaneously Dutch and non-Dutch. In the case of hymenoplasty, a patient who is seen by physicians to desire the operation due to their non-Dutchness, are interestingly perceived by her family to resort to the procedure particularly because she is somewhat Dutch. Dutchness becomes a state of flux in which a person with migrant ancestry can be seen by others to aspire to be more and more Dutch.

### **Women Empowerment and Hymenoplasty**

The fifth article can be seen as a companion to that of the fourth as it addresses similar issue but from a needed angle of women empowerment. Here, I look at how Dutch doctors, coming from the understanding that the patients they are seeing are in need of help, provide assistance to surgery seeking women and frame the help in the claim to empower them. The empowerment efforts Dutch doctors offer their patients are very much informed by the kind of 'deficiency' they consider their patients to be in. These deficiencies boil down to two main aspects: (1) patients' perceived lack of knowledge about the hymen and virginity and (2) patients' deemed inability to rectify her dilemmatic social situation. To overcome the first 'deficiency', some Dutch doctors treat their time meeting with patients as an education session. They enlighten patients with 'medically correct' knowledge of the hymen and virginity. As explored in the first article on variability as well as in the third article on demedicalization, some Dutch physicians are convinced that the 'right' knowledge of issue at hand will persuade patients to decide against the surgery. In this context, the aim of the empowerment is for patients to choose not to undergo hymenoplasty at the end. To deal with the second 'lack', Dutch doctors encourage the patients to 'talk', particularly to their betrothed and family. 'Talking' is seen by the physicians as a way to convince the people who might be causing the dilemma for the patients to understand the situation and lax their demand. Notably, it is the responsibility of the patients to convince their family to change their mind.

This article also looks at how the empowerment afforded by Dutch doctors to the patients aim to change more than just the immediate situation of the patients. The empowerment efforts are done in the hope to alter the customary practice of people of patients' ancestry in expecting women to stay virgin before marriage. The empowerment is also targeted for the future as patients are perceived by the physicians to be potential mothers who would be able to amend the situation, educate and make things 'better' for the next generation Dutch. This dual role of women as 'victims' but also as the 'solution' of 'problems' are reflective in the wider debate on migration in the Netherlands. However, in the case of hymenoplasty, the roles of women of migrant ancestry are not only perceived, at least by the physicians, to end there. Women are also seen to be potential future 'oppressor' for the next generation Dutch women as

they might in turn demand their daughter to also keep their virginity before marriage. Ultimately, by interrogating the assumptions the doctors have in providing help and by examining the kind of empowerment they offer and by looking at what roles are casted for surgery seeking women, this article looks at what kind of women subject that are reproduced through the consultation with the doctors on hymenoplasty.